

# CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS

## Policy Session Worksheet

**Presentation Date:** Nov 8, 2016 **Approx Start Time:** 10:30 **Approx Length:** 30 min

**Presentation Title:** Benefit Renewals Update

**Department:** Employee Services

**Presenters:** Evelyn Minor-Lawrence, DES Director

**Other Invitees:** Kristi Durham, Benefits Manager & Julia Getchell, Asst. DES Director

### **WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?**

This is primarily an informational update about benefit renewals. During the presentation, the Board will be asked for their preferences regarding timing and content of future Board communications from staff on benefit matters.

### **EXECUTIVE SUMMARY:**

Employee Services and our health plan broker Mercer have been working over the past several months to implement changes aimed toward improvements to our benefit renewal process. This policy session will prepare the Board to finalize 2016 health plan renewals as well as continue to update the Board on 2017 renewals.

Near final County health plan contract changes were presented to the Board in October 2015. Please see Attachment 1, 10/2015 Study Session Worksheet and Clackamas County 2016 Renewal Report. However, we have found no record that the adoption of the 2016 Summary Plan Descriptions for the Providence plans were executed. Adoption of the 2016 Summary Plan Descriptions for the County's health plans finalizing the contracts for the 2016 plan year is scheduled on this week's Board Business Meeting Consent Agenda. You will find summaries of contract language changes and contract addenda to be signed for the 2016 plan year in the business meeting packet.

The health plans have seen significant claims increases over this past year, necessitating a more strategic approach to ensure the County can continue to offer cost-effective and competitive benefit options. The 2017 plan year Summary Plan Descriptions are currently being finalized for the general County health plans. Attachment 2, Clackamas County 2017 Renewal Report, describes the plan options that the Benefit Review Committee (BRC) elected to renew for the General County plans, including optional benefit changes and any legislatively required changes. Attachment 3, Clackamas County General County – Plan Options, contains a yellow table showing the renewal increase impact to the composite rate. This document also illustrates a comparison of the overall percentage of increase (employee contribution highlighted) between renewing plans "as is" and the BRC approved plans for 2017. Attachment 4, 2017 Rate Sheet, illustrates the Employer and Employee monthly contributions by plan for non-represented and represented employee groups.

The next steps toward final approval of the 2017 County health plan renewals will include finalizing the plan changes and bringing an addendum forward for Board approval which should take place in January 2017. Staff will also continue to provide progress updates on renewal of the POA health plans for 2017. Going forward, staff is interested in hearing the Board's preferences on benefits matters. While we plan to engage the Board earlier in the renewal process next August through October, we would also be happy to provide quarterly experience report documents and/or policy session updates.

**FINANCIAL IMPLICATIONS** (current year and ongoing):

Is this item in your current budget?  YES  NO

What is the cost? 2017 costs will be available by signing date.  
What is the funding source? Departments & employees.

**STRATEGIC PLAN ALIGNMENT**

- How does this item align with your Department’s Strategic Business Plan goals?

*By 2017 the Benefits Program will have a plan in place to address the rising cost of medical claims.*

- How does this item align with the County’s Performance Clackamas goals?

*Build trust through good government.*

**LEGAL/POLICY REQUIREMENTS:** Adherence to current labor contracts. Statutory requirement to include retirees in benefits risk pool and health plans.

**PUBLIC/GOVERNMENTAL PARTICIPATION:** The County Benefits Review Committee met regularly throughout the 2017 renewal period. The Benefits Program, with the assistance of Public & Government Affairs (PGA), created and delivered a robust communication plan that has resulted, in addition to other activities, in a new website for employees to understand their benefit options during open enrollment. This focus on communication has increased employee awareness and engagement. Benefits will continue to partner with PGA to maintain a strong communications presence regarding benefits going forward.

**OPTIONS:**

1. Forward 2016 health plan renewal information and addendum to 11/9/16 business meeting and add a quarterly report and/or policy session update on benefits matters to the Board of County Commissioners.
2. Not forward 2016 health plan renewal information and addendum to 11/9/16 business meeting or add a quarterly report and/or policy session update on benefits matters to the Board of County Commissioners.
3. Return at a later date for additional discussion.

**RECOMMENDATION:** Approve option 1.

**ATTACHMENTS:**

1. 10-2015 Study Session Packet
2. Clackamas County 2017 Renewal Report
3. Clackamas County General County – Plan Options FINAL
4. 2017 Rate Sheet

**SUBMITTED BY:**

Division Director/Head Approval                     KD                      
 Department Director/Head Approval                     EM-L                      
 County Administrator Approval                     LSB                    

For information on this issue or copies of attachments, please contact Kristi Durham @ 503-742-5470.

Attachment 1

October 2015 Study Session Packet

# CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS

## Study Session Worksheet

**Presentation Date:** 10/27/15 **Approximate Start Time:** 3:30 pm **Approximate Length:** 30 Minutes

**Presentation Title:** Benefits Renewals for 2016

**Department:** Employee Services

**Presenters:** Evelyn Minor-Lawrence, Director of Employee Services  
Julia Getchell, Assistant Director of Employee Services  
Carolyn Williams, Benefits Manager  
Jan Long, Mercer

**Other Invitees:** N/A

### **WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?**

DES is seeking formal approval to renew contracts with benefit providers for the 2016 plan year. Contracts are in the process of being prepared by providers. When completed, they will be reviewed and approved by County Counsel prior to submission to the Board for final approval.

### **EXECUTIVE SUMMARY:**

The Department of Employee Services and its employee benefits consultant, Mercer, have completed negotiations with the County's insurance carriers and third party administrators for the 2016 employee benefit plan renewals. The County must confirm the renewals prior to November 1, 2015 to ensure coverage for the 2016 plan year. See attached Renewal Report for detailed information on the 2016 renewals.

#### Medical

Preliminary renewal rates for self-insured plans administered by Providence came in at 9.1%. The Benefits Review Committee worked very diligently to make plan design changes to reduce the increases to 6% for the Personal Option and 5.6% for the Open Option. With the increased enrollment in the Kaiser plan and 2.1% decrease and renewal for the POA Providence plans decrease of 9.7%, the overall medical plan increase for 2016 plan year is 3.0%.

#### Dental

Dental plans experienced rates changes ranging from a decrease of -3.6% to an increase of 24.1%.

#### Other Benefits

There will be no rate changes to the group term life, dependent life or group universal life insurance provided through Met Life.

The fully-insured long-term disability coverage provided through Standard Insurance will have a 0% increase. For the self-insured short-term disability program, there will be a 5.9% increase in the funding rate.

There will be no rate changes to the employee-paid long term care coverage rates.

There were no premium changes for accidental death and dismemberment, wellness and employee assistance program, or flexible spending account administration.

#### Nonrepresented Employee Cost Sharing

The current practice for nonrepresented employees is to provide benefit cost sharing in a similar manner as represented employees so that there is no disincentive to promote into a management or supervisory position and for the County to remain competitive in attracting and retaining employees. Under the current cost sharing method, the County pays 95% and the employee pays 5% of the tiered medical premium and the County pays 100% of the dental, life and disability premiums and the administrative costs for the flexible spending accounts.

**FINANCIAL IMPLICATIONS (current year and ongoing):**

The estimated fiscal impact for the 2016 plan year is:

Medical:	\$837,886
Dental:	\$291,494
STD	<u>\$7,007</u>
Total:	\$1,136,387

**LEGAL/POLICY REQUIREMENTS:**

Employee benefits must be provided as required under the collective bargaining agreements and County policy.

**PUBLIC/GOVERNMENTAL PARTICIPATION:**

N/A

**OPTIONS:**

It is highly unlikely that the County would be able to negotiate lower increases or find any other carrier willing to offer lower rates over a sustained period of time. In addition, we have developed strong business partner relationships with our carriers.

**RECOMMENDATION:**

1. Approve renewal contracts with Providence, Kaiser, MODA, VSP, Metropolitan Life, Standard Insurance and Flex-Plan.
2. Approve paying 95% of the premiums for the medical coverage, and 100% of the premiums for dental, life, and disability plans for nonrepresented employees.

**ATTACHMENTS:**

Mercer's 2016 Health and Welfare Benefit Plan Renewal Report

**SUBMITTED BY:**

Division Director/Head Approval \_\_\_\_\_

Department Director/Head Approval \_\_\_\_\_

County Administrator Approval \_\_\_\_\_

For information on this issue or copies of attachments, Please contact Carolyn Williams @ 503-742-5470.
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**2016 HEALTH AND WELFARE BENEFIT  
PLAN RENEWAL REPORT  
CLACKAMAS COUNTY**  
OCTOBER 21, 2015

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## Summary

The Clackamas County General County and Peace Officers Association (POA) 2016 health and welfare benefit plans renewal decisions are outlined in this report.

After reviewing the presented plan options, the Benefit Review Committee (BRC) elected to renew all the General County plans, electing optional benefit changes in addition to the legislatively required changes. The accepted plan design changes are described in detail later in this report.

The POA will renew all health and welfare plans with no benefit changes in addition to the legislatively required changes. The accepted plan design changes are described in detail later in this report.

The table on the following pages is a summary of renewal rates by plan for the General County and POA plans.



	Rates PEPM		
	2015	2016	% Change
<b>Medical/Prescription/Vision Plans</b>			
<b>Providence Health Plan – General County<sup>1</sup></b>			
Personal Option 20/20/1500 \$500 Common Deductible (includes VSP vision)			
Employee Only	\$609.93	\$647.00	
Employee + Spouse	1,219.92	1,293.00	
Employee + Children	1,100.75	1,167.00	
Employee + Family	1,833.37	1,944.00	
Composite	1,357.97	1,439.00	<b>6.0%</b>
Open Option 15/10/30/2500 \$500 Common Deductible (includes VSP vision)			
Employee Only	\$627.17	\$664.00	
Employee + Spouse	1,254.42	1,328.00	
Employee + Children	1,131.80	1,198.00	
Employee + Family	1,885.11	1,995.00	
Composite	1,370.91	1,448.00	<b>5.6%</b>
<b>Providence Health Plan – POA<sup>1</sup></b>			
Personal Option 15/0/1000 (includes VSP vision)			
Employee Only	\$635.08	\$573.00	
Employee + Spouse	1,270.24	1,147.00	
Employee + Children	1,144.76	1,034.00	
Employee + Family	1,907.27	1,722.00	
Composite	1,572.98	1,420.00	<b>-9.7%</b>
Open Option 10/0/20/2000 \$50 Common Deductible (includes VSP vision)			
Employee Only	\$647.25	\$584.00	
Employee + Spouse	1,294.58	1,169.00	
Employee + Children	1,166.67	1,053.00	
Employee + Family	1,943.78	1,755.00	
Composite	1,586.26	1,432.00	<b>-9.7%</b>
<b>Kaiser Permanente HMO – General County (with hearing aids)<sup>1</sup></b>			
Employee Only	\$629.60	\$616.39	
Employee + Spouse	1,259.20	1,232.77	
Employee + Children	1,133.28	1,109.50	
Employee + Family	1,888.80	1,849.16	
Composite	1,382.78	1,353.76	<b>-2.1%</b>
<b>Kaiser Permanente HMO – POA<sup>1</sup></b>			
Employee Only	\$627.42	\$614.25	
Employee + Spouse	1,254.83	1,228.50	
Employee + Children	1,129.35	1,105.65	
Employee + Family	1,882.25	1,842.75	
Composite	1,467.46	1,436.66	<b>-2.1%</b>

	Rates PEPM		
	2015	2016	% Change
<b><i>Providence Retirees - \$1000 Deductible<sup>1</sup></i></b>			
Retiree Only	\$528.24	\$578.42	<b>9.5%</b>
Retiree + Spouse	1,056.55	1,156.92	
Retiree + Children	950.82	1,041.15	
Retiree + Family	1,584.73	1,735.28	
<b><i>Kaiser Permanente Retirees – General County \$1000 Deductible<sup>1</sup></i></b>			
Retiree Only	\$473.19	\$463.26	<b>-2.1%</b>
Retiree + Spouse	946.37	926.52	
Retiree + Children	851.73	833.86	
Retiree + Family	1,419.60	1,389.82	
<b><i>Kaiser Permanente Retirees – POA \$1000 Deductible<sup>1</sup></i></b>			
Retiree Only	\$473.25	\$463.31	<b>-2.1%</b>
Retiree + Spouse	946.49	926.63	
Retiree + Children	851.84	833.97	
Retiree + Family	1,419.78	1,389.99	
<b><i>Kaiser Permanente Medicare Retirees<sup>1</sup></i></b>			
Retiree Only (GC)	\$344.58	\$364.26	<b>5.7%</b>
Retiree Only (POA)	\$339.03	\$358.71	<b>5.8%</b>

**Vision Plan****VSP**

## General County

12/12/12; \$10/\$30 copay; \$130/\$70 allowance	Providence	VSP	
Employee Only	\$8.57	\$8.57	
Employee + Spouse	17.13	17.13	
Employee + Children	18.33	18.33	
Employee + Family	29.29	29.29	
Composite	21.00	21.00	<b>0.0%</b>

## POA

12/24/24; \$10 copay; \$130 allowance	Providence	VSP	
Employee Only	\$4.79	\$4.79	
Employee + Spouse	\$9.58	\$9.58	
Employee + Children	\$10.25	\$10.25	
Employee + Family	\$16.39	\$16.39	
Composite	\$13.00	\$13.00	<b>0.0%</b>

	Rates PEPM		
	2015	2016	% Change
<b>Dental Plans</b>			
<b>Delta Dental of Oregon (formerly Moda/ODS)<sup>2</sup></b>			
Administration	\$6.10	\$6.18	<b>1.3%</b>
Incentive Plan - General County			
Employee Only	\$74.00	\$90.00	
Employee + Spouse	149.00	182.00	
Employee + Children	105.00	128.00	
Employee + Family	180.00	219.00	
Composite	140.00	171.00	<b>22.1%</b>
Incentive Plan - POA			
Employee Only	\$70.00	\$68.00	
Employee + Spouse	139.00	134.00	
Employee + Children	99.00	96.00	
Employee + Family	169.00	163.00	
Composite	139.00	134.00	<b>-3.6%</b>
50% Plan – General County Only			
Employee Only	\$30.00	\$37.00	
Employee + Spouse	59.00	74.00	
Employee + Children	41.00	52.00	
Employee + Family	69.00	87.00	
Composite	58.00	72.00	<b>24.1%</b>
Preventive Plan – General County Only			
Employee Only	\$79.00	\$78.00	
Employee + Spouse	160.00	159.00	
Employee + Children	114.00	113.00	
Employee + Family	194.00	192.00	
Composite	151.00	149.00	<b>-1.3%</b>
<b>Kaiser Permanente<sup>1</sup></b>			
Employee Only	\$90.99	\$96.48	
Employee + Spouse	180.16	191.03	
Employee + Children	125.57	133.15	
Employee + Family	215.64	228.65	
General County Composite	170.97	181.00	<b>5.9%</b>

	Rates PEPM		
	2015	2016	% Change
<b>Life and AD&amp;D – MetLife</b>			
<b>Basic Life (Rate per \$1,000 benefit)</b>			
Non-represented – General County Only	\$0.211	\$0.211	0.0%
Represented – General County and POA	0.197	0.197	0.0%
<b>Group Universal Life</b>	Age rated	Age rated	0.0%
<b>Dependent Life per Employee (Rate per Family)</b>			
\$5,000 per Dependent – General County	\$2.39	\$2.39	0.0%
\$2,000 per Dependent – POA	0.38	0.38	0.0%
<b>Voluntary AD&amp;D – General County Only (Rate per \$1,000 benefit)</b>			
Employee Only	\$0.040	\$0.040	0.0%
Employee and Family	0.060	0.060	0.0%
<b>LTD – The Standard Insurance</b>			
<b>Self-Insured – General County</b>			
Funding Rate (Rate per \$100 covered salary)	\$0.17	\$0.18	5.9%
General Fee (Rate per Employee)	0.36	0.36	0.0%
New Claim Fee (Rate per Claim)	390.00	390.00	0.0%
Open Claim Fee (Rate per Claim)	19.00	19.00	0.0%
<b>Fully Insured – General County</b>			
Base Plan (Rate per \$100 Covered Salary)	\$0.38	\$0.38	0.0%
Buy-Up Plan (Rate per \$100 Covered Salary)	0.38	0.38	0.0%
<b>Fully Insured – Peace Officers</b>			
Base Plan (Rate per \$100 Covered Salary)	\$0.35	\$0.35	0.0%
Buy-Up Plan (Rate per \$100 Covered Salary)	0.39	0.39	0.0%
<b>Employee Assistance Plan (EAP) – The Standard Insurance – General County Only</b>			
General Fee per Employee	\$0.10	\$0.10	0.0%
<b>Flexible Spending Account – Flex Plan – General County Only</b>			
Monthly Fee per Participant	\$5.00	\$5.00	0.0%
<b>LTC – Unum – General County Only</b>			
Monthly Rate per Participant	Age rated	Age rated	0.0%

<sup>1</sup>Rates include the standard 2016 contract changes.

<sup>2</sup>The dental composite projection calls for a 9.2% increase.

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## Medical/Prescription Drug/Vision/Alternative Care Plans

### **Self-Funded Plans**

The County elected to self-fund the Providence Medical/Rx, effective January 1, 2015. The 2016 projection for the Open and Personal Options called for an overall 9.5% increase for the General County and a 9.7% decrease for the POA.

The 2016 Providence ASO fees are shown below as per employee per month (PEPM).

### **Providence Health Plan Administrative Fees**

	PEPM
Administrative	\$36.83
PPO	7.72
Case Management/Disease Management	8.39
Health Coaching – 12 Sessions	1.90

### **Stop Loss Administrative Fees – Optum Health**

The 2016 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is \$175,000.

In addition to the fees above, the Transitional Reinsurance Fee, which is a fee imposed by the Affordable Care Act, is estimated to be \$5.83 PEPM for 2016.

Mercer's underwriting projection for the 2016 renewal is included in **Exhibit A** for reference

### **General County**

The BRC elected the following plan changes for the 2016 plan year:

#### **Personal Option**

1. Out-of-Pocket Maximum increase from \$1200 to \$1500
2. Deductible increase from \$250 to \$500
3. Pharmacy benefit changed from a 1x copay for a 90-day supply to a 2x copay for a 90-day supply
4. Travel expense insurance added

#### **Open Option**

1. Out-of-Pocket Maximum increase from \$2000 to \$2500
2. Deductible increase from \$250 to \$500
3. Pharmacy benefit changed from a 1x copay for a 90-day supply to a 2x copay for a 90-day supply
4. Travel expense insurance added

**Exhibit B(1)** contains the required 2016 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2016.

See **Exhibit C** for the Providence 2016 General County benefit summaries.

### *Peace Officers*

There were no plan changes for the 2016 plan year for the POA plans.

The standard 2016 contract changes summary for grandfathered plans in **Exhibit B(2)** apply to the POA plans.

See **Exhibit C** for the Providence 2016 POA benefit summaries.

### *Retirees – General County and Peace Officers*

Early (pre-age 65) retirees are eligible for the Providence Personal and Open Option active employee plans.

For those early retirees who live outside of the Providence service area, the County offers the Traditional Option plan for medical coverage. These early retiree rates and prescription drug benefits are the same as the Open Option plans for active employees.

### **Open Option 15/30/50/2000 \$1000 Common Deductible**

The County elected no plan changes for the 2016 plan year. The 2016 benefit summary is included in **Exhibit C**.

### **Providence Fully-Insured Medicare Align Plan (Medicare Eligible)**

The County accepted a rate increase of 20.3%. The 2016 premium rate for the Providence Medicare Align plan is shown below as a PEPM:

#### **Medicare Align Plan**

Medicare Align With Prescription Drug	\$332.00
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**Exhibits B(1) and B(2)** contain the standard 2016 contract changes for grandfathered and non-grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2016 early retiree benefit summaries.

### ***Kaiser Permanente***

#### *General County and Peace Officers*

Kaiser proposed an overall 2.1% decrease to the 2016 premium rates.

The BRC and POA did not elect to make benefit changes to these plans. The County renewed the medical, vision, and prescription drug plans with Kaiser Permanente effective January 1, 2016.

Kaiser's underwriting worksheets for their renewal calculations are included in **Exhibit D** for reference.

**Exhibit E** contains the 2016 contract changes provided by Kaiser. The BRC and POA accepted the proposed 2016 benefit and administrative clarifications applicable to grandfathered plans.

See **Exhibit F** for the Kaiser 2016 benefit summaries.

The 2016 premium rates are shown below as a per employee per month (PEPM), and include the required contract changes and PPACA fees for the plans:

### **Medical/Prescription Drug/Vision Plans**

General County	
Employee Only	\$616.39
Employee + Spouse	1,232.77
Employee + Children	1,109.50
Employee + Family	1,849.16
Composite	1,353.76
Peace Officers Association	
Employee Only	\$614.25
Employee + Spouse	1,228.50
Employee + Children	1,105.65
Employee + Family	1,842.75
Composite	1,436.66

### *Retirees – General County and Peace Officers*

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a \$1,000 deductible plan for early retirees and COBRA participants. The proposed rate decrease of -2.1% for the General County and POA plans were accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan.

**Exhibit E** contains the 2016 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2016 benefit summaries.

The 2016 premium rates for the current \$1,000 Deductible plan and Medicare plan are shown below as a per employee per month (PEPM). The premiums include the required contract changes and PPACA fees for the plans:

\$1,000 Deductible Plan COBRA <sup>1</sup> and Early Retirees	
General County	
Employee Only	\$463.26
Employee + Spouse	926.52
Employee + Children	833.86
Employee + Family	1,389.82
Peace Officers Association	
Employee Only	\$463.31
Employee + Spouse	926.63
Employee + Children	833.97
Employee + Family	1,389.99
Medicare (Parts A, B and D)	
Retiree Only (GC)	\$364.26
Retiree Only (POA)	\$358.71

## Vision Plans

### ***Vision Service Plan (VSP)***

The County elected to review their vision plans with VSP for both General County and POA. The proposed rates for the 2016 plan year are provided below:

#### ***General County***

Employee Only	\$8.57
Employee + Spouse	17.13
Employee + Children	18.33
Employee + Family	29.29
Composite	21.00

#### ***Peace Officers Association***

Employee Only	\$4.79
Employee + Spouse	9.58
Employee + Children	10.25
Employee + Family	16.39
Composite	13.00

The above VSP rates are in a rate guarantee period of 24 months. The plan will next renew January 1, 2017.

See **Exhibit G** for the 2016 VSP benefit summaries.

<sup>1</sup> COBRA participants are charged an additional 2% administrative fee as allowed by law, which is not included in these rates.



## Dental Plans

### *Delta Dental of Oregon*

The Incentive Plan is available to all employees – General County and Peace Officers. The 50 Percent Plan and Preventive Plan are only available to General County employees. All three plans are self-funded and administered by Delta Dental of Oregon (Delta).

The County is entering the third year of a three-year administrative fee guarantee. The administration fee for the 2016 plan year will be as follows:

Rates per Employee per Month	2016
Administration fee	\$6.18
% Change	1.35%

The County renewed the dental administration services with Delta effective January 1, 2016, with the following plan changes:

- Acceptance of the administrative changes that were provided with the renewal for all General County and POA plans
- General County will add coverage for night guards at 50% up to \$250 to the Incentive, Constant and Preventive plans
- The POA did not elect any benefit changes

There are no additional plan changes.

**Exhibit I** contains the Delta administrative contract changes for 2016 for General County and POA.

See **Exhibit J** for the 2016 Delta benefit summaries.

### *Underwriting*

Mercer projected a 2016 combined funding increase of 9.2% for the 2016 self-insured dental plans. The County elects to apply the individual plan funding adjustments to each plan. The break out of adjustments used for the 2016 plan year is provided in the underwriting calculation in **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from August 1, 2014, through July 31, 2015. An annual trend factor of 6.0% and 0% margin were used.

Mercer recommended and the County accepted the 2016 funding rates listed below. The below rates include all plan changes.

### Self-Funded Dental Plans: Budgeting Rates per Employee per Month

<b>Incentive Plan – General County</b>	
Employee Only	\$90.00
Employee + Spouse	182.00
Employee + Children	128.00
Employee + Family	219.00
Composite	171.00

<b>Incentive Plan – POA</b>	
Employee Only	\$68.00
Employee + Spouse	134.00
Employee + Children	96.00
Employee + Family	163.00
Composite	134.00

<b>50% Plan – General County Only</b>	
Employee Only	\$37.00
Employee + Spouse	74.00
Employee + Children	52.00
Employee + Family	87.00
Composite	72.00

<b>Preventive Plan – General County Only</b>	
Employee Only	\$78.00
Employee + Spouse	159.00
Employee + Children	113.00
Employee + Family	192.00
Composite	149.00

### ***Kaiser Permanente***

The County has a fully insured dental plan through Kaiser that is available to all employees – General County and POA. Kaiser proposed a 5.7% increase to the 2016 premium rates.

The County requested that Kaiser quote an option to add implant coverage to the dental plan with a benefit of 50% up to a \$2,000 annual maximum, effective January 1, 2016. The quote was a 0.3% increase over renewal or a 6.0% increase from current.

The BRC elected to add implant coverage effective January 1, 2016, for General County employees. As this plan is also available to the POA, they will receive this benefit change.

**Exhibit E** contains the 2016 standard contract changes provided by Kaiser, which will be effective January 1, 2016.

See **Exhibit F** for the Kaiser 2016 benefit summaries.

The 2016 premium rates for Kaiser dental plan is shown below as a per employee per month (PEPM), and include the contract changes for the plans:

***Dental Plan***

Employee Only	\$96.48
Employee + Spouse	191.03
Employee + Children	133.15
Employee + Family	228.65
Composite	181.00

**Life and Voluntary AD&D Insurance*****MetLife***

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. MetLife proposed a rate decrease for all plans effective January 1, 2014, with a three-year rate guarantee. The below rates are effective through December 31, 2016. The County renewed the plans with MetLife effective January 1, 2014, with no change in benefits.

A summary of the rates effective January 1, 2014, through December 31, 2016, are as follows:

***General County***

<b>Basic Life</b>	
Non-Represented Employees	\$0.211/\$1,000
Represented Employees	\$0.197/\$1,000
<b>Dependent Life</b>	
\$5,000 per spouse/domestic partner or child	\$2.39 PEPM
<b>Voluntary Accidental Death and Dismemberment</b>	
Employee	\$0.040/\$1,000
Employee and Family (spouse/domestic partner or child)	\$0.060/\$1,000

***Peace Officer Association***

<b>Basic Life</b>	
Represented Employees	\$0.197/\$1,000
<b>Dependent Life</b>	
\$2,000 per spouse/domestic partner or child	\$0.38 PEPM

***General County***

<b>Group Universal Life (Rates Per \$1,000)</b>		
<b>Age</b>	<b>Non-Smoker Rates</b>	<b>Smoker Rates</b>
< 30	\$0.044	\$0.066
30-34	0.049	0.074
35-39	0.062	0.102
40-44	0.096	0.149
45-49	0.164	0.223
50-54	0.270	0.330
55-59	0.424	0.518

Group Universal Life (Rates Per \$1,000)		
Age	Non-Smoker Rates	Smoker Rates
60-64	0.641	0.797
65-69	1.186	1.269
70-74	1.986	1.986

The following levels and corresponding premium rates apply to covered dependent children:

Coverage Amount	\$2,000	\$4,000	\$6,000	\$8,000	\$10,000
Monthly Rate	\$0.118	\$0.236	\$0.354	\$0.472	\$0.59

## Long Term Disability Insurance

### *The Standard*

The County offers three LTD plans through Standard as follows:

- **Base LTD Plans**
  - **General County and POA.** This coverage is provided by the County without contributions from employees. The disability benefit is 60% of the first \$3,333 of monthly predisability income. The plan is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.
- **Buy-up LTD Plans**
  - **General County.** This plan offers General County employees the option of buying additional disability coverage, equal to 60% of the next \$5,000 of monthly pre-disability earnings above \$3,333 up to a maximum of \$8,333.
  - **Peace Officers.** This plan offers POA employees the option of buying additional disability coverage, equal to 60% of the next \$6,667 of monthly pre-disability earnings above \$3,333 up to a maximum of \$10,000.

Both buy-up LTD benefit plans for the General County and Peace Officers are 100% paid by employees on a pretax basis. The Plans have two funding components – self-funded and fully insured. Both components are administered by Standard.

The benefits will remain unchanged for the 2016 plan year.

### *Fees and Premium Rates*

The County is entering the second year of a two-year rate guarantee with Standard. The next renewal will be January 1, 2017.

The 2016 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	\$0.18 per \$100 covered payroll
Administration Fees	
General	\$0.36 PEPM
New Claim	\$390 per claim
Open Claim	\$19 per open claim at month end
Incidental	As incurred

### Insured Plan

Base – General County	\$0.38/\$100
Buy-Up – General County	\$0.38/\$100
Base – Peace Officers	\$0.35/\$100
Buy-Up – Peace Officers	\$0.39/\$100

## Employee Assistance Plan

### *The Standard*

The County also receives services through an Employee Assistance Program (EAP) from Standard for employees covered by the long term disability plan. The rate will remain at \$0.10 per employee per month.

The County also purchases EAP coverage for part-time employees who are not covered under the LTD plan. The rate will remain at \$0.35 per employee per month.

## Flexible Spending Account Administrator

### *Navia Benefits Solutions*

The County uses Navia Benefits Solutions (Navia), formerly Flex-Plan Services, to provide FSA plans, which are available only to General County employees. Navia proposed a rate hold for the 2016 plan year. The County renewed these services with Navia effective January 1, 2016.

The 2016 fees remain the same as the 2015 fees, as follows:

### Fees per Participant per Month

Health Care FSA	\$5
Dependent Care FSA	\$5

## Long Term Care Insurance

### *Unum*

Unum insures the voluntary long term care (LTC) coverage for General County employees. There was no rate increase for the 2016 plan year.

# 3

## Employee Contributions

### General County

For FOPPO represented employees, the County will pay 95% of the renewal composite medical/prescription/vision rate up to a collectively bargained capped composite amount. AFSCME and Employee's Association members will receive the same if agreement is reached prior to the end of the calendar year.

The County will pay 95% of the tiered premium rates for nonrepresented employees.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
<b>NONREPRESENTED</b>				
<b>Providence Personal Option</b>				
Employer	\$614.65	\$1,228.35	\$1,108.65	\$1,846.80
Employee	32.35	64.65	58.35	97.20
<b>Providence Open Option</b>				
Employer	630.80	1,261.60	1,138.10	1,895.25
Employee	33.20	66.40	59.90	99.75
<b>Kaiser</b>				
Employer	585.57	1,171.13	1,054.03	1,756.70
Employee	30.82	61.64	55.47	92.46
<b>Medical Opt Out</b>				
Cash Back	71.00	142.00	128.00	213.00
<b>REPRESENTED</b>				
<b>Providence Personal Option</b>				
Employer	579.56	1225.56	1099.56	1876.56
Employee	67.44	67.44	67.44	67.44
<b>Providence Open Option</b>				
Employer	587.56	1251.56	1121.56	1918.56
Employee	76.44	76.44	76.44	76.44
<b>Kaiser</b>				
Employer	548.70	1,165.08	1,041.81	1,781.47
Employee	67.69	67.69	67.69	67.69
<b>Medical Opt Out</b>				
Cash Back	160.00	160.00	160.00	160.00

The County pays 100% of the premium for the Delta Dental of Oregon Incentive and Preventive dental plans and the Kaiser dental plan. The Delta Dental of Oregon Constant (50%) plan and Dental Opt Out cash back for all employees are as follows:

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Delta Dental Of Oregon Constant (50%)				
<b>Nonrepresented</b>				
Cash Back	\$45.00	\$88.00	\$61.00	\$107.00
<b>Represented</b>				
Cash Back	82.00	82.00	82.00	82.00
Dental Opt Out				
<b>Nonrepresented</b>				
Cash Back	72.00	143.00	100.00	172.00
<b>Represented</b>				
Cash Back	136.00	136.00	136.00	136.00

**Peace Officers**

The County pays 95% of the premium for the Providence medical plans. The County pays 100% of the premium for employees enrolled in the Kaiser medical plan.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
<b>Providence Personal Option</b>				
Employer	\$502.00	\$1,076.00	\$963.00	\$1,651.00
Employee	71.00	71.00	71.00	71.00
<b>Providence Open Option</b>				
Employer	512.40	1,097.40	981.40	1,683.40
Employee	71.60	71.60	71.60	71.60
<b>Kaiser</b>				
Employer	614.25	1,228.50	1,105.65	1,842.75
Employee	0.00	0.00	0.00	0.00

The County pays 100% of the premium for the Delta Dental of Oregon and Kaiser dental plans. The County removed the dental contribution for all employees. The Dental Opt Out cash back for all employees is as follows.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
<b>Dental Opt Out</b>				
Cash Back	136.00	136.00	136.00	136.00

# 4

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## Exhibits

- Exhibit A – Self-Funded Medical/Rx Underwriting (Providence Health Plan)
- Exhibit B – Providence Health Plan – 2016 Contract Changes
  - Exhibit B(1) – Non-Grandfathered – General County
  - Exhibit B(2) – Grandfathered – POA
- Exhibit C – Providence Health Plan – 2016 Benefit Summaries
- Exhibit D – Kaiser Permanente Medical and Dental Underwriting
- Exhibit E – Kaiser Permanente – 2016 Contract Changes
- Exhibit F – Kaiser Permanente – 2016 Benefit Summaries
- Exhibit G – VSP – 2016 Benefit Summaries
- Exhibit H – Self-funded Dental Underwriting Calculation
- Exhibit I – Delta Dental of Oregon – 2016 Contract Changes
- Exhibit J – Delta Dental of Oregon – 2016 Benefit Summaries
- Exhibit K – Carrier Information – A.M. Best Score



# EXHIBIT A

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## Self-Funded Medical/Rx Underwriting (Providence Health Plan)

## Clackamas County – General County

### Medical/Rx Projection for Jan 1, 2016, through Dec 31, 2016

	Open Option	Personal Option	GC Combined
<b>Most Recent 12 Months Ending</b>		<b>July 2015</b>	
Paid Claims Entered for Entire 12-Month Period	\$6,022,780	\$8,208,068	\$14,230,849
Stop Loss Credit	(237,244)	(264,033)	(501,277)
Historical Benefit Changes Adjustment	1.010	1.011	1.010
Adjusted Paid Claims during This Period	\$5,843,094	\$8,028,554	\$13,871,649
Average Setback Lives during This Period	440	591	1,031
Adjusted Paid Claims per Capita per Month	\$1,106.65	\$1,132.06	\$1,121.21
Annual Trend	7.0%	7.0%	7.0%
Number of Months of Trend	18	18	18
Trend Factor	1.107	1.107	1.107
<b>Projected Claims per Capita</b>	<b>\$1,224.85</b>	<b>\$1,252.98</b>	<b>\$1,240.98</b>
Claims Margin (%)	1.0%	1.0%	1.0%
Claims Margin (\$ per Capita per Month)	\$12.25	\$12.53	\$12.41
<b>Projected Claims per Capita per Month + Margin</b>	<b>\$1,237.10</b>	<b>\$1,265.51</b>	<b>\$1,253.39</b>
<b>Fixed Expenses</b>			
Providence Admin Fees - PEPM (Admin, Case Mgmt., Disease Mgmt.)	\$54.84	\$54.84	\$54.84
Stop Loss Premium - PEPM	107.24	107.24	107.24
Temporary Reinsurance Fee (HCR) - PEPM	5.83	5.83	5.83
<b>Total Administration / Retention per Capita per Month</b>	<b>\$167.91</b>	<b>\$167.91</b>	<b>\$167.91</b>
<b>Projected Total Cost per Capita per Month for Projection Period</b>	<b>\$1,405.02</b>	<b>\$1,433.42</b>	<b>\$1,421.30</b>
<b>Budget per Capita per Month for Projection Period with Current Rates</b>	<b>\$1,302.54</b>	<b>\$1,293.36</b>	<b>\$1,297.48</b>
<b>Needed Increase</b>	<b>7.9%</b>	<b>10.8%</b>	<b>9.5%</b>

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

## Clackamas County – POA

### Medical/Rx Projection for Jan. 1, 2016, through Dec. 31, 2016

	Open Option	Personal Option	POA Combined
<b>Most Recent 12 Months Ending</b>		<b>July 2015</b>	
Paid Claims Entered for Entire 12-Month Period	\$3,931,177	\$571,927	\$4,503,105
Stop Loss Credit	0	0	0
Historical Benefit Changes Adjustment	0.998	0.998	0.998
Adjusted Paid Claims during This Period	\$3,923,168	\$570,549	\$4,493,717
Average Setback Lives during This Period	312	55	367
Adjusted Paid Claims per Capita per Month	\$1,047.85	\$864.47	\$1,020.37
Annual Trend	7.0%	7.0%	7.0%
Number of Months of Trend	18	18	18
Trend Factor	1.107	1.107	1.107
<b>Projected Claims per Capita</b>	<b>\$1,159.78</b>	<b>\$956.81</b>	<b>\$1,129.36</b>
Claims Margin (%)	1.0%	1.0%	1.0%
Claims Margin (\$ per Capita per Month)	\$11.60	\$9.57	\$11.29
<b>Projected Claims per Capita per Month + Margin</b>	<b>\$1,171.38</b>	<b>\$966.38</b>	<b>\$1,140.66</b>
<b>Fixed Expenses</b>			
Providence Admin Fees - PEPM (Admin, Case Mgmt., Disease Mgmt.)	\$54.84	\$54.84	\$54.84
Stop Loss Premium - PEPM	107.24	107.24	107.24
Temporary Reinsurance Fee (HCR) - PEPM	5.83	5.83	5.83
<b>Total Administration / Retention per Capita per Month</b>	<b>\$167.91</b>	<b>\$167.91</b>	<b>\$167.91</b>
<b>Projected Total Cost per Capita per Month for Projection Period</b>	<b>\$1,339.29</b>	<b>\$1,134.29</b>	<b>\$1,308.57</b>
<b>Budget per Capita per Month for Projection Period with Current Rates</b>	<b>\$1,429.60</b>	<b>\$1,559.98</b>	<b>\$1,449.55</b>
<b>Needed Increase</b>	<b>-6.3%</b>	<b>-27.3%</b>	<b>-9.7%</b>

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

# EXHIBIT B

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## Providence Health Plans – 2016 Contract Changes

## Exhibit B(1) – Non-Grandfathered Plans (General County)

# Plan Changes for Clackamas County from 1/2015 to 1/2016

Applies to Non-Grandfathered General County renewing 1/1/2016

Clackamas County General County 2016

	1/2015	1/2016	Type of Change
EPO Network Name Change	EPO Network	Providence Signature Network	Network name change only
Protected Health Information (PHI)	Administered but not stated.	Added language to the SPD to reaffirm members must provide authorization for PHI to be released to appointed representatives and employers.	PHP change for clarification purposes only
Travel Expense Reimbursement for Non-transplant Related Services	No benefit.	<p>Adding a \$1,500 calendar year limited benefit. Services must be covered and are subject to prior authorization and medical necessity.</p> <p>If a member is unable to locate a participating provider within 50 miles of home, the plan will reimburse travel expenses to the nearest participating provider within 300 miles. Reimbursement is based on the federal medical mileage reimbursement rate in effect on the date of service.</p> <p>Transplant services continue to include a separate limited \$5,000 lifetime travel expense benefit.</p>	<p>PHP change</p> <p>Optional but recommended</p>
Prior Authorization List Updated	Not applicable.	<p>Services added to the Prior Authorization list:</p> <ol style="list-style-type: none"> <li>1. Travel expense reimbursement</li> <li>2. Echocardiography services</li> </ol>	<p>PHP change</p> <p>Mandatory</p>
Prescription Drug Benefit – multi-use or unit-of-use container copayment	Administered but not stated.	Language was added to the SPD and benefit summary to clarify that multiple copayments may be applied to these types of drugs, depending on the medication and the number of days supplied.	PHP change for clarification purposes only

<p><b>Non-preventive Colonoscopies for Members Age 50+</b></p>	<p>Covered in full regardless of diagnosis when provided by in-network providers.</p>	<p>Non-preventive - Covered under outpatient services as referenced on the benefit summary.</p> <p>Preventive - Covered in full when provided by in-network providers.</p> <p>Colonoscopies for members under age 50 continue to be covered under outpatient services.</p>	<p>PHP change</p> <p>Optional</p>
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## Exhibit B(2) – Grandfathered Plans (POA)



# Plan Changes for Clackamas County from 1/2015 to 1/2016

Applies to Grandfathered POA renewing 1/1/2016

	1/2015	1/2016	Type of Change
EPO Network Name Change	EPO Network	Providence Signature Network	Network name change only
Protected Health Information (PHI)	Administered but not stated.	Added language to the SPD to reaffirm members must provide authorization for PHI to be released to appointed representatives and employers.	PHP change for clarification purposes only
Travel Expense Reimbursement for Non-transplant Related Services	No benefit.	<p>Adding a \$1,500 calendar year limited benefit. Services must be covered and are subject to prior authorization and medical necessity.</p> <p>If a member is unable to locate a participating provider within 50 miles of home, the plan will reimburse travel expenses to the nearest participating provider within 300 miles. Reimbursement is based on the federal medical mileage reimbursement rate in effect on the date of service.</p> <p>Transplant services continue to include a separate limited \$5,000 lifetime travel expense benefit.</p>	<p>PHP change</p> <p>Optional but recommended</p>
Prior Authorization List Updated	Not applicable.	<p>Services added to the Prior Authorization list:</p> <ol style="list-style-type: none"> <li>Travel expense reimbursement</li> <li>Echocardiography services</li> </ol>	<p>PHP change</p> <p>Mandatory</p>
Prescription Drug Benefit – multi-use or unit-of-use container copayment	Administered but not stated.	Language was added to the SPD and benefit summary to clarify that multiple copayments may be applied to these types of drugs, depending on the medication and the number of days supplied.	PHP change for clarification purposes only

# EXHIBIT C

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## Providence Health Plans – 2016 Benefit Summaries

# Your Benefit Summary

## Personal Option Plan

### Clackamas County - General County Employees

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
\$20	20% coinsurance (after deductible)	\$1,500 per person \$3,000 per family (2 or more)	\$500 per person \$1,000 per family (2 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- Prior authorization is required for some services
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- View a list of Providence Signature network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### Benefit Highlights

After you pay your calendar year deductible, then you pay the following for covered services:

✓ No deductible needs to be met prior to receiving this service	Copay or Coinsurance (from in-network providers only)
<b>Preventive Care</b>	
<ul style="list-style-type: none"> <li>• Periodic health exams and well-baby care</li> <li>• Vision and hearing screenings for children under 18</li> <li>• Routine immunizations and shots</li> <li>• Gynecological exams (calendar year) and Pap tests</li> <li>• Mammograms</li> <li>• Colonoscopy; sigmoidoscopy</li> <li>• Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits</li> <li>• Office visits to alternative care provider (Chiropractic manipulation &amp; acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)</li> <li>• Phone and video visits (including Providence Health eXpress®)</li> <li>• Allergy shots, serums, infusions and injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul>	\$20 / visit ✓ \$20 / visit ✓ \$5 / visit ✓ \$20 / visit ✓ 20% 20%
<b>Diagnostic Services</b>	
<ul style="list-style-type: none"> <li>• X-ray and lab services</li> <li>• High-tech imaging services (such as PET, CT or MRI)</li> <li>• Sleep studies</li> </ul>	Covered in full ✓ Covered in full ✓ Covered in full ✓
<b>Emergency and Urgent Services</b>	
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Emergency medical transportation (air and/or ground)</li> </ul>	\$100 ✓ \$20 / visit ✓ 20%
<b>Hospital Services</b>	
<ul style="list-style-type: none"> <li>• Inpatient/Observation care</li> <li>• Rehabilitative care (limited to 30 days per calendar year)</li> <li>• Skilled nursing facility (limited to 60 days per calendar year)</li> </ul>	20% 20% 20%

Benefit Highlights (continued)	Copay or Coinsurance
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)</li> </ul>	20% 50% \$20 / visit <sup>✓</sup>
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery and postnatal services</li> <li>• Inpatient hospital/facility services</li> <li>• Routine newborn nursery care</li> </ul>	Covered in full <sup>✓</sup> \$150 / delivery <sup>✓</sup> 20% 20% <sup>✓</sup>
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>• Medical equipment, appliances and supplies</li> <li>• Diabetes supplies (lancets, test strips and needles)</li> <li>• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)</li> </ul>	20% <sup>✓</sup> 20% <sup>✓</sup> 20% <sup>✓</sup>
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.) <ul style="list-style-type: none"> <li>• Inpatient and residential services</li> <li>• Day treatment, intensive outpatient, and partial hospitalization services</li> <li>• Applied behavior analysis</li> <li>• Outpatient provider visits</li> </ul>	20% 20% 20% \$20 / visit <sup>✓</sup>
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>• Home health care</li> <li>• Hospice care</li> </ul>	20% Covered in full <sup>✓</sup>

## Your guide to the words or phrases used to explain your benefits

### Coinsurance

The percentage of the cost that you may need to pay for a covered service.

### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### Deductible

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible

### Formulary

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

### In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan.

### Limitations and Exclusions

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Summary Plan Description or contract for a complete list.

### Out-of-Network

Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### Out-of-Pocket Maximum

The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Summary Plan Description for details.

### Personal Physician/Provider

A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

### Prior authorization

Some services must be pre-approved, your in-network provider will request prior authorization for these services.

### Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.



Portland Metro Area: **503-574-7500**  
 All other areas: **800-878-4445**  
 TTY: **711**



Have questions about your benefits and want to contact us via email? Go to our website at:  
[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)

# Your Benefit Summary

## Chiropractic Manipulation, Acupuncture and Massage Therapy Clackamas County - General County Employees on a Personal Option Plan

<b>Copay</b>	<b>Maximum Calendar Year Benefit</b>
\$20	\$2,000 per member

### Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- With this benefit you have access to in-network qualified practitioners, including chiropractors, acupuncturists and massage therapists, for chiropractic manipulations, acupuncture and massage therapy.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### About your chiropractic manipulation, acupuncture, and massage therapy benefits

This plan covers chiropractic manipulations, acupuncture and massage therapy when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physician, acupuncturist or massage therapist, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Summary Plan Description.

### What you need to know before you use this benefit

- Routine preventive care in the absence of an illness, injury, or disease is not covered.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory) or call us.

### Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

### Acupuncture covered services

- Acupuncture
- Services may require review for medical necessity.

### Massage therapy covered services

- Short-term rehabilitative therapy.
- Services may require review for medical necessity.

## Your guide to the words or phrases used to explain your benefits

#### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

#### In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan.

#### Maximum calendar year benefit

The total dollar amount of benefits, and/or visits, that you can receive per calendar year.

#### Medical Necessity Review

A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

#### Out-of-Network

Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

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# Your Benefit Summary

## Out-of-Area Dependent

## Clackamas County - General County Employees

### What You Pay

**20%**  
coinsurance

### Calendar Year Out-of-Pocket Maximum

**\$1,000** per person  
**\$2,000** per family  
(2 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- Prior authorization is required for some services.
- Some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### Benefit Highlights

You pay the following for covered services:

	Coinsurance
<b>Preventive Care</b>	
• Periodic health exams and well-baby care	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations and shots	Covered in full
• Colonoscopy (age 50+)	Covered in full
• Gynecological exams (calendar year) and Pap tests	Covered in full
• Mammograms	Covered in full
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full
<b>Physician / Provider Services</b>	
• Office visits	20%
• Phone and video visits from in-network providers only (including Providence Health eXpress®)	5%
• Office visits to alternative care provider (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	20%
• Allergy shots, serums, infusions and injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
<b>Diagnostic Services</b>	
• X-ray and lab services	20%
• High-tech imaging services (such as PET, CT or MRI)	20%
• Sleep studies	20%
<b>Emergency and Urgent Services</b>	
• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Emergency medical transportation (air and/or ground)	20%
<b>Hospital Services</b>	
• Inpatient/Observation care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
<b>Outpatient Services</b>	
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)	50%
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	20%

Benefit Highlights (continued)	Coinsurance
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery; postnatal care</li> <li>• Inpatient hospital/facility services</li> <li>• Routine newborn nursery care</li> </ul>	Covered in full 20% 20% 20%
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>• Medical equipment, appliances and supplies</li> <li>• Diabetes supplies (lancets, test strips and needles)</li> <li>• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year)</li> </ul>	20% 20% 20%
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.) <ul style="list-style-type: none"> <li>• Inpatient and residential services</li> <li>• Day treatment, intensive outpatient, and partial hospitalization services</li> <li>• Applied behavior analysis</li> <li>• Outpatient provider visits</li> </ul>	20% 20% 20% 20%
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>• Home health care</li> <li>• Hospice care</li> </ul>	20% Covered in full

## Your guide to the words or phrases used to explain your benefits

### Coinsurance

The percentage of the cost that you may need to pay for a covered service.

### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### Formulary

A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

### In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan.

### Limitations and Exclusions

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Summary Plan Description or contract for a complete list.

### Out-of-Network

Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### Out-of-Pocket Maximum

The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Summary Plan Description for details.

### Prior authorization

Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

### Usual, Customary & Reasonable (UCR)

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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# Your Benefit Summary

## Open Option Plan

### Clackamas County - General County Employees

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
\$15	10% coinsurance (after deductible)	30% coinsurance (after deductible; UCR applies)	\$2,500 per person \$5,000 per family (2 or more)	\$500 per person \$1,000 per family (2 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### Benefit Highlights

Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
✓ No deductible needs to be met prior to receiving this benefit.		
<b>Preventive Care</b>		
• Periodic health exams and well-baby care	Covered in full✓	30%✓
• Vision and hearing screenings for children under 18	Covered in full✓	30%✓
• Routine immunizations and shots	Covered in full✓	30%✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	30%✓
• Mammograms	Covered in full✓	30%
• Colonoscopy; sigmoidoscopy	Covered in full✓	30%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
<b>Physician / Provider Services</b>		
• Office visits	\$15 / visit✓	30%✓
• Office visits to alternative care provider (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	\$15 / visit✓	30%✓
• Phone and video visits (including Providence Health eXpress®)	\$5 / visit✓	Not covered
• Allergy shots, serums, infusions and injectable medications	10%	30%
• Inpatient hospital visits	10%	30%
• Surgery; anesthesia	10%	30%
<b>Diagnostic Services</b>		
• X-ray and lab services	10%✓	30%
• High-tech imaging services (such as PET, CT or MRI)	10%✓	30%
• Sleep studies	10%✓	30%
<b>Emergency and Urgent Services</b>		
• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	\$100✓	\$100✓
• Urgent care services (for non-life threatening illness/minor injury)	\$15 / visit✓	30%✓
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	10%	10%



Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
<b>Hospital Services</b> <ul style="list-style-type: none"> <li>● Inpatient/Observation care</li> <li>● Rehabilitative care (30 days per calendar year)</li> <li>● Skilled nursing facility (60 days per calendar year)</li> </ul>	10% 10% 10%	30% 30% 30%
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>● Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>● Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>● Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)</li> </ul>	10% 50% 10%	30% Not covered 30%
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>● Prenatal care</li> <li>● Delivery and postnatal services</li> <li>● Inpatient hospital/facility services</li> <li>● Routine newborn nursery care</li> </ul>	Covered in full✓ \$150 / delivery✓ 10% 10%✓	30% 30% 30% 30%
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>● Medical equipment, appliances and supplies</li> <li>● Diabetes supplies (lancets, test strips and needles)</li> <li>● Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)</li> </ul>	10%✓ 10%✓ 10%✓	30% 30% 30%
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.) <ul style="list-style-type: none"> <li>● Inpatient and residential services</li> <li>● Day treatment, intensive outpatient, and partial hospitalization services</li> <li>● Applied behavior analysis</li> <li>● Outpatient provider visits</li> </ul>	10% 10% 10% \$15 / visit✓	30% 30% 30% 30%✓
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>● Home health care</li> <li>● Hospice care</li> </ul>	10% Covered in full✓	30% Covered in full✓

## Your guide to the words or phrases used to explain your benefits

### **Coinsurance**

The percentage of the cost that you may need to pay for a covered service.

### **Common deductible**

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible

### **Common out-of-pocket maximum**

The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-plan services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Summary Plan Description for details.

### **Copay**

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### **Formulary**

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

### **In-Network**

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

### **Limitations and Exclusions**

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Summary Plan Description or contract for a complete list.

### **Out-of-Network**

Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### **Personal Physician/Provider**

A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

### **Prior authorization**

Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

### **Usual, Customary & Reasonable (UCR)**

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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# Your Benefit Summary

## Chiropractic Manipulation, Acupuncture and Massage Therapy Clackamas County - General County Employees on an Open Option Plan

<b>Copay</b>	<b>Maximum Calendar Year Benefit</b>
<b>\$15</b>	<b>\$2,000</b> per member

### Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- With this benefit you have access to in-network qualified practitioners, including chiropractors, acupuncturists and massage therapists, for chiropractic manipulations, acupuncture and massage therapy.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### About your chiropractic manipulation, acupuncture, and massage therapy benefits

This plan covers chiropractic manipulations, acupuncture and massage therapy when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physician, acupuncturist or massage therapist, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Summary Plan Description.

### What you need to know before you use this benefit

- Routine preventive care in the absence of an illness, injury, or disease is not covered.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory) or call us.

### Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

### Acupuncture covered services

- Acupuncture
- Services may require review for medical necessity.

### Massage therapy covered services

- Short-term rehabilitative therapy.
- Services may require review for medical necessity.

## Your guide to the words or phrases used to explain your benefits

#### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

#### In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan.

#### Maximum calendar year benefit

The total dollar amount of benefits, and/or visits, that you can receive per calendar year.

#### Medical Necessity Review

A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

#### Out-of-Network

Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

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# Your Benefit Summary

## Hearing Aid

### Clackamas County - General County Employees on an Open Option Plan

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#### Benefits

Your Providence Health Plan Supplemental Hearing Aid Benefit provides coverage for members age 18 and older who are not covered by the Oregon mandated hearing aid benefit described in your Summary Plan Description:

- Up to \$1,500 per hearing aid, per ear, per three-calendar-year period.

You do not need to meet any medical health plan deductibles, regardless of your medical plan type, before accessing your Supplemental Hearing Aid Benefit.

The \$1,500 coverage can be applied to the following services:

- Hearing aid assessment, evaluation and audiogram testing
- Hearing aids

Please see your Summary Plan Description for information regarding Oregon mandated hearing aid benefits.

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#### Using your hearing aid benefits

For the service to be a covered benefit, you must receive all services to obtain a hearing aid from a licensed hearing professional.

- Please submit your itemized receipts suitable for insurance billing purposes to us for reimbursement.

Submit claims to:

Providence Health Plan  
Attn: Claims Dept.  
P.O. Box 3125  
Portland, OR 97208-3125

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#### Exclusions

- Replacement parts or batteries
- Replacement of lost or broken hearing aids
- Repair of hearing aids are not covered under this benefit. Repair needs should be discussed with your provider via your warranty period.
- Hearing aids prescribed and ordered prior to coverage, or prescribed or ordered after termination of coverage, whichever occurs first
- Bone anchored hearing aids

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# Your Benefit Summary

## Prescription Drug Plan

### Clackamas County - General County Employees

#### Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) or call us.
- You have broad access to over 26,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at [www.ProvidenceHealthPlan.com/planpharmacies](http://www.ProvidenceHealthPlan.com/planpharmacies) or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

Drug Coverage Category	Copay or Coinsurance		
	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	\$15	\$30	\$15
Brand-name drug	\$30	\$60	\$30
Compounded drug	50%	Does not apply	Does not apply

#### What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug. The cost difference does not apply to your medical plan out-of-pocket maximum.
- Compounded drugs are medications that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

#### Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Summary Plan Description for details.

#### Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) for answers to frequently asked questions about both generic drugs and the formulary.

## Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).

## If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

## Your guide to the words or phrases used to explain your benefits

### Brand-name drug

Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

### Coinsurance

The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

### Compounded drug

The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

### Copay

The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

### Formulary

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

### Generic drug

Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

### Maintenance drug

Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

### Participating pharmacies

Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Summary Plan Description.

### Prior authorization

The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

### Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

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# Your Benefit Summary

Personal Option Plan  
Clackamas County POA

<b>Copay</b>	<b>What You Pay</b>	<b>Calendar Year Out-of-Pocket Maximum</b>
\$15	Covered in full for most services	\$1,000 per person \$3,000 per family (3 or more)

## Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Summary Plan Description, register for [myProvidence](http://www.ProvidenceHealthPlan.com/getstarted) at [www.ProvidenceHealthPlan.com/getstarted](http://www.ProvidenceHealthPlan.com/getstarted).

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan only provides benefits for medically necessary services when provided by a participating physician or provider.
- Some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

Benefit Highlights	You pay the following for covered services:
	Copay or Coinsurance (from participating providers only)
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits</li> <li>• Phone and video visits (including Providence Health eXpress®)</li> <li>• Periodic health exams; well-baby care (from a Personal Physician/Provider only)</li> <li>• Vision and hearing screenings for children under 18</li> <li>• Routine immunizations; shots</li> <li>• Maternity services: prenatal</li> <li>• Maternity services: delivery and postnatal</li> <li>• Allergy shots; serums; injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul>	<ul style="list-style-type: none"> <li>\$15 / visit</li> <li>\$5 / visit</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>\$150 / delivery</li> <li>\$15 / visit</li> <li>Covered in full</li> <li>Covered in full</li> </ul>
<b>Women's Health Services</b>	
<ul style="list-style-type: none"> <li>• Gynecological exams (calendar year); Pap tests</li> <li>• Mammograms</li> </ul>	<ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full</li> </ul>
<b>Hospital Services</b>	
<ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Observation care</li> <li>• Maternity care</li> <li>• Routine newborn nursery care</li> <li>• Rehabilitative care (30 days per calendar year)</li> <li>• Skilled nursing facility (60 days per calendar year)</li> </ul>	<ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> <li>Covered in full</li> </ul>
<b>Outpatient Diagnostic Services</b>	
<ul style="list-style-type: none"> <li>• X-ray; lab services</li> <li>• Imaging services (such as PET, CT, MRI)</li> </ul>	<ul style="list-style-type: none"> <li>Covered in full</li> <li>Covered in full</li> </ul>
<b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices</b>	
(Removable custom shoe orthotics are limited to \$200 per calendar year)	20%
<b>Emergency / Urgent Care / Emergency Medical Transportation</b>	
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Emergency medical transportation</li> </ul>	<ul style="list-style-type: none"> <li>\$100</li> <li>\$15 / visit</li> <li>\$50</li> </ul>

## Benefit Highlights (continued)

Copay or Coinsurance

### Other Covered Services

- Outpatient rehabilitative services (30 visits per calendar year)
- Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy
- Temporomandibular joint (TMJ) service  
(limited to \$1,000 per calendar year / \$5,000 per lifetime)
- Home health care
- Hospice care
- Tobacco use cessation; counseling/classes and deterrent medications
- Self-administered chemotherapy  
(Up to a 30-day supply from a designated participating pharmacy)
  - Generic drugs
  - Formulary brand-name drugs
  - Non-formulary brand-name drugs

\$15 / visit  
Covered in full  
50%  
Covered in full  
Covered in full  
Covered in full  
Covered in full  
Covered in full  
Covered in full

### Mental Health / Chemical Dependency

(To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)

- Inpatient and day treatment services
- Residential services
- Applied behavior analysis
- Outpatient provider visits

Covered in full  
Covered in full  
\$15 / visit  
\$15 / visit

## Your guide to the words or phrases used to explain your benefits

### Coinsurance

The percentage of the cost that you may need to pay for a covered service.

### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### Formulary

A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

### Non-participating provider

Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

### Out-of-Pocket Maximum

The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Summary Plan Description for details.

### Participating provider

A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

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# Your Benefit Summary

## Out-of-Area Dependent Clackamas County POA

What You Pay In-Plan	Calendar Year Out-of-Pocket Maximum
20% coinsurance	\$1,000 per person \$3,000 per family (3 or more)

### Important information about your plan

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- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Some services must be prior authorized by us or a penalty will apply. See your Summary Plan Description for a list of these services
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

Benefit Highlights	You pay the following for covered services:
	<b>Coinsurance</b>
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits</li> <li>• Phone and video visits (including Providence Health eXpress®) (In-network providers only. You must be physically located in OR or WA to use Providence Health eXpress ®)</li> <li>• Periodic health exams; well-baby care (from a Personal Physician/Provider only)</li> <li>• Vision and hearing screenings for children under 18</li> <li>• Routine immunizations; shots</li> <li>• Maternity services: prenatal</li> <li>• Maternity services: delivery and postnatal</li> <li>• Allergy shots; serums; injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul>	20% 5% Covered in full Covered in full Covered in full Covered in full 20% 20% 20% 20%
<b>Women's Health Services</b>	
<ul style="list-style-type: none"> <li>• Gynecological exams (calendar year); Pap tests</li> <li>• Mammograms</li> </ul>	Covered in full Covered in full
<b>Hospital Services</b>	
<ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Observation care</li> <li>• Maternity care</li> <li>• Routine newborn nursery care</li> <li>• Rehabilitative care (30 days per calendar year)</li> <li>• Skilled nursing facility (60 days per calendar year)</li> </ul>	20% 20% 20% 20% 20% 20%
<b>Outpatient Diagnostic Services</b>	
<ul style="list-style-type: none"> <li>• X-ray; lab services</li> <li>• Imaging services (such as PET, CT, MRI)</li> </ul>	20% 20%
<b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices</b>	
(Removable custom shoe orthotics are limited to \$200 per calendar year)	20%
<b>Emergency / Urgent Care / Emergency Medical Transportation</b>	
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Emergency medical transportation</li> </ul>	20% 20% 20%

## Benefit Highlights (continued)

Coinsurance

### Other Covered Services

● Outpatient rehabilitative services (30 visits per calendar year)	20%
● Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
● Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)	50%
● Home health care	20%
● Hospice care	Covered in full
● Tobacco use cessation; counseling/classes and deterrent medications	Covered in full
● Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)	
-Generic drugs	\$10
-Formulary brand-name drugs	\$50
-Non-formulary brand-name drugs	\$100

### Mental Health / Chemical Dependency

(To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)

● Inpatient, residential services	20%
● Day treatment, intensive outpatient, and partial hospitalization services	20%
● Applied behavior analysis	20%
● Outpatient provider visits	20%

## Your guide to the words or phrases used to explain your benefits

### Coinsurance

The percentage of the cost that you may need to pay for a covered service.

### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### Formulary

A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

### Non-participating provider

Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

### Out-of-Pocket Maximum

The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Summary Plan Description for details.

### Participating provider

A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### Prior authorization

Some services must be pre-approved. You are responsible for obtaining prior authorization.

### Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

### Usual, Customary & Reasonable (UCR)

Describes your plan's allowed charges for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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# Your Benefit Summary

## Open Option Plan

### Clackamas County POA

Copay	What You Pay In-Plan	What You Pay Out-of-Plan	Calendar Year Common Out-of-Pocket Maximum (after deductible)	Calendar Year Common Deductible
\$10	Covered in full for most services	20% coinsurance (after deductible; UCR applies)	\$2,000 per person \$6,000 per family (3 or more)	\$50 per person \$150 per family (3 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Summary Plan Description, register for [myProvidence](http://www.ProvidenceHealthPlan.com/getstarted) at [www.ProvidenceHealthPlan.com/getstarted](http://www.ProvidenceHealthPlan.com/getstarted).

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### Benefit Highlights

After you pay your calendar year common deductible, then you pay the following for covered services:

	In-Plan Co-Pay or Coinsurance (after deductible, when you use a participating provider)	Out-of-Plan Copay or Coinsurance (after deductible, when you use a non-participating provider)
✓ No deductible needs to be met prior to receiving this benefit.		
<b>Physician / Provider Services</b>		
• Office visits	\$10 / visit <sup>✓</sup>	20% <sup>✓</sup>
• Phone and video visits (including Providence Health eXpress®)	\$5 / visit <sup>✓</sup>	Not covered
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full <sup>✓</sup>	20% <sup>✓</sup>
• Vision and hearing screenings for children under 18	Covered in full <sup>✓</sup>	20% <sup>✓</sup>
• Routine immunizations; shots	Covered in full <sup>✓</sup>	20% <sup>✓</sup>
• Maternity services: prenatal	Covered in full <sup>✓</sup>	20%
• Maternity services: delivery and postnatal	\$50 / delivery <sup>✓</sup>	20%
• Allergy shots; serums; injectable medications	Covered in full	20%
• Inpatient hospital visits	Covered in full	20%
• Surgery; anesthesia	Covered in full	20%
<b>Women's Health Services</b>		
• Gynecological exams (calendar year); Pap tests	Covered in full <sup>✓</sup>	20% <sup>✓</sup>
• Mammograms	Covered in full <sup>✓</sup>	20%
<b>Hospital Services</b>		
• Inpatient care	Covered in full	20%
• Observation care	Covered in full	20%
• Maternity care	Covered in full	20%
• Routine newborn nursery care	Covered in full <sup>✓</sup>	20%
• Rehabilitative care (30 days per calendar year)	Covered in full	20%
• Skilled nursing facility (60 days per calendar year)	Covered in full	20%
<b>Outpatient Diagnostic Services</b>		
• X-ray; lab services	Covered in full <sup>✓</sup>	20%
• Imaging services (such as PET, CT, MRI)	Covered in full <sup>✓</sup>	20%
<b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices</b>	20%*	20%

(Removable custom shoe orthotics are limited to \$200 per calendar year; deductible waived)

\*Your deductible(s) do not apply to purchases of diabetes supplies.

Benefit Highlights (continued)	In-Plan Co-Pay or Coinsurance	Out-of-Plan Copay or Coinsurance
<b>Emergency / Urgent Care / Emergency Medical Transportation</b>		
<ul style="list-style-type: none"> <li>Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits)</li> <li>Urgent care services (for non-life threatening illness/minor injury)</li> <li>Emergency medical transportation</li> </ul>	\$100✓ \$10 / visit✓ \$50	\$100✓ 20%✓ \$50
<b>Other Covered Services</b>		
<ul style="list-style-type: none"> <li>Outpatient rehabilitative services (30 visits per calendar year)</li> <li>Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>Home health care</li> <li>Hospice care</li> <li>Tobacco use cessation; counseling/classes and deterrent medications</li> <li>Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)               <ul style="list-style-type: none"> <li>-Generic drugs</li> <li>-Formulary brand-name drugs</li> <li>-Non-formulary brand-name drugs</li> </ul> </li> </ul>	\$10 / visit \$10 / visit 50% Covered in full Covered in full✓ Covered in full✓ \$10✓ \$10✓ \$10✓	20% 20% Not covered 20% Covered in full✓ Not covered Not covered Not covered
<b>Mental Health / Chemical Dependency</b>		
(To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
<ul style="list-style-type: none"> <li>Inpatient, residential services</li> <li>Day treatment, intensive outpatient, and partial hospitalization services</li> <li>Applied behavior analysis</li> <li>Outpatient provider visits</li> </ul>	Covered in full Covered in full \$10 / visit✓ \$10 / visit✓	20% 20% 20% 20%✓

## Your guide to the words or phrases used to explain your benefits

**Coinsurance**  
The percentage of the cost that you may need to pay for a covered service.

**Common deductible**  
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-plan or out-of-plan providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays or coinsurance for any supplemental benefits provided by your employer, such as prescription drugs, or routine vision care

**Common out-of-pocket maximum**  
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-plan services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Summary Plan Description for details.

**Copay**  
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

**Deductible carryover**  
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

**Formulary**  
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

**In-plan benefit**  
The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

**Non-participating provider**  
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

**Out-of-plan**  
Refers to services you receive from a non-participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

**Participating provider**  
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).


**Prior authorization**  
Some services must be pre-approved. In-Plan, your provider will request prior authorization. Out-of-Plan, you are responsible for obtaining prior authorization.

**Self-administered chemotherapy**  
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

**Usual, Customary & Reasonable (UCR)**  
Describes your plan's allowed charges for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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# Your Benefit Summary

## Chiropractic Care Plan

### Clackamas County - POA Active Employee

#### Plans

#### Copay

\$10

#### Maximum Calendar Year Benefit

\$1,500 per member

### Important information about your plan

• This chiropractic care benefit is offered as an additional option to your medical plan. This summary provides only highlights of your benefits. To view all your plan details, including your Summary Plan Description, register for **myProvidence** at [www.ProvidenceHealthPlan.com/getstarted](http://www.ProvidenceHealthPlan.com/getstarted).

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Your copays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### About your chiropractic care benefit

This plan covers chiropractic care services when they are:

- Received from a participating licensed chiropractic physician who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

### What you need to know before you use this benefit

- While you don't need a physician's referral to see a chiropractic provider, you must see a Providence Health Plan participating provider. To find a participating provider in your area, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory) or call us.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- Routine preventive care in the absence of an illness, injury, or disease is not covered.

### What is covered

Benefits for outpatient chiropractic services include:

- Office visits;
- Manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations;
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are medically necessary for the treatment of neuromusculoskeletal disorders;
- Related diagnostic X-rays and laboratory services.
- Services may require review for medical necessity.

### Your guide to the words or phrases used to explain your benefits

#### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

#### Maximum calendar year benefit

The total dollar amount of benefits that you can receive, per calendar year.

#### Medical Necessity Review

A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

#### Non-participating provider

Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

#### Participating provider

A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

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# Your Benefit Summary

## Prescription Drug Plan Clackamas County POA

### Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) or call us.
- You have broad access to over 26,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at [www.ProvidenceHealthPlan.com/planpharmacies](http://www.ProvidenceHealthPlan.com/planpharmacies) or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copays, coinsurance and any difference in costs for prescription drugs do not apply to your calendar year medical plan out-of-pocket maximums or deductibles.

Drug Coverage Category	Copay or Coinsurance		
	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	\$10	\$10	\$10
Brand-name drug	\$15	\$15	\$15
Compounded drug	50%	Does not apply	Does not apply

### What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug. The cost difference does not apply to your medical plan out-of-pocket maximum.
- Compounded drugs are medications that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

### Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.

## Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) for answers to frequently asked questions about both generic drugs and the formulary.

## Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).

## If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

## Your guide to the words or phrases used to explain your benefits

### Brand-name drug

Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

### Coinsurance

The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

### Compounded drug

The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

### Copay

The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

### Formulary

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

### Generic drug

Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

### Maintenance drug

Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

### Participating pharmacies

Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Summary Plan Description.

### Prior authorization

The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

### Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

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# Your Benefit Summary

## Open Option Plan

### Clackamas County Early Retirees, COBRA Participants & Temporary Employees

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
\$15	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	\$2,000 per person \$4,000 per family (2 or more)	\$1,000 per person \$2,000 per family (2 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
<ul style="list-style-type: none"> <li>✓ No deductible needs to be met prior to receiving this benefit.</li> </ul>		
<b>Preventive Care</b> <ul style="list-style-type: none"> <li>• Periodic health exams and well-baby care</li> <li>• Vision and hearing screenings for children under 18</li> <li>• Routine immunizations and shots</li> <li>• Colonoscopy (age 50+)</li> <li>• Gynecological exams (calendar year) and Pap tests</li> <li>• Mammograms</li> <li>• Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓	50% ✓ 50% ✓ 50% ✓ 50% 50% ✓ 50% Not covered
<b>Physician / Provider Services</b> <ul style="list-style-type: none"> <li>• Office visits</li> <li>• Office visits to alternative care provider (Chiropractic manipulation &amp; acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)</li> <li>• Phone and video visits (including Providence Health eXpress®)</li> <li>• Allergy shots, serums, infusions and injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul>	\$15 / visit ✓ \$15 / visit ✓ \$5 / visit ✓ 30% 30% 30%	50% ✓ 50% ✓ Not covered 50% 50% 50%
<b>Diagnostic Services</b> <ul style="list-style-type: none"> <li>• X-ray and lab services</li> <li>• High-tech imaging services (such as PET, CT or MRI)</li> <li>• Sleep studies</li> </ul>	30% ✓ 30% ✓ 30% ✓	50% 50% 50%
<b>Emergency and Urgent Services</b> <ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)</li> </ul>	\$100 ✓ \$15 / visit ✓ 30%	\$100 ✓ 50% ✓ 30%



Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
<b>Hospital Services</b> <ul style="list-style-type: none"> <li>● Inpatient/Observation care</li> <li>● Rehabilitative care (30 days per calendar year)</li> <li>● Skilled nursing facility (60 days per calendar year)</li> </ul>	30% 30% 30%	50% 50% 50%
<b>Outpatient Services</b> <ul style="list-style-type: none"> <li>● Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>● Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>● Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)</li> </ul>	30% 50% 30%	50% Not covered 50%
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>● Prenatal care</li> <li>● Delivery and postnatal services</li> <li>● Inpatient hospital/facility services</li> <li>● Routine newborn nursery care</li> </ul>	Covered in full✓ \$100 / delivery✓ 30% 30%✓	50% 50% 50% 50%
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>● Medical equipment, appliances and supplies</li> <li>● Diabetes supplies (lancets, test strips and needles)</li> <li>● Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)</li> </ul>	30% 30%✓ 30%	50% 50% 50%
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.) <ul style="list-style-type: none"> <li>● Inpatient and residential services</li> <li>● Day treatment, intensive outpatient, and partial hospitalization services</li> <li>● Applied behavior analysis</li> <li>● Outpatient provider visits</li> </ul>	30% 30% 30% \$15 / visit✓	50% 50% 50% 50%✓
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>● Home health care</li> <li>● Hospice care</li> </ul>	30% Covered in full✓	50% Covered in full✓

## Your guide to the words or phrases used to explain your benefits

### Coinsurance

The percentage of the cost that you may need to pay for a covered service.

### Common deductible

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible

### Common out-of-pocket maximum

The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-network services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Summary Plan Description for details.

### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### Formulary

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

### In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

### Limitations and Exclusions

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Summary Plan Description or contract for a complete list.

### Out-of-Network

Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### Personal Physician/Provider

A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

### Prior authorization

Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

### Usual, Customary & Reasonable (UCR)

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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# Your Benefit Summary

## Chiropractic Manipulation and Acupuncture Clackamas County Retirees and COBRA Participants

<b>Copay</b>	<b>Maximum Calendar Year Benefit</b>
<b>\$25</b>	<b>\$500</b> per member

### Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- With this benefit you have access to in-network qualified practitioners, including chiropractors and acupuncturists, for chiropractic manipulations and acupuncture
- Your medical Deductible does not apply to these benefits and copayments do not apply to your medical plan Out-of-Pocket maximum.
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### About your chiropractic and acupuncture benefits

This plan covers chiropractic manipulations and acupuncture when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physicians or acupuncturists, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Summary Plan Description.

### What you need to know before you use this benefit

- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory) or call us.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. Unless you are enrolled in an HSA plan, you do not need to meet any applicable medical plan deductibles before receiving this benefit.
- Routine preventive care in the absence of an illness, injury, or disease is not covered.

### Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

### Acupuncture covered services

- Acupuncture
- Services may require review for medical necessity.

## Your guide to the words or phrases used to explain your benefits

#### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

#### In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

#### Maximum calendar year benefit

The total dollar amount of benefits that you can receive, per calendar year.

#### Medical Necessity Review

A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

#### Out-of-Network

Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

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# Your Benefit Summary

## Prescription Drug Plan

### Clackamas County Early Retirees and COBRA Participants

#### Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, including your Summary Plan Description, register for [myProvidence](http://www.ProvidenceHealthPlan.com/myProvidence) at [www.ProvidenceHealthPlan.com/getstarted](http://www.ProvidenceHealthPlan.com/getstarted).

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) or call us.
- You have broad access to over 26,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at [www.ProvidenceHealthPlan.com/planpharmacies](http://www.ProvidenceHealthPlan.com/planpharmacies) or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

Drug Coverage Category	Copay or Coinsurance		
	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	\$10	\$30	\$10
Brand-name drug	50%	50%	50%
Compounded drug	50%	Does not apply	Does not apply

#### What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug. The cost difference does not apply to your medical plan out-of-pocket maximum.
- Compounded drugs are medications that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

#### Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Summary Plan Description for details.

#### Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) for answers to frequently asked questions about both generic drugs and the formulary.

## Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).

## If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

## Your guide to the words or phrases used to explain your benefits

### Brand-name drug

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### Coinsurance

The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

### Compounded drug

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### Copay

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### Generic drug

Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

### Maintenance drug

Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

### Participating pharmacies

Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Summary Plan Description.

### Prior authorization

The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

### Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

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# Your Benefit Summary

## Non-Medicare Eligible Retired Employees Clackamas County

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### Important information about your plan

This Benefit Summary supplements your employer group's health plan to include non-Medicare Retired Employee coverage.

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### Retired Employee definition

A Retired Employee is a non-Medicare eligible subscriber who retires from employment with the employer.

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### Retired Employee eligibility

A retiring subscriber is eligible for retiree medical coverage on the date of retirement upon satisfying the eligibility requirements as stated in the Summary Plan Description and/or the Employer Group Contract.

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### Retired Employee dependent eligibility

Eligible family dependents of Retired Employees are eligible for coverage when indicated as covered in the Employer/Group Agreement. Please check with your employer to see if your family dependents are eligible for coverage. Eligible family dependents are subject to the eligibility and enrollment requirements as stated in your Summary Plan Description.

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### Enrollment

Notification of the subscriber's retirement must be submitted to us by your employer within 60 days of the date of retirement, unless otherwise indicated on your employer's group contract.

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### Termination of coverage

In addition to the termination provisions stated in your Summary Plan Description, members who become eligible for Medicare will no longer qualify for coverage under this supplemental benefit. Termination will occur on the earlier of the effective date stated in the Employer/Group Agreement or the last day of the month in which the individual no longer qualifies for this coverage.

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### Continuation of coverage

Retired employees and their eligible family dependents who qualify for Continuation Coverage are entitled to elect Continuation Coverage under this group contract.

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# Your Benefit Summary

## Men's Elective Sterilization

### Clackamas County

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#### Covered Services

Covered services include male elective sterilization (vasectomy) services. Prior authorization is not required and Members may receive covered services from the provider and/or facility of their choice.

Please review your medical Benefit Summary for your Copayment or Coinsurance amounts. For Members enrolled on a medical plan with In-Network and Out-of-Network benefits, elective sterilization services are covered at the Outpatient Surgery In-Network Copayment or Coinsurance amount.

Your medical plan Deductible, if any, does not apply to this benefit.

Copayments and coinsurance apply to your medical plan Out-of-Pocket Maximum.

All Covered Services are subject to the specific conditions, duration limitations and all applicable maximums of the Group Administrative Services Agreement on a Usual, Customary and Reasonable (UCR) cost basis.

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#### Please note:

Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience does not offer these services at Providence Health & Services facilities. Services are available at other Participating facilities.

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# Your Benefit Summary

## Domestic Partner Plus Clackamas County

### Important information about your plan

This Benefit Summary supplements your employer group's health plan and amends your standard domestic partner coverage.

### Domestic partner definition

The domestic partner definition found in your Summary Plan Description is amended to read:

Domestic partner means either of the following:

An Oregon Registered Domestic Partner is a person who is:

1. At least 18 years of age;
2. Has entered into a domestic partnership with a subscriber of the same sex; and
3. Has legally registered a Declaration of Domestic Partnership and obtained a Certificate of Registered Domestic Partnership in accordance with Oregon state law.

A domestic partner who is not an Oregon Registered Domestic Partner is a person at least 18 years of age who:

1. Shares a close personal relationship with a subscriber such that each is responsible for each other's welfare;
2. Is the subscriber's sole domestic partner;
3. Is not married to any person and does not have another domestic partner;
4. Is not related by blood to the subscriber as a first cousin or nearer;
5. Shares with the subscriber the same regular and permanent residence, with the current intention of doing so indefinitely;
6. Is jointly financially responsible with the subscriber for basic living expenses such as food and shelter;
7. Was mentally competent to consent to contract when the domestic partnership began; and
8. Has provided the required employer documentation establishing that a domestic partnership exists.

- Note: All provisions of your Summary Plan Description that apply to a spouse shall apply to a domestic partner.

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# EXHIBIT D

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## Kaiser Permanente Medical and Dental Underwriting


**Rate Buildup**
**Group Name:** CLACKAMAS COUNTY

**Group Number(s):** 1183

**Subgroup(s):** 001 ,007 ,013 ,018 ,024 ,028 ,029 ,  
030 ,031 ,032 ,040 ,042 ,058 ,059

**Product Type:** Traditional

**Quote Name:** Plan C16C – Custom subgroups 001, etc.

**Region:** Northwest

**Contract Period:** 01/01/2016 – 12/31/2016

**Report Period:** Mar 2014 through Feb 2015

**Mar14-Feb15**
**Average Members:**

1,572

**Rating Month:** March 2015

**Rating Members:** 1,334

Medical Calculation		Weight	Factor	Total\$	PMPM\$
A	<b>Projected Claims Calculation</b>				
A1	Paid Claims			\$6,907,077	\$366.248
A2	- Pooling Credit			0	0.000
	Pooling Point:\$185,000				
A3	+ Pooling Charge			182,744	9.690
A4	Claims Net of Pooling			\$7,089,821	\$375.938
A5	X Incurred Claims Adjustment		1.03218		
A6	X Demographic Change		1.00805		
A7	X Historical Benefit Change		1.002740		
A8	Adjusted Claims				\$392.231
A9	X Trend Factor		1.11237		
	Annual Trend: 5.98%				
A10	Claims based PMPM				\$436.306
	22.0 Months Midpoint to Midpoint				
A11	Credibility	100%			

Total Rate Calculation		Factor	Mo. Prem.	PMPM\$
D	<b>Total Rate Calculation</b>			
D1	Blended Rate		\$582,032	\$436.306
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		\$582,032	\$436.306
D4	+ Retention		43,088	32.300
D5	+ Other Benefits		17,355	13.010
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		5,601	4.199
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		3,242	2.430
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	<b>Uncapped PMPM Premium Requirement</b>		<b>\$651,319</b>	<b>\$488.245</b>
E	<b>Capping</b>	<b>Increase</b>		
E1	In-Force Rate		\$666,494	\$499.621
E2	Premium Requirement without Changes and Underwriter Adjustment	(2.28%)	651,319	488.245
E3	Capping Rate	(2.10)%	652,506	489.135
E4	<b>Quoted Rate PMPM before Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>652,506</b>	<b>489.135</b>
E5	X Underwriter Adjustment	1.00000		
E6	<b>Quoted Rate PMPM after Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>652,506</b>	<b>489.135</b>
E7	Capping Adjustment		1,187	0.890


**Rate Buildup**
**Group Name:** CLACKAMAS COUNTY

**Group Number(s):** 1183

**Subgroup(s):** 001 ,007 ,013 ,018 ,024 ,028 ,029 ,  
030 ,031 ,032 ,040 ,042 ,058 ,059

**Product Type:** Traditional

**Quote Name:** Plan C16B – Custom subgroups 007, 018, 030

**Region:** Northwest

**Contract Period:** 01/01/2016 – 12/31/2016

**Report Period:** Mar 2014 through Feb 2015

**Mar14-Feb15**
**Average Members:**

1,572

**Rating Month:** March 2015

**Rating Members:** 267

Medical Calculation		Weight	Factor	Total\$	PMPM\$
A	<b>Projected Claims Calculation</b>				
A1	Paid Claims			\$6,907,077	\$366.248
A2	- Pooling Credit			0	0.000
	Pooling Point:\$185,000				
A3	+ Pooling Charge			182,744	9.690
A4	Claims Net of Pooling			\$7,089,821	\$375.938
A5	X Incurred Claims Adjustment		1.03218		
A6	X Demographic Change		1.00805		
A7	X Historical Benefit Change		1.000040		
A8	Adjusted Claims				\$391.175
A9	X Trend Factor		1.11237		
	Annual Trend: 5.98%				
A10	Claims based PMPM				\$435.131
	22.0 Months Midpoint to Midpoint				
A11	Credibility	100%			

Total Rate Calculation		Factor	Mo. Prem.	PMPM\$
D	<b>Total Rate Calculation</b>			
D1	Blended Rate		\$116,180	\$435.131
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		\$116,180	\$435.131
D4	+ Retention		8,624	32.300
D5	+ Other Benefits		3,303	12.370
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		1,117	4.183
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		649	2.430
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	<b>Uncapped PMPM Premium Requirement</b>		<b>\$129,873</b>	<b>\$486.414</b>
E	<b>Capping</b>	<b>Increase</b>		
E1	In-Force Rate		\$129,248	\$484.074
E2	Premium Requirement without Changes and Underwriter Adjustment	0.48%	129,873	486.414
E3	Capping Rate	(2.10)%	126,535	473.915
E4	<b>Quoted Rate PMPM before Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>126,535</b>	<b>473.915</b>
E5	X Underwriter Adjustment	1.00000		
E6	<b>Quoted Rate PMPM after Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>126,535</b>	<b>473.915</b>
E7	Capping Adjustment		(3,337)	(12.499)


**Rate Buildup**
**Group Name:** CLACKAMAS COUNTY

**Group Number(s):** 1183

**Subgroup(s):** 001 ,007 ,013 ,018 ,024 ,028 ,029 ,  
030 ,031 ,032 ,040 ,042 ,058 ,059

**Product Type:** Traditional-Low Deductible

**Quote Name:** Plan 3C16 – Custom subgroups 058, 060, 066

**Region:** Northwest

**Contract Period:** 01/01/2016 – 12/31/2016

**Report Period:** Mar 2014 through Feb 2015

**Mar14-Feb15**
**Average Members:**

1,572

**Rating Month:** March 2015

**Rating Members:** 10

Medical Calculation		Weight	Factor	Total\$	PMPM\$
A	<b>Projected Claims Calculation</b>				
A1	Paid Claims			\$6,907,077	\$366.248
A2	- Pooling Credit	Pooling Point:\$185,000		0	0.000
A3	+ Pooling Charge			182,744	9.690
A4	Claims Net of Pooling			\$7,089,821	\$375.938
A5	X Incurred Claims Adjustment		1.03218		
A6	X Demographic Change		1.00805		
A7	X Historical Benefit Change		0.761840		
A8	Adjusted Claims				\$298.002
A9	X Trend Factor	Annual Trend: 5.98%	1.11237		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint			\$331.489
A11	Credibility	100%			

Total Rate Calculation		Factor	Mo. Prem.	PMPM\$
D	<b>Total Rate Calculation</b>			
D1	Blended Rate		\$3,315	\$331.489
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		\$3,315	\$331.489
D4	+ Retention		323	32.300
D5	+ Other Benefits		124	12.370
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		33	3.284
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		24	2.430
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	<b>Uncapped PMPM Premium Requirement</b>		<b>\$3,819</b>	<b>\$381.873</b>
E	<b>Capping</b>	<b>Increase</b>		
E1	In-Force Rate		\$4,733	\$473.251
E2	Premium Requirement without Changes and Underwriter Adjustment	(19.31%)	3,819	381.873
E3	Capping Rate	(2.10)%	4,633	463.319
E4	<b>Quoted Rate PMPM before Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>4,633</b>	<b>463.319</b>
E5	X Underwriter Adjustment	1.00000		
E6	<b>Quoted Rate PMPM after Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>4,633</b>	<b>463.319</b>
E7	Capping Adjustment		814	81.446


**Rate Buildup**
**Group Name:** CLACKAMAS COUNTY

**Group Number(s):** 1183

**Subgroup(s):** 001 ,007 ,013 ,018 ,024 ,028 ,029 ,  
030 ,031 ,032 ,040 ,042 ,058 ,059

**Product Type:** Traditional-Low Deductible

**Quote Name:** Plan 3C16 – Custom subgroups 059, 063, 068

**Region:** Northwest

**Contract Period:** 01/01/2016 – 12/31/2016

**Report Period:** Mar 2014 through Feb 2015

**Mar14-Feb15**
**Average Members:**

1,572

**Rating Month:** March 2015

**Rating Members:** 15

Medical Calculation		Weight	Factor	Total\$	PMPM\$
A	<b>Projected Claims Calculation</b>				
A1	Paid Claims			\$6,907,077	\$366.248
A2	- Pooling Credit			0	0.000
	Pooling Point:\$185,000				
A3	+ Pooling Charge			182,744	9.690
A4	Claims Net of Pooling			\$7,089,821	\$375.938
A5	X Incurred Claims Adjustment		1.03218		
A6	X Demographic Change		1.00805		
A7	X Historical Benefit Change		0.763900		
A8	Adjusted Claims				\$298.807
A9	X Trend Factor		1.11237		
	Annual Trend: 5.98%				
A10	Claims based PMPM				\$332.384
	22.0 Months Midpoint to Midpoint				
A11	Credibility	100%			

Total Rate Calculation		Factor	Mo. Prem.	PMPM\$
D	<b>Total Rate Calculation</b>			
D1	Blended Rate		\$4,986	\$332.384
D2	X Future Benefit Change	1.000000		
D3	Adjusted PMPM		\$4,986	\$332.384
D4	+ Retention		485	32.300
D5	+ Other Benefits		186	12.370
D6	+ Group Specific Charge		0	0.000
D7	+ Late Payment Charge		0	0.000
D8	+ Federal Health Insurer Fee		49	3.292
D9	+ Federal PCORI Fee/Transitional Reinsurance Program Contribution		36	2.430
D10	+ Premium Tax		0	0.000
D11	+ Commission		0	0.000
D12	<b>Uncapped PMPM Premium Requirement</b>		<b>\$5,742</b>	<b>\$382.776</b>
E	<b>Capping</b>	<b>Increase</b>		
E1	In-Force Rate		\$7,098	\$473.189
E2	Premium Requirement without Changes and Underwriter Adjustment	(19.11%)	5,742	382.776
E3	Capping Rate	(2.10)%	6,949	463.258
E4	<b>Quoted Rate PMPM before Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>6,949</b>	<b>463.258</b>
E5	X Underwriter Adjustment	1.00000		
E6	<b>Quoted Rate PMPM after Underwriter Adjustment</b>	<b>(2.10)%</b>	<b>6,949</b>	<b>463.258</b>
E7	Capping Adjustment		1,207	80.482


**Rate Buildup**

**Group Name:** Clackamas County      **Region:** Northwest  
**Contract Period:** 01/01/2016 – 12/31/2016  
**Group Number(s):** 01183-043, 045, 046, 047, 049, 050, 051      **Report Period:** Apr 2014 through Mar 2015

**Product Type:** Traditional

**Average Members:** 1,632

**Rating Month:** March 2015

**Quote name:** Dental Plan C

**Rating Members:** 1,680

**Dental Calculation**

A. Projected Claims Calculation		Weight	Factor	Total\$	PMPM\$
A1	Paid Claims			\$986,516	\$50.37
A2	x Incurred Claim Adjustment		1.0000		
A3	x Demographic Change		0.9983		
A4	x Historical Benefit Change		1.0000		
A5	x Historical Deductible Change		1.0000		
A6	x Historical Office Visit Change		1.0000		
A7	x Trend Factor		1.0801		
A8	Claims Based PMPM	21 Months Midpoint to Midpoint			\$54.31
A9	Credibility	100%			

Annual Trend: 4.50%

**Total Rate Calculation**

C. Total Rate Calculation		Factor	Mo. Prem.\$	PMPM\$
C1	Blended Rate		\$91,249	\$54.31
C2	x Future Benefit Change	1.0000		
C3	+ Future Office Visit Change	1.0000		
C4	x Future Deductible Change	1.0000		
C5	Adjusted PMPM		\$91,249	\$54.31
C6	+ Retention		\$6,888	\$4.10
C7	+ Group Specific Charges		0	\$0.00
C8	+ Late Payment Charge		0	\$0.00
C9	+ Orthodontics (L)		7,594	\$4.52
C10	+ Commission		0	\$0.00
C11	+ Insurer Tax		917	\$0.55
C12	PMPM Revenue Requirement		<b>\$106,647</b>	<b>\$63.48</b>
D. Capping		Increase		
D1	In-Force rate		\$100,898	\$60.06
D2	Revenue Requirement without Benefit Change and UW Adjustmt	5.7%	106,647	\$63.48
D3	Capping Rate	5.7%	106,647	\$63.48
<b>D4</b>	<b>Quoted rate PMPM before UW Adj</b>	<b>5.7%</b>	<b>106,647</b>	<b>\$63.48</b>
D5	x Underwriter Adjustment	1.0000		
<b>D6</b>	<b>Quoted rate PMPM after UW Adj</b>	<b>5.7%</b>	<b>106,647</b>	<b>\$63.48</b>
D7	Capping Adjustment	0.0%	(0)	(\$0.00)

# EXHIBIT E

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## Kaiser Permanente – 2016 Contract Changes

# 2016 CONTRACT CHANGES CLACKAMAS COUNTY

Jennifer Pittman, Executive Account Manager



# Clackamas County 2016 Contract Changes

Contract Change	Current (2015)	New (2016)	Rationale	Rate Impact
<b>Student Out of Area Coverage</b>	Student Out-of-Area: 20% coinsurance, \$1,200 Benefit Maximum. Does not accumulate to Out-of-Pocket Maximum.	Dependent child: 10 OV, 10 X-ray/Lab, 10 Prescriptions. 20% coinsurance for all services. Benefit accumulates to Out-of-Pocket Maximum. <i>*no student verification needed</i>	ACA mandate to remove dollar limits and accumulate to the Out-of-Pocket Maximum, as benefit covers Essential Health Benefits.	Enhancement  <i>\$.02 increase to PMPM</i>
<b>Physical, Occupational, Speech Therapies</b>	Subject to deductible.	Not subject to deductible, copays apply	Member experience, steers members to the most appropriate medical care.	Enhancement  <i>Increases rates by less than 0.01%</i>
<b>Pediatric and Adult Vision Hardware</b>	Adult hardware allowance is based on a rolling 24 months since last use. Pediatric is based on calendar year.	Both Adult AND Pediatric hardware will refresh on a calendar year cycle, every 12/24 months (peds/adult).	Member experience, all family members will have the same benefit refresh cycle.	Enhancement  <i>No rate impact</i>
<b>Mental Health Service Exclusions and Limitations</b>	Specific diagnosis codes listed as excluded or limited (example: mental retardation, paraphilia, learning disorders, life transition).	No mental health services are listed as excluded or limited.	Mental Health Parity Compliance Clarification.	Enhancement  <i>No rate impact</i>

# Clackamas County 2016 Contract Changes, cont.

Contract Change	Current (2015)	New (2016)	Rationale	Rate Impact
<b>Port Wine Stain Treatment (on the face)</b>	Treatment <i>only</i> for members under the age of 18.	No age limit to treat port wine stains on the face.	HHS final rules released in March 2015 prohibit discrimination in adjudicating benefits based on age, unless there are age-related clinical criteria.	Enhancement <i>No rate impact</i>
<b>Detained or Confined Members</b>	Services arranged by criminal justice officials (unless emergency) listed as excluded.	These services are not excluded.	OR state legislation	Enhancement <i>No rate impact</i>
<b>Genetic Testing</b>	Genetic testing for non-Kaiser members is excluded. Examples: cystic fibrosis, breast cancer, Huntington's diseases.	Genetic testing for family members who are non-Kaiser members are covered, if for the benefit of the member. Subject to medical necessity.	Member health outcomes.	Enhancement <i>No rate impact</i>
<b>Unlicensed Providers</b>	Services provided by non-licensed providers are excluded. This was a concern regarding ABA therapies. Example: Board Certified Behavior Analysts.	Services by certain non-licensed providers for ABA therapies are covered.	OR state legislation related to ABA therapy	Enhancement <i>No rate impact</i>

# EXHIBIT F

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## Kaiser Permanente – 2016 Benefit Summaries

All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

# Summary of Medical Benefits

Oregon C16C-General County

January 1, 2016 - December 31, 2016

Clackamas County

Group Number: 1183

**Out-of-Pocket Maximum** (Note: All Copayment and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)

For one Member	\$600
For an entire Family	\$1,200
<b>Office visits</b>	<b>You pay</b>
Routine preventative physical exam	\$0
Primary Care	\$10
Specialty Care	\$10
Urgent Care	\$10
<b>Tests (outpatient)</b>	<b>You pay</b>
Preventive Tests	\$0
Laboratory	\$0
X-ray, imaging, and special diagnostic procedures	\$0
CT, MRI, PET scans	\$0 per department visit
<b>Medications (outpatient)</b>	<b>You pay</b>
Prescription drugs (up to a 30 day supply)*	\$10 generic/\$20 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)*	\$20 generic/\$40 preferred brand
Administered medications, including injections (all outpatient settings)	\$0
Nurse treatment room visits to receive injections	\$0
<b>Maternity Care</b>	<b>You pay</b>
Scheduled prenatal care and first postpartum visit	\$0
Laboratory	\$0
X-ray, imaging, and special diagnostic procedures	\$0
Inpatient Hospital Services	\$0
<b>Hospital Services</b>	<b>You pay</b>
Ambulance Services (per transport)	\$75
Emergency department visit	\$75 (Waived if admitted)
Inpatient Hospital Services	\$0
<b>Outpatient Services (other)</b>	<b>You pay</b>
Outpatient surgery visit	\$10
Chemotherapy/radiation therapy visit	\$10
Durable medical equipment, external prosthetic devices, and orthotic devices	\$0

Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	\$10
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	\$0
<b>Chemical Dependency Services</b>	<b>You pay</b>
Outpatient Services (Group visit ½ copay)	\$10
Inpatient hospital & residential Services	\$0
<b>Mental Health Services</b>	<b>You pay</b>
Outpatient Services (Group visit ½ copay)	\$10
Inpatient hospital & residential Services	\$0
<b>Alternative Care</b>	<b>You pay</b>
Alternative care (self-referred)*	\$10 per visit for acupuncture, chiropractic, and naturopathic visits. \$25 per massage therapy visit (up to 12 visits per Calendar Year). \$1,500 benefit maximum for all Services combined.
<b>Vision Services</b>	<b>You pay</b>
Routine eye exam (through first month of age 19)	\$0
Vision hardware and optical Services (through first month of age 19) *	No charge for one pair standard frames and lenses or contact lenses every 12 months.
Routine eye exam (age 19 and older)	\$10
Vision hardware and optical Services (ages 19 years and older)*	Balance after \$250 allowance every 24 months

\* Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

### Additional Features

#### Online Access anytime, anywhere at no additional charge: [kp.org](http://kp.org)

- Access medical records
- Refill Prescriptions
- Email doctor
- Check lab results
- Schedule appointments
- Health Risk Assessments – personal online tool for members

#### Member Discounts: [kp.org/choosehealthy](http://kp.org/choosehealthy)

- CHP Active and Healthy
- Fitness club discounts
- Vitamins and supplements
- Alternative and chiropractic care

#### Facilities and Services: [kp.org/facilities](http://kp.org/facilities)

- 37 Medical office
- 8 Urgent Care Services
- 17 Dental offices
- The Portland Clinic (7 locations)
- 24-hours advise nurses
- Health coach services

## Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the *Evidence of Coverage (EOC)*. For a complete list and description of Exclusions and Limitations please refer to *EOC*.

**Acupuncture** unless your employer Group has purchased the "Alternative Care Services Rider". **Chiropractic** unless your employer Group has purchased the "Alternative Care Services Rider" or the "Chiropractic Services Rider" (for self-referred chiropractic care). **Cosmetic Services**; This exclusion does not apply to Services that are covered under "Reconstructive Surgery Services" in the "Benefits" section of the *EOC*. **Custodial Services. Dental Services. Designated Blood Donations. Employer Responsibility**; We do not reimburse the employer for any Services that the law requires an employer to provide. **Experimental or Investigational Services. Eye Surgery**; Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures. **Family Services**; Services provided by a member of your immediate family. **Genetic Testing. Hearing Aids** unless your Group has purchased the "Hearing Aid Rider." **Hypnotherapy. Infertility Services** unless your group has purchased the "Infertility Treatment Services Rider." **Intermediate Services**; Services in an intermediate care facility are excluded. **Low-Vision Aids. Massage Therapy Services** unless your employer Group has purchased the "Alternative Care Services Rider". **Naturopathy Services** unless your employer Group has purchased the "Alternative Care Services Rider". **Non-Medically Necessary Services. Services Related to a Non-Covered Service. Services That are Not Health Care Services, Supplies, or Items. Sterilization Services. Supportive Care and Other Services. Surrogacy.** Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. **Travel and Lodging. Travel Services.** All travel-related Services including travel-only immunizations (such as yellow fever, typhoid, and Japanese encephalitis), unless your Group has purchased the "Travel Services Rider." **Vision Hardware and Optical Services** unless your Group has purchased an "Adult Vision Hardware and Optical Services Rider" and/or "Pediatric Vision Hardware and Optical Services Rider." **Vision Therapy and Orthoptics or Eye Exercises.**

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**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org**

Portland area.503-813-2000. All other areas.1-800-813-2000. TTY.711. Language Interpretation Services, all areas.1-800-324-8010

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This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on benefit coverage, claims review, and adjudication procedures, please see your *EOC* or call Membership Services. In the case of conflict between this summary and the *EOC*, the *EOC* will prevail.

# Summary of Medical Benefits

Oregon C16B-Peace Officers (POA)

January 1, 2016 - December 31, 2016

Clackamas County

Group Number: 1183

**Out-of-Pocket Maximum** (Note: All Copayment and Coinsurance amounts count toward the Out-of-Pocket Maximum, unless otherwise noted.)

For one Member	\$600
For an entire Family	\$1,200
<b>Office visits</b>	<b>You pay</b>
Routine preventative physical exam	\$0
Primary Care	\$10
Specialty Care	\$10
Urgent Care	\$10
<b>Tests (outpatient)</b>	<b>You pay</b>
Preventive Tests	\$0
Laboratory	\$0
X-ray, imaging, and special diagnostic procedures	\$0
CT, MRI, PET scans	\$0 per department visit
<b>Medications (outpatient)</b>	<b>You pay</b>
Prescription drugs (up to a 30 day supply)*	\$10 generic/\$20 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)*	\$20 generic/\$40 preferred brand
Administered medications, including injections (all outpatient settings)	\$0
Nurse treatment room visits to receive injections	\$0
<b>Maternity Care</b>	<b>You pay</b>
Scheduled prenatal care and first postpartum visit	\$0
Laboratory	\$0
X-ray, imaging, and special diagnostic procedures	\$0
Inpatient Hospital Services	\$0
<b>Hospital Services</b>	<b>You pay</b>
Ambulance Services (per transport)	\$75
Emergency department visit	\$75 (Waived if admitted)
Inpatient Hospital Services	\$0
<b>Outpatient Services (other)</b>	<b>You pay</b>
Outpatient surgery visit	\$10
Chemotherapy/radiation therapy visit	\$10
Durable medical equipment, external prosthetic devices, and orthotic devices	\$0

Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	\$10
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	\$0
<b>Chemical Dependency Services</b>	<b>You pay</b>
Outpatient Services (Group visit ½ copay)	\$10
Inpatient hospital & residential Services	\$0
<b>Mental Health Services</b>	<b>You pay</b>
Outpatient Services (Group visit ½ copay)	\$10
Inpatient hospital & residential Services	\$0
<b>Alternative Care</b>	<b>You pay</b>
Alternative care (self-referred)*	\$10 per visit for acupuncture, chiropractic, and naturopathic visits. \$25 per massage therapy visit (up to 12 visits per Calendar Year). \$1,500 benefit maximum for all Services combined.
<b>Vision Services</b>	<b>You pay</b>
Routine eye exam (through first month of age 19)	\$0
Vision hardware and optical Services (through first month of age 19) *	No charge for one pair standard frames and lenses or contact lenses every 12 months.
Routine eye exam (age 19 and older)	\$10
Vision hardware and optical Services (ages 19 years and older)*	Balance after \$200 allowance every 24 months

\* Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

### Additional Features

#### Online Access anytime, anywhere at no additional charge: [kp.org](http://kp.org)

- Access medical records
- Refill Prescriptions
- Email doctor
- Check lab results
- Schedule appointments
- Health Risk Assessments – personal online tool for members

#### Member Discounts: [kp.org/choosehealthy](http://kp.org/choosehealthy)

- CHP Active and Healthy
- Fitness club discounts
- Vitamins and supplements
- Alternative and chiropractic care

#### Facilities and Services: [kp.org/facilities](http://kp.org/facilities)

- 37 Medical office
- 8 Urgent Care Services
- 17 Dental offices
- The Portland Clinic (7 locations)
- 24-hours advise nurses
- Health coach services



## Exclusions and Limitations

The Services listed below are either completely excluded from coverage or partially limited. This applies to all Services that would otherwise be covered and is in addition to the exclusions and limitations that apply only to a particular Service as listed in the description of that Service in the *Evidence of Coverage (EOC)*. For a complete list and description of Exclusions and Limitations please refer to *EOC*.

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**Questions? Call Member Services** (M-F, 8 am-6 pm) or visit **kp.org**

Portland area.503-813-2000. All other areas.1-800-813-2000. TTY.711. Language Interpretation Services, all areas.1-800-324-8010

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All plans offered and underwritten by Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St., Suite 100, Portland, OR 97232

# Summary of Medical Benefits

Oregon 3C16-General County Early Retirees

January 1, 2016 - December 31, 2016

Clackamas County

Group Number: 1183

## Deductible

For one Member per Calendar Year	\$1,000
For an entire Family per Calendar Year	\$3,000

**Out-of-Pocket Maximum** (Note: Deductible amounts and Services not subject to the Deductible do not count toward your Out-of-Pocket Maximum.)

For one Member	\$3,000
For an entire Family	\$9,000

## Office visits

### You pay

Routine preventative physical exam	\$0
Primary Care	\$25
Specialty Care	20% Coinsurance after Deductible
Urgent Care	\$25

## Tests (outpatient)

### You pay

Preventive Tests	\$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
CT, MRI, PET scans	\$0 per department visit

## Medications (outpatient)

### You pay

Prescription drugs (up to a 30 day supply)*	\$15 generic/\$30 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)*	\$30 generic/\$60 preferred brand
Administered medications, including injections (all outpatient settings)	\$0
Nurse treatment room visits to receive injections	\$5

## Maternity Care

### You pay

Scheduled prenatal care and first postpartum visit	\$0
Laboratory	20% Coinsurance after Deductible
X-ray, imaging, and special diagnostic procedures	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible

## Hospital Services

### You pay

Ambulance Services (per transport)	20% Coinsurance after Deductible
Emergency department visit	20% Coinsurance after Deductible
Inpatient Hospital Services	20% Coinsurance after Deductible

## Outpatient Services (other)

### You pay

Outpatient surgery visit	20% Coinsurance after Deductible
Chemotherapy/radiation therapy visit	20% Coinsurance after Deductible
Durable medical equipment, external prosthetic devices, and orthotic devices	20% Coinsurance after Deductible

Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	20% Coinsurance after Deductible
<b>Skilled Nursing Facility Services</b>	<b>You pay</b>
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
<b>Chemical Dependency Services</b>	<b>You pay</b>
Outpatient Services (Group visit ½ copay)	\$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
<b>Mental Health Services</b>	<b>You pay</b>
Outpatient Services (Group visit ½ copay)	\$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
<b>Alternative Care</b>	<b>You pay</b>
Alternative care (self-referred)*	\$10 per visit for acupuncture, chiropractic, and naturopathic visits. \$25 per massage therapy visit (up to 12 visits per Calendar Year). \$1,500 benefit maximum for all Services combined.
<b>Vision Services</b>	<b>You pay</b>
Routine eye exam (through first month of age 19)	\$0
Vision hardware and optical Services (through first month of age 19) *	No charge for one pair standard frames and lenses or contact lenses every 12 months.
Routine eye exam (age 19 and older)	\$25
Vision hardware and optical Services (ages 19 years and older)*	Balance after \$200 allowance every 24 months

\* Any amount you pay for covered Services does not count toward the Out-of-Pocket Maximum.

### Additional Features

#### Online Access anytime, anywhere at no additional charge: [kp.org](http://kp.org)

- Access medical records
- Refill Prescriptions
- Email doctor
- Check lab results
- Schedule appointments
- Health Risk Assessments – personal online tool for members

#### Member Discounts: [kp.org/choosehealthy](http://kp.org/choosehealthy)

- CHP Active and Healthy
- Fitness club discounts
- Vitamins and supplements
- Alternative and chiropractic care

#### Facilities and Services: [kp.org/facilities](http://kp.org/facilities)

- 37 Medical office
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# Summary of Medical Benefits

Oregon 3C16-Peace Officers (POA) Early Retirees

January 1, 2016 - December 31, 2016

Clackamas County

Group Number: 1183

## Deductible

For one Member per Calendar Year	\$1,000
For an entire Family per Calendar Year	\$3,000

**Out-of-Pocket Maximum** (Note: Deductible amounts and Services not subject to the Deductible do not count toward your Out-of-Pocket Maximum.)

For one Member	\$3,000
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## Office visits

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Routine preventative physical exam	\$0
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Preventive Tests	\$0
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## Medications (outpatient)

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Prescription drugs (up to a 30 day supply)*	\$15 generic/\$30 preferred brand
Mail Order Prescription drugs (up to a 90 day supply)*	\$30 generic/\$60 preferred brand
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# EXHIBIT G

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## VSP – 2016 Benefit Summaries





Protect  
your vision  
with VSP.

## Get the best in eyecare and eyewear with CLACKAMAS COUNTY (General County) and VSP® Vision Care.



At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

### You'll like what you see with VSP.

- **Value and Savings.** You'll enjoy more value and the lowest out-of-pocket costs.
- **High Quality Vision Care.** You'll get the best care from a VSP provider, including a WellVision Exam®—the most comprehensive exam designed to detect eye and health conditions.
- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

### Using your VSP benefit is easy.

- **Register at [vsp.com](http://vsp.com)** Once your plan is effective, review your benefit information.
- **Find an eyecare provider who's right for you.** To find a VSP provider, visit [vsp.com](http://vsp.com) or call 800.877.7195.
- **At your appointment, tell them you have VSP.** There's no ID card necessary. If you'd like a card as a reference, you can print one on [vsp.com](http://vsp.com).

**That's it! We'll handle the rest**—there are no claim forms to complete when you see a VSP provider.

### Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options. Choose from featured frame brands like Anne Klein, bebe®, Calvin Klein, Flexon®, Lacoste, Nike, Nine West, and more<sup>1</sup>. Visit [vsp.com](http://vsp.com) to find a VSP provider who carries these brands.

See why we're consumers' #1 choice in vision care<sup>2</sup>.

Contact us. 800.877.7195  
[vsp.com](http://vsp.com)

# Your VSP Vision Benefits Summary



CLACKAMAS COUNTY (General County) and VSP provide you with an affordable eyecare plan..

**VSP Coverage Effective Date:** 01/01/2016

**VSP Provider Network:** VSP Choice

Benefit	Description	Copay	Frequency
<b>Your Coverage with a VSP Provider</b>			
<b>WellVision Exam</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> </ul>	\$10	Every calendar year
<b>Prescription Glasses</b>			
<b>Frame</b>	<ul style="list-style-type: none"> <li>\$130 allowance for a wide selection of frames</li> <li>\$150 allowance for featured frame brands</li> <li>20% savings on the amount over your allowance</li> <li>\$70 equivalent frame allowance at Costco Optical</li> </ul>	\$0	Every calendar year
<b>Lenses</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Polycarbonate lenses for dependent children</li> </ul>	\$0	Every calendar year
<b>Lens Enhancements</b>	<ul style="list-style-type: none"> <li>Standard progressive lenses</li> <li>Premium progressive lenses</li> <li>Custom progressive lenses</li> <li>Average savings of 20-25% on other lens enhancements</li> </ul>	\$30 \$30 \$30	Every calendar year
<b>Contacts (instead of glasses)</b>	<ul style="list-style-type: none"> <li>\$130 allowance for contacts; copay does not apply</li> <li>Contact lens exam (fitting and evaluation)</li> </ul>	Up to \$60	Every calendar year
<b>Diabetic Eyecare Plus Program</b>	<ul style="list-style-type: none"> <li>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</li> </ul>	\$20	As needed
<b>Extra Savings</b>	<p><b>Glasses and Sunglasses</b></p> <ul style="list-style-type: none"> <li>Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/specialoffers">vsp.com/specialoffers</a> for details.</li> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li> </ul> <p><b>Retinal Screening</b></p> <ul style="list-style-type: none"> <li>No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam</li> </ul> <p><b>Laser Vision Correction</b></p> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>		
<b>Your Coverage with Out-of-Network Providers</b>			
Visit <a href="http://vsp.com">vsp.com</a> for details, if you plan to see a provider other than a VSP network provider.			
Exam .....	up to \$45	Lined Bifocal Lenses .....	up to \$50
Frame .....	up to \$70	Lined Trifocal Lenses .....	up to \$70
Single Vision Lenses .....	up to \$30	Progressive Lenses .....	up to \$50
		Contacts .....	up to \$105
Coverage with a participating retail chain may be different. Once your benefit is effective, visit <a href="http://vsp.com">vsp.com</a> for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.			

Contact us. [800.877.7195](tel:800.877.7195) | [vsp.com](http://vsp.com)

<sup>1</sup>Brands/Promotion subject to change.

<sup>2</sup>Blueocean Market Intelligence National Vision Plan Member Research, 2014

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# Protect your vision with VSP.



## Get the best in eyecare and eyewear with CLACKAMAS COUNTY (POA) and VSP® Vision Care.



At VSP, we invest in the things you value most—the best care at the lowest out-of-pocket costs. Because we're the only national not-for-profit vision care company, you can trust that we'll always put your wellness first.

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- **Choice of Providers.** The decision is yours to make—choose a VSP doctor, a participating retail chain, or any out-of-network provider.
- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

### Using your VSP benefit is easy.

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choice in vision care<sup>2</sup>.

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# Your VSP Vision Benefits Summary



CLACKAMAS COUNTY (POA) and VSP provide you with an affordable eyecare plan for Adults and Children 19 and over..

**VSP Coverage Effective Date:** 01/01/2016

**VSP Provider Network:** VSP Choice

Benefit	Description	Copay	Frequency
<b>Your Coverage with a VSP Provider</b>			
<b>WellVision Exam</b>	<ul style="list-style-type: none"> <li>Focuses on your eyes and overall wellness</li> </ul>	\$10	Every calendar year
<b>Prescription Glasses</b>		\$0	See frame and lenses
<b>Frame</b>	<ul style="list-style-type: none"> <li>\$130 allowance for a wide selection of frames</li> <li>\$150 allowance for featured frame brands</li> <li>20% savings on the amount over your allowance</li> <li>\$70 equivalent frame allowance at Costco Optical</li> </ul>		Every other calendar year
<b>Lenses</b>	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, and lined trifocal lenses</li> <li>Polycarbonate lenses for dependent children</li> </ul>	\$0	Every other calendar year
<b>Lens Enhancements</b>	<ul style="list-style-type: none"> <li>Average savings of 20-25% on lens enhancements</li> </ul>		Every other calendar year
<b>Contacts (instead of glasses)</b>	<ul style="list-style-type: none"> <li>\$130 allowance for contacts; copay does not apply</li> <li>Contact lens exam (fitting and evaluation)</li> </ul>	Up to \$60	Every other calendar year
<b>Diabetic Eyecare Plus Program</b>	<ul style="list-style-type: none"> <li>Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.</li> </ul>	\$20	As needed
<b>Extra Savings</b>	<p><b>Glasses and Sunglasses</b></p> <ul style="list-style-type: none"> <li>Extra \$20 to spend on featured frame brands. Go to <a href="http://vsp.com/specialoffers">vsp.com/specialoffers</a> for details.</li> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.</li> </ul> <p><b>Retinal Screening</b></p> <ul style="list-style-type: none"> <li>No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam</li> </ul> <p><b>Laser Vision Correction</b></p> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>		

## Your Coverage with Out-of-Network Providers

Visit [vsp.com](http://vsp.com) for details, if you plan to see a provider other than a VSP network provider.

Exam .....	up to \$45	Lined Bifocal Lenses .....	up to \$50	Progressive Lenses .....	up to \$50
Frame .....	up to \$70	Lined Trifocal Lenses .....	up to \$65	Contacts .....	up to \$105
Single Vision Lenses .....	up to \$30				

Coverage with a participating retail chain may be different. Once your benefit is effective, visit [vsp.com](http://vsp.com) for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

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## Clackamas County (POA) partners with VSP® to provide Vision Coverage for Children

Your child is fully covered for an eye exam and glasses or contacts every year.

Your child's eyes deserve the best care to keep them healthy year after year. Plus, with VSP, you'll get a great value on eyecare and eyewear for your child.

### You'll like what you see with VSP.

Log in to [vsp.com](http://vsp.com) to:

- Find a VSP doctor who's right for your child.
- Review your child's benefit information and plan coverage before an appointment.
- At the appointment, tell them your child has VSP.

**That's it! We'll handle the rest**—there are no claim forms to complete when your child sees a VSP doctor.

Visit [vsp.com](http://vsp.com) for more details on your child's vision benefit and the exclusive savings and promotions for VSP members.

Contact us.

[vsp.com](http://vsp.com) | 800-877-7195

### Eye Exams for Children

80% of what we learn is through our eyes.\* Many states require that children get a comprehensive eye exam before Kindergarten. Schedule an eye exam for your child at the beginning of every school year and start the year off right. Visit [vsp.com](http://vsp.com) to find a VSP doctor that specializes in pediatric eyecare.



\*Source: Ritty et al. (1993) [Ritty M.J., Solan H.K., Cool S.J. Visual and sensory-motor function in the classroom a primary report of ergonomic demands., JAm. Optom. Assoc 1993, 64:238-244]

## Vision Benefit Summary- Coverage for children

Taking care of your child's eyes with VSP includes a covered-in-full benefit outlined below. You'll have access to the highest quality vision care from a VSP doctor you can trust. Visit [vsp.com](http://vsp.com) to find a doctor who's right for your child and one who carries children's frames from our exclusive Otis & Piper™ Eyewear Collection.

### POA EMPLOYEES' Children age 0-18

Benefit	Description	Copay (Your cost)	Frequency
<b>Your Coverage with a VSP Choice Doctor only; Not available at Retail providers</b>			
WellVision Exam®	<ul style="list-style-type: none"> <li>A thorough eye exam that tests for childhood eye health and vision issues, like nearsightedness, amblyopia (lazy eye), and strabismus (cross-eye)</li> </ul>	\$0	Every calendar year
<b>Prescription Glasses</b>			
Frame	<ul style="list-style-type: none"> <li>1 Frame from our exclusive Otis &amp; Piper Eyewear Collection</li> </ul>	\$0	Every calendar year
Lenses	<ul style="list-style-type: none"> <li>Single vision, lined bifocal, lined trifocal, or lenticular lenses</li> <li>Polycarbonate, scratch-resistant coating, and UV protection</li> </ul>	\$0	Every calendar year
Lens Enhancements	<ul style="list-style-type: none"> <li>Average savings of 20% - 25% on lens enhancements</li> </ul>		Every calendar year
Contacts (Instead of glasses)	<ul style="list-style-type: none"> <li>Contact lens exam and a minimum three-month's supply of contact lenses are fully covered.                             <ul style="list-style-type: none"> <li>Standard (one pair annually)</li> <li>Monthly (six-month supply)</li> <li>Bi-weekly (three-month supply)</li> <li>Dailies (three-month supply)</li> </ul> </li> <li>Ask your VSP doctor which contacts qualify for your child's plan.</li> </ul>	\$0	Every calendar year
<b>Extra Savings</b>			
	<b>Glasses and Sunglasses</b> <ul style="list-style-type: none"> <li>20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam</li> </ul>		
	<b>Laser Vision Correction</b> <ul style="list-style-type: none"> <li>Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities</li> </ul>		

### Your Coverage with Other Providers

Visit [vsp.com](http://vsp.com) for details, if you plan to see a provider other than a VSP doctor. You pay 50% of the provider's billed amount.

Once your child's benefit is effective, visit [vsp.com](http://vsp.com) for details. VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and the applicable contract, the terms of the contract will prevail.

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# EXHIBIT H

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## Self-Funded Dental Plan Underwriting Calculation

**Clackamas County 10000174  
Oregon ASO Dental Plan Changes  
Effective January 1, 2016**

The following is a summary of the significant changes that will be made to the Delta Dental ASO agreement and member handbook effective January 1, 2016. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic, or formatting changes, are not included in this summary.

<b>REGULATORY CHANGES</b>	
<b>Reference</b>	<b>Change/Rationale/Exceptions</b>
None as of 08/20/2015	

<b>ADMINISTRATIVE CHANGES – Delta Dental</b>	
<b>Reference</b>	<b>Change/Rationale/Exceptions</b>
<b>Throughout book</b>	Name change. Oregon Dental Service/ODS is doing business as Delta Dental Plan of Oregon/Delta Dental.
<b>Benefits and Limitations</b> Endodontic Limitations	Clarified that pulp capping is covered only when there is exposure of the pulp.
<b>Exclusions</b> Illegal Acts, Riot or Rebellion, War	Added additional examples of what is considered War or Rebellion.
<b>Exclusions</b> Self-treatment	Added exclusion for self-treatment.
<b>Enrollment</b> When coverage begins	Clarified that coverage does not begin before loss of other coverage.



BENEFIT CHANGES – Delta Dental					
Accepted		Reference	Former Benefit	Change/Rationale/Exceptions	Claims Impact*
Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>	Benefits and Limitations Other Services	Not previously covered.	Nightguard (occlusal guard) covered once every 5 years at 50%, up to \$0-500 maximum.	+0.6% (\$150 max) +0.4% (\$100 max)

The following change was declined in 2015. We are including it below for reconsidering:

BENEFIT CHANGES – Delta Dental				
Accepted		Reference	Change/Rationale/Exceptions	Claims Impact*
Yes	No			
<input type="checkbox"/>	<input type="checkbox"/>	Definitions	Revised Maximum Plan Allowance to change fee schedule for non-participating providers in Oregon.	-0.1%

\*Based on Delta Dental book of business

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations. Delta Dental will provide written notice of any additional changes including any modification to premium rates or administrative fees, and will administer such changes accordingly.

Services are provided by Oregon Dental Service doing business as Delta Dental Plan of Oregon (Delta Dental). Delta Dental is part of the Moda Health organization.

Signature \_\_\_\_\_ Date \_\_\_\_\_

## Clackamas County – Dental

### 2016 Preliminary Projection – Dental

	Self-Funded Dental				
	<i>Incentive GC</i>	<i>Incentive POA</i>	<i>Constant (50%)</i>	<i>Preventive</i>	<i>Combined</i>
<b>Most Recent 12 Months Ending</b>	<b>July 31, 2015</b>				
Mature Months	12	12	12	12	12
Paid Claims for Entire 12-Month Period	\$1,218,962	\$448,523	\$45,597	\$478,139	\$2,191,221
Stop loss/Pooling Credit	0	0	0	0	0
Historical Benefit Changes Adjustment	1.000	1.000	1.000	1.000	1.000
Adjusted Net Paid Claims during this Period	\$1,218,962	\$448,523	\$45,597	\$478,139	\$2,191,221
Average Enrollment Setback (1) Month	679	318	64	307	1,368
Adjusted Paid Claims per Capita per Month (PEPM)	\$149.60	\$117.54	\$59.37	\$129.79	\$133.48
Annual Trend	6.0%	6.0%	6.0%	6.0%	6.0%
Number of Months of Trend	18	18	18	18	18
Extended Trend Factor	1.091	1.091	1.091	1.091	1.091
Multiplicative Adjustments Not Related to Trend	1.000	1.000	1.000	1.000	1.000
<b>Projected Claims PEPM</b>	<b>\$163.27</b>	<b>\$128.27</b>	<b>\$64.79</b>	<b>\$141.64</b>	<b>\$145.67</b>
Claims Fluctuation Margin	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Projected Claims PEPM with Margin</b>	<b>\$163.27</b>	<b>\$128.27</b>	<b>\$64.79</b>	<b>\$141.64</b>	<b>\$145.67</b>
2015 Moda Administration Fee	\$6.18	\$6.18	\$6.18	\$6.18	\$6.18
<b>Projected Total Cost (Claims+Margin+Admin) PEPM</b>	<b>\$169.45</b>	<b>\$134.45</b>	<b>\$70.97</b>	<b>\$147.82</b>	<b>\$151.85</b>
Current 2014 Budget, based on Current Rates	\$140.37	\$139.19	\$57.02	\$150.93	\$139.01
<b>Needed Increase to 2014 Rates</b>	<b>20.7%</b>	<b>-3.4%</b>	<b>24.5%</b>	<b>-2.1%</b>	<b>9.2%</b>

# EXHIBIT I

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## Delta Dental of Oregon – 2016 Contract Changes

**Clackamas County 10000174  
Oregon ASO Dental Plan Changes  
Effective January 1, 2016**

The following is a summary of the significant changes that will be made to the Delta Dental ASO agreement and member handbook effective January 1, 2016. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic, or formatting changes, are not included in this summary.

<b>REGULATORY CHANGES</b>	
<b>Reference</b>	<b>Change/Rationale/Exceptions</b>
None as of 08/20/2015	

<b>ADMINISTRATIVE CHANGES – Delta Dental</b>	
<b>Reference</b>	<b>Change/Rationale/Exceptions</b>
<b>Throughout book</b>	Name change. Oregon Dental Service/ODS is doing business as Delta Dental Plan of Oregon/Delta Dental.
<b>Benefits and Limitations</b> Endodontic Limitations	Clarified that pulp capping is covered only when there is exposure of the pulp.
<b>Exclusions</b> Illegal Acts, Riot or Rebellion, War	Added additional examples of what is considered War or Rebellion.
<b>Exclusions</b> Self-treatment	Added exclusion for self-treatment.
<b>Enrollment</b> When coverage begins	Clarified that coverage does not begin before loss of other coverage.

BENEFIT CHANGES – Delta Dental					
Accepted		Reference	Former Benefit	Change/Rationale/Exceptions	Claims Impact*
Yes	No				
<input type="checkbox"/>	<input type="checkbox"/>	Benefits and Limitations Other Services	Not previously covered.	Nightguard (occlusal guard) covered once every 5 years at 50%, up to \$0-500 maximum.	+0.6% (\$150 max) +0.4% (\$100 max)

The following change was declined in 2015. We are including it below for reconsidering:

BENEFIT CHANGES – Delta Dental				
Accepted		Reference	Change/Rationale/Exceptions	Claims Impact*
Yes	No			
<input type="checkbox"/>	<input type="checkbox"/>	Definitions	Revised Maximum Plan Allowance to change fee schedule for non-participating providers in Oregon.	-0.1%

\*Based on Delta Dental book of business

Additional changes may be required at any time as a result of new federal rules or regulations; changes to existing ACA rules or regulations. Delta Dental will provide written notice of any additional changes including any modification to premium rates or administrative fees, and will administer such changes accordingly.

Services are provided by Oregon Dental Service doing business as Delta Dental Plan of Oregon (Delta Dental). Delta Dental is part of the Moda Health organization.

Signature \_\_\_\_\_ Date \_\_\_\_\_

# EXHIBIT J

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## Delta Dental of Oregon – 2016 Benefit Summaries



**Dental Benefits Summary  
Clackamas County  
General County Incentive Dental Plan  
Effective January 1, 2016**

**How To Use this Dental Plan**

When you visit your dental provider, tell him or her you are a member of a Delta Dental program.

<b>Calendar year maximum, per member</b>	<b>\$2,000</b>
<b>Calendar year deductible, per member</b>	<b>\$0</b>
<b>Service</b>	<b>Benefit Amount</b>
<b>PREVENTIVE</b>	<b>*1st year- 70%</b>
- <u>Examination/X-rays</u> (routine exam & bitewing x-rays twice per calendar year)	<b>2nd year- 80%</b>
- <u>Prophylaxis</u> (cleanings twice per calendar year)	<b>3rd year- 90%</b>
- <u>Fissure Sealants</u>	<b>4th year- 100%</b>
- <u>Fluoride</u>	
- <u>Space Maintainers</u>	
<b>BASIC</b>	<b>*1st year- 70%</b>
- <u>Restorative Fillings</u>	<b>2nd year- 80%</b>
- <u>Oral Surgery</u> (extractions & certain minor surgical procedures)	<b>3rd year- 90%</b>
- <u>Endodontic</u> (pulp therapy & root canal filling)	<b>4th year- 100%</b>
- <u>Periodontics</u> (treatment of tissues supporting the teeth)	
- <u>Crowns</u>	
- <u>Cast Restorations</u>	
<b>MAJOR</b>	<b>50%</b>
- <u>Implants</u>	
- <u>Cast Restorations</u>	
- <u>Denture and Bridge Work</u> (construction or repair of fixed bridges, partials, and complete dentures)	
<b>ORTHODONTICS</b>	<b>**50%</b>

\* Under this plan, payments increase by 10% each calendar year provided the individual has visited the dentist at least once during the year. Failure to do so will cause a 10% decrease in payment the following year, although payment will never fall below 70%.

\*\* See your member handbook for specific orthodontic benefits.

**Advantages**

- **Freedom to choose your dentist** Delta Dental Plan of Oregon offers a large network of dentists, having over 2,300 contracted licensed dentists in Oregon participating in our Delta Dental Premier network. As the Delta Dental Plan of Oregon, we offer access to over 151,000 Delta Dental Premier dentists nationwide.
- **Professional Arrangements** Delta Dental has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file. We believe that the underlying unique feature inherent to all Delta Dental programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to Delta Dental Plan of Oregon for you.
- **myModa is** a customized member website with current, accurate and easy to understand information about the member's plan. Log onto [www.modahealth.com/members](http://www.modahealth.com/members) to access myModa.

**Dependent Eligibility**

Dependents are lawful spouse and registered domestic partners under any legal registry in the United States. An unregistered domestic partner is eligible for coverage if he or she complies with the Affidavit of Domestic Partnership provided by the Group. Children are eligible to age 26. This includes administrative orders that require the employee to provide health insurance.

<b>This is a benefit summary only.</b>
<b>For a more detailed description of benefits, refer to your member handbook.</b>
<b>Visit our website at <a href="http://www.modahealth.com">www.modahealth.com</a></b>
Delta Dental Plan of Oregon provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

## LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

### Preventive (Class I Services)

- **Diagnostic** Routine examination and bitewing x-rays limited to twice per calendar year. Full mouth x-rays limited to once every (3) years.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to twice in a calendar year. Topical application of fluoride is covered twice in a calendar year for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a history of periodontal disease or high risk of decay. Sealant benefits are limited to the occlusal surfaces of unrestored permanent Bicuspids and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period

### Basic (Class II Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splitting, including crowns or bridgework for splinting are not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate or plastic, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate or plastic. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

### Major (Class III Services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Prosthodontic** Replacement of an existing prosthetic device is covered only if it cannot be made satisfactory. Replacement is never covered if existing device is less than 5 years old. Specialized or personalized prosthetics are limited to the cost of standard devices.

## EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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**Dental Benefits Summary  
Clackamas County  
Preventive Dental Plan  
Effective January 1, 2016**

**How To Use this Dental Plan**

When you visit your dental provider, tell him or her you are a member of the Delta Dental program.

<b>Calendar year maximum, per member</b>	<b>\$2,000</b>
<b>Calendar year deductible, per member</b>	<b>\$50</b>
<b>Calendar year maximum deductible, per family</b>	<b>\$100</b>
<b>Service</b>	<b>Benefit Amount</b>
<b>PREVENTIVE*</b> - <u>Examination/X-rays</u> (routine exam & bitewing x-rays twice in a calendar year) - <u>Prophylaxis</u> (cleanings-twice in a calendar year) - <u>Fissure Sealants</u> - <u>Fluoride</u> - <u>Space Maintainers</u>	<b>100%</b>
<b>BASIC</b> - <u>Restorative Dentistry</u> (treatment of tooth decay with amalgam, synthetic porcelain & plastic materials) - <u>Oral Surgery</u> (extractions & certain minor surgical procedures) - <u>Endodontic</u> (pulp therapy & root canal filling) - <u>Periodontics</u> (treatment of tissues supporting the teeth) - <u>Partial Cast Restorations</u>	<b>80%</b>
<b>MAJOR</b> - <u>Crowns</u> - <u>Implants</u> - <u>Denture and Bridge Work</u> (construction or repair of fixed bridges, partials, and complete dentures)	<b>70%</b>
<b>ORTHODONTIC</b> - Eligible employees and their covered dependents	<b>50% to a \$3,000 lifetime maximum</b>

\* **Deductible waived for preventive services.**

**Advantages**

- **Freedom to choose your dentist** Delta Dental Plan of Oregon offers a large network of dentists, having over 2,300 contracted licensed dentists in Oregon participating in our Delta Dental Premier network. As the Delta Dental Plan of Oregon, we offer access to over 151,000 Delta Dental Premier dentists nationwide.
- **Professional Arrangements** Delta Dental has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file. We believe that the underlying unique feature inherent to all Delta Dental programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to Delta Dental Plan of Oregon for you.
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<p>Delta Dental Plan of Oregon provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.</p>

## LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

### Preventive

- **Diagnostic** Routine examination and bitewing x-rays limited to twice in a calendar year. Full mouth x-rays limited to once every (3) years.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to twice in a calendar year. Topical application of fluoride is covered twice in a calendar year for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a history of periodontal disease or high risk of decay. Sealant benefits are limited to the occlusal surfaces of unrestored permanent Bicuspid and molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period.

### Basic

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splinting, including crowns or bridgework for splinting, is not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate, plastic or composite, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate, plastic or composite. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

### Major

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Restorative** Replacement of necessary crowns, jackets, and gold or full cast restorations is covered only if 5 years have elapsed since last prior crown, jacket, and gold or cast restoration was furnished on the tooth.
- **Prosthodontic** Replacement of an existing prosthetic device is covered only if it cannot be made satisfactory. Replacement is never covered if existing device is less than 5 years old. Specialized or personalized prosthetics are limited to the cost of standard devices.

## EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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**Dental Benefits Summary  
Clackamas County  
Constant Dental Plan  
Effective January 1, 2016**

**How To Use this Dental Plan**

When you visit your dental provider, tell him or her you are a member of a Delta Dental program.

<b>Calendar year maximum, per member</b>	<b>\$2,000</b>
<b>Calendar year deductible, per member</b>	<b>\$0</b>
<b>Service</b>	<b>Benefit Amount</b>
<b>PREVENTIVE</b> - <u>Examination/X-rays</u> (routine exam & bitewing x-rays twice per calendar year) - <u>Prophylaxis</u> (cleanings twice per calendar year) - <u>Fissure Sealants</u> - <u>Fluoride</u> - <u>Space Maintainers</u>	<b>50%</b>
<b>BASIC</b> - <u>Restorative Fillings</u> - <u>Oral Surgery</u> (extractions & certain minor surgical procedures) - <u>Endodontic</u> (pulp therapy & root canal filling) - <u>Periodontics</u> (treatment of tissues supporting the teeth) - <u>Crowns</u> - <u>Cast Restorations</u>	<b>50%</b>
<b>MAJOR</b> - <u>Implants</u> - <u>Cast Restorations</u> - <u>Denture and Bridge Work</u> (construction or repair of fixed bridges, partials, and complete dentures)	<b>50%</b>

**Advantages**

- **Freedom to choose your dentist** Delta Dental Plan of Oregon offers a large network of dentists, having over 2,300 contracted licensed dentists in Oregon participating in our Delta Dental Premier network. As the Delta Dental Plan of Oregon, we offer access to over 151,000 Delta Dental Premier dentists nationwide.
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<p><b>Visit our website at <a href="http://www.modahealth.com">www.modahealth.com</a></b></p>
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## LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

### Preventive (Class I Services)

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### Basic (Class II Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splitting, including crowns or bridgework for splinting are not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate or plastic, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate or plastic. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

### Major (Class III Services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Prosthodontic** Replacement of an existing prosthetic device is covered only if it cannot be made satisfactory. Replacement is never covered if existing device is less than 5 years old. Specialized or personalized prosthetics are limited to the cost of standard devices.

## EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Orthodontic services.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

Visit our website at [www.modahealth.com](http://www.modahealth.com)

Delta Dental Plan of Oregon provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.



**Dental Benefits Summary  
Clackamas County  
POA Incentive Dental Plan  
Effective January 1, 2016**

**How To Use this Dental Plan**

When you visit your dental provider, tell him or her you are a member of a Delta Dental program.

<b>Calendar year maximum, per member</b>	<b>\$1,500</b>
<b>Calendar year deductible, per member</b>	<b>\$0</b>
<b>Service</b>	<b>Benefit Amount</b>
<b>PREVENTIVE</b> - <u>Examination/X-rays</u> (routine exam & bitewing x-rays twice per calendar year) - <u>Prophylaxis</u> (cleanings twice per calendar year) - <u>Fissure Sealants</u> - <u>Fluoride</u> - <u>Space Maintainers</u>	<b>*1st year- 70%</b> <b>2nd year- 80%</b> <b>3rd year- 90%</b> <b>4th year- 100%</b>
<b>BASIC</b> - <u>Restorative Fillings</u> - <u>Oral Surgery</u> (extractions & certain minor surgical procedures) - <u>Endodontic</u> (pulp therapy & root canal filling) - <u>Periodontics</u> (treatment of tissues supporting the teeth) - <u>Crowns</u> - <u>Cast Restorations</u>	<b>*1st year- 70%</b> <b>2nd year- 80%</b> <b>3rd year- 90%</b> <b>4th year- 100%</b>
<b>MAJOR</b> - <u>Implants</u> - <u>Cast Restorations</u> - <u>Denture and Bridge Work</u> (construction or repair of fixed bridges, partials, and complete dentures)	<b>50%</b>
<b>ORTHODONTICS</b>	<b>**50%</b>

\* Under this plan, payments increase by 10% each calendar year provided the individual has visited the dentist at least once during the year. Failure to do so will cause a 10% decrease in payment the following year, although payment will never fall below 70%.

\*\* See your member handbook for specific orthodontic benefits.

**Advantages**

- **Freedom to choose your dentist** Delta Dental Plan of Oregon offers a large network of dentists, having over 2,300 contracted licensed dentists in Oregon participating in our Delta Dental Premier network. As the Delta Dental Plan of Oregon, we offer access to over 151,000 Delta Dental Premier dentists nationwide.
- **Professional Arrangements** Delta Dental has specific fee arrangements with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted fees on file. We believe that the underlying unique feature inherent to all Delta Dental programs is every participating dentist becomes a party to cost control as well as the quality of care. Participating dentists will update your records with your new information and will submit claims to Delta Dental Plan of Oregon for you.
- **myModa is** a customized member website with current, accurate and easy to understand information about the member's plan. Log onto [www.modahealth.com/members](http://www.modahealth.com/members) to access myModa.

**Dependent Eligibility**

Dependents are lawful spouse and registered domestic partners under any legal registry in the United States. An unregistered domestic partner is eligible for coverage if he or she complies with the Affidavit of Domestic Partnership provided by the Group. Children are eligible to age 26. This includes administrative orders that require the employee to provide health insurance.

<b>This is a benefit summary only.</b>
<b>For a more detailed description of benefits, refer to your member handbook.</b>
<b>Visit our website at <a href="http://www.modahealth.com">www.modahealth.com</a></b>
Delta Dental Plan of Oregon provides dental claims payment services only and does not assume financial risk or obligation with respect to payment of claims.

## LIMITATIONS

If a more expensive treatment that is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

### Preventive (Class I Services)

- **Diagnostic** Routine examination limited to twice per calendar year. Bitewing x-rays limited to once every 12 months. Full mouth x-rays limited to once every five (5) years.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance limited to twice in a calendar year. Topical application of fluoride is covered twice in a calendar year for members age 18 and under. For members age 19 and up, topical application of fluoride is covered once every six (6) month period if there is a history of periodontal disease or high risk of decay. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any five (5) year period

### Basic (Class II Services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Periodontal splitting, including crowns or bridgework for splinting are not covered.
- **Restorative** If a tooth can be restored with a material such as amalgam, silicate or plastic, but another type of restoration is selected, covered expense will be limited to the cost of amalgam, silicate or plastic. Partial cast restorations are covered under basic services, however, full cast restorations will be covered under major services.

### Major (Class III Services)

- **Implants** and implant removal are limited to once per lifetime per tooth space.
- **Prosthodontic** Replacement of an existing prosthetic device will be covered only if it is unserviceable and cannot be made serviceable, and a replacement of an existing prosthetic device will be covered once in a seven (7) year period. Specialized or personalized prosthetics are limited to the cost of standard devices.

## EXCLUSIONS

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital or developmental malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia, fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing teeth.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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# EXHIBIT K

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## Carrier Information – A.M. Best Score

## Carrier Information Exhibit

**A.M. Best Ratings as of: October 15, 2015**

**Financial ratings source: © A.M. Best Company - used by permission.**

Mercer recommends that you place your business with institutions that are in good financial standing, well capitalized and highly rated. When available, we will supply you with a Financial Strength Rating (FSR) from A.M. Best, and we recommend that you select insurers rated by A.M. Best as Excellent (A- or A) or Superior (A+ or A++).

A.M. Best's Financial Strength Rating addresses the relative ability of an insurer to meet its ongoing insurance obligations. It is not a warranty of a company's financial strength and ability to meet its obligations to policyholders. This is further explained by A.M. Best in its Important Notice: Best's Credit Ratings (see link below) which includes its disclaimer notice and complete details. Please also refer to A.M. Best's explanations of its ratings (see link below). Published financial ratings may not be available for certain insurers and many other service providers, and this may or may not be indicative of the institution's financial condition. If not rated, we are unable to provide information to you on the institution's financial condition.

Mercer does not endorse or corroborate the financial ratings issued by any rating agency. Any rating is judgmental and

subject to various interpretations. The financial ratings cited in our reports are published by A.M. Best, an independent rating agency, based in part on information not available to Mercer. All information is gathered from sources considered reliable, but Mercer cannot and does not warrant the accuracy of such information. Mercer is not responsible for the current or future financial condition, solvency or ability of any insurance carrier or other service provider to pay claims or provide service.

Ultimately, the decision is yours and you should undertake your own evaluation to select insurers most appropriate for your needs, including considering information and ratings that may be available from other sources. High ratings are not a guarantee of future solvency but may be indicative of the institution's current financial condition and prospects.

Following your evaluation that we suggest should include the financial criteria noted, we will proceed with the procurement or renewal of coverage or service you select. Please contact your Mercer consultant if you would like to discuss financial security ratings further.

[Important Notice: Best's Credit Ratings](#)

[A.M. Best's explanations of its ratings](#)

Insurance Company	A.M. Best Carrier #	A.M. Best FSR and, where applicable, FSR Modifier as of 10/15/2015
Kaiser Northwest	68585	Not Rated
Providence Health Plan	68651	Not Rated
Vision Service Plan	64607	A
Delta Dental of Oregon / Moda	64364	B++ u
Unum	6256	A
MetLife	58175	A-
Standard Insurance Company	7069	A u





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Portland, OR 97201-5839  
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## Attachment 2

### 2017 Renewal Report

**2017 HEALTH AND WELFARE BENEFIT  
PLAN RENEWAL REPORT  
CLACKAMAS COUNTY**  
NOVEMBER 2, 2016

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# 1

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## Summary

The Clackamas County General County and Peace Officers Association (POA) 2017 health and welfare benefit plans renewal decisions are outlined in this report.

After reviewing the presented plan options, the Benefit Review Committee (BRC) elected to renew all the General County plans, implementing optional benefit changes in addition to the legislatively required changes. The accepted plan designs are described in detail later in this report.

**As of November 1, 2016**, the POA are undecided on decisions. The POA sections will be updated upon confirmation of the 2017 plan year decisions.

The table on the following pages is a summary of renewal rates by plan for the General County and POA plans.

	Rates PEPM		
	2016	2017	% Change
<b>Medical/Prescription/Vision Plans</b>			
<b>Providence Health Plan – General County<sup>1</sup></b>			
BASE: Personal Option 25/20/3000 \$1000 Common Deductible (includes VSP vision)			
Employee Only	\$647.00	\$681.00	
Employee + Spouse	1,293.00	1,363.00	
Employee + Children	1,167.00	1,229.00	
Employee + Family	1,944.00	2,048.00	
Composite	1,436.00	1,512.00	<b>5.3%</b>
BUY-UP: Open Option 20/10/30/2500 \$750 Common Deductible (includes VSP vision)			
Employee Only	\$664.00	\$758.00	
Employee + Spouse	1,328.00	1,516.00	
Employee + Children	1,198.00	1,367.00	
Employee + Family	1,995.00	2,277.00	
Composite	1,476.00	1,685.00	<b>14.2%</b>
<b>Providence Health Plan – POA<sup>1</sup> (STILL PENDING)</b>			
Personal Option 15/0/1000 (includes VSP vision)			
Employee Only	\$573.00	\$708.00	
Employee + Spouse	1,147.00	1,415.00	
Employee + Children	1,034.00	1,275.00	
Employee + Family	1,722.00	2,124.00	
Composite	1,375.00	1,697.00	<b>23.4%</b>
Open Option 10/0/20/2000 \$50 Common Deductible (includes VSP vision)			
Employee Only	\$584.00	\$721.00	
Employee + Spouse	1,169.00	1,442.00	
Employee + Children	1,053.00	1,299.00	
Employee + Family	1,755.00	2,165.00	
Composite	1,440.00	1,776.00	<b>23.3%</b>
<b>Kaiser Permanente HMO – General County (with hearing aids)<sup>1</sup></b>			
VALUE: 10/10/1000 \$250 Deductible; Vision \$250/12 months			
Employee Only	\$616.39	\$652.19	
Employee + Spouse	1,232.77	1,304.38	
Employee + Children	1,109.50	1,173.94	
Employee + Family	1,849.16	1,956.57	
Composite	1,334.27	1,411.77	<b>5.8%</b>
<b>Kaiser Permanente HMO – POA<sup>1</sup> (STILL PENDING)</b>			
Employee Only	\$614.25	\$665.98	
Employee + Spouse	1,228.50	1,331.96	
Employee + Children	1,105.65	1,198.76	
Employee + Family	1,842.75	1,997.94	
Composite	1,321.20	1,432.46	<b>8.4%</b>

	Rates PEPM		
	2016	2017	% Change
<b>Providence Retirees - \$1000 Deductible<sup>1</sup></b>			
Retiree Only	\$578.42	\$673.86	<b>16.5%</b>
Retiree + Spouse	1,156.92	1,347.81	
Retiree + Children	1,041.15	1,212.94	
Retiree + Family	1,735.28	2,021.60	
<b>Kaiser Permanente Retirees – General County \$1000 Deductible<sup>1</sup></b>			
Retiree Only	\$463.26	\$502.27	<b>8.4%</b>
Retiree + Spouse	926.52	1,004.55	
Retiree + Children	833.86	904.09	
Retiree + Family	1,389.82	1,506.87	
<b>Kaiser Permanente Retirees – POA \$1000 Deductible<sup>1</sup> (STILL PENDING)</b>			
Retiree Only	\$463.31	\$502.33	<b>8.4%</b>
Retiree + Spouse	926.63	1,004.66	
Retiree + Children	833.97	904.20	
Retiree + Family	1,389.99	1,507.04	
<b>Kaiser Permanente Medicare Retirees<sup>1</sup></b>			
Retiree Only (GC)	\$364.26	\$363.17	<b>-0.3%</b>
Retiree Only (POA)	\$358.71	\$357.62	<b>-0.3%</b>

**Vision Plan****VSP**

## General County

12/12/12; \$10/\$30 copay; \$130/\$70 allowance	VSP	VSP	
Employee Only	\$8.57	\$6.65	
Employee + Spouse	17.13	13.30	
Employee + Children	18.33	14.23	
Employee + Family	29.29	22.74	
Composite	21.00	16.00	<b>-23.8%</b>

## POA (STILL PENDING)

12/24/24; \$10 copay; \$130 allowance	VSP	VSP	
Employee Only	\$4.79	\$3.72	
Employee + Spouse	9.58	7.44	
Employee + Children	10.25	7.96	
Employee + Family	16.39	12.73	
Composite	13.00	10.00	<b>-23.1%</b>

	Rates PEPM		
	2016	2017	% Change
<b>Dental Plans</b>			
<b>Delta Dental of Oregon (formerly Moda/ODS)<sup>2</sup></b>			
Administration	\$6.18	\$6.30	<b>1.9%</b>
Incentive Plan - General County			
Employee Only	\$90.00	\$88.00	
Employee + Spouse	182.00	178.00	
Employee + Children	128.00	125.00	
Employee + Family	219.00	214.00	
Composite	171.00	167.00	<b>-2.3%</b>
Incentive Plan - POA <b>(STILL PENDING)</b>			
Employee Only	\$68.00	\$73.00	
Employee + Spouse	134.00	143.00	
Employee + Children	96.00	103.00	
Employee + Family	163.00	174.00	
Composite	134.00	143.00	<b>6.7%</b>
50% Plan – General County Only			
Employee Only	\$37.00	\$38.00	
Employee + Spouse	74.00	76.00	
Employee + Children	52.00	53.00	
Employee + Family	87.00	89.00	
Composite	69.00	71.00	<b>2.9%</b>
Preventive Plan – General County Only			
Employee Only	\$78.00	\$83.00	
Employee + Spouse	159.00	168.00	
Employee + Children	113.00	120.00	
Employee + Family	192.00	203.00	
Composite	151.00	160.00	<b>6.0%</b>
<b>Kaiser Permanente<sup>1</sup></b>			
Employee Only	\$96.48	\$96.99	
Employee + Spouse	191.03	192.04	
Employee + Children	133.15	133.85	
Employee + Family	228.65	229.86	
General County Composite	179.00	179.88	<b>0.5%</b>



	Rates PEPM		% Change
	2016	2017	
<b>Life and AD&amp;D – MetLife</b>			
<b>Basic Life (Rate per \$1,000 benefit)</b>			
Non-represented – General County Only	\$0.211	\$0.211	0.0%
Represented – General County and POA	0.197	0.197	0.0%
<b>Group Universal Life</b>	Age rated	Age rated	0.0%
<b>Dependent Life per Employee (Rate per Family)</b>			
\$5,000 per Dependent – General County	\$2.39	\$2.39	0.0%
\$2,000 per Dependent – POA	0.38	0.38	0.0%
<b>Voluntary AD&amp;D – General County Only (Rate per \$1,000 benefit)</b>			
Employee Only	\$0.040	\$0.040	0.0%
Employee and Family	0.060	0.060	0.0%
<b>LTD – The Standard Insurance</b>			
<b>Self Insured – General County</b>			
Funding Rate (Rate per \$100 covered salary)	\$0.18	\$0.19	5.6%
General Fee (Rate per Employee)	0.36	0.36	0.0%
New Claim Fee (Rate per Claim)	390.00	390.00	0.0%
Open Claim Fee (Rate per Claim)	19.00	19.00	0.0%
<b>Fully Insured – General County</b>			
Base Plan (Rate per \$100 Covered Salary)	\$0.38	\$0.38	0.0%
Buy-Up Plan (Rate per \$100 Covered Salary)	0.38	0.38	0.0%
<b>Fully Insured – Peace Officers</b>			
Base Plan (Rate per \$100 Covered Salary)	\$0.35	\$0.35	0.0%
Buy-Up Plan (Rate per \$100 Covered Salary)	0.39	0.39	0.0%
<b>Employee Assistance Plan (EAP) – The Standard Insurance – General County Only</b>			
General Fee per Employee per Month	\$0.10	\$0.10	0.0%
<b>Flexible Spending Account – Flex Plan – General County Only</b>			
Monthly Fee per Participant	\$5.00	\$5.00	0.0%
<b>LTC – Unum – General County Only</b>			
Monthly Rate per Participant	Age rated	Age rated	20.0%

<sup>1</sup>Rates include the standard 2017 contract changes. For Kaiser dental, nitrous oxide copay increasing from \$15 to \$25 for ages 13+.

<sup>2</sup>The dental composite projection calls for a 1.6% increase.

# 2

## Medical/Prescription Drug/Vision/Alternative Care Plans

### **Self-Funded Plans**

The County elected to self-fund the Providence Medical/Rx, effective January 1, 2015. The 2017 projection for the Open and Personal Options called for an overall 16.5% increase for the General County and a 23.8% increase for the POA.

The 2017 Providence ASO fees are shown below as per employee per month (PEPM).

### **Providence Health Plan Administrative Fees**

	PEPM
Administrative	\$37.85
PPO Network Fees	7.94
Case Management/Disease Management	8.64
Health Coaching – 12 Sessions	1.95

### **Stop Loss Administrative Fees – Optum Health**

The 2017 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is \$200,000.

Mercer's underwriting projection for the 2017 renewal is included in **Exhibit A** for reference

### *General County*

The BRC elected the following plan changes for the 2017 plan year:

#### **Move to a Base / Buy-Up plan option:**

#### **Personal Option (Base)**

1. Deductible increase from \$500 to \$1,000
2. Out-of-Pocket Maximum increase from \$1,500 to \$3,000
3. Office Visit copay increase from \$20 to \$25
4. Lab and X-Ray coinsurance increase from covered-in-full to 10%
5. Alternative Care copay increase from \$20 to \$25
6. Pharmacy benefit changed from \$15/\$30 to \$10/\$10/50%<\$200/50%<\$200/50%<\$200

#### **Open Option (Buy-Up)**

1. Deductible increase from \$500 to \$750
2. Office Visit copay increase from \$15 to \$20
3. Lab and X-Ray coinsurance decreasing from 10% to covered-in-full
4. Alternative Care copay increase from \$15 to \$20

**Exhibit B(1)** contains the required 2017 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2017.

See **Exhibit C** for the Providence 2017 General County benefit summaries.

### *Peace Officers (STILL PENDING)*

There were no plan changes for the 2017 plan year for the POA plans.

The standard 2017 contract changes summary for grandfathered plans in **Exhibit B(2)** apply to the POA plans.

See **Exhibit C** for the Providence 2017 POA benefit summaries.

### *Retirees – General County and Peace Officers (POA STILL PENDING)*

Early (pre-age 65) retirees are eligible for the Providence Personal and Open Option active employee plans.

For those early retirees who live outside of the Providence service area, the County offers the Traditional Option plan for medical coverage. These early retiree rates and prescription drug benefits are the same as the Open Option plans for active employees.

### **Open Option 15/30/50/2000 \$1000 Common Deductible**

The County elected no plan changes for the 2017 plan year. The 2017 benefit summary is included in **Exhibit C**.

### **Providence Fully-Insured Medicare Align Plan (Medicare Eligible)**

The County accepted a rate increase of 18.2%. The 2017 premium rate for the Providence Medicare Align plan is shown below as a PEPM:

#### **Medicare Align Plan**

Medicare Align With Prescription Drug	\$392.37
---------------------------------------	----------

**Exhibits B(1) and B(2)** contain the standard 2017 contract changes for grandfathered and non-grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2017 early retiree benefit summaries.

### ***Kaiser Permanente***

#### *General County and Peace Officers*

Kaiser proposed an overall 8.42% increase to the 2016 premium rates.

#### *General County*

The BRC elected the following plan changes for the 2017 plan year:

**HMO (Value)**

1. Add a \$250 Deductible
2. Out-of-Pocket Maximum increase from \$600 to \$1,000
3. Add a 10% Inpatient Hospital Coinsurance
4. Change Vision hardware benefit from \$250/24 months to \$250/12 months

The POA did / did not elect to make benefit changes to these plans.

**POA (STILL PENDING)**

The POA elected the following plan changes for the 2017 plan year:

**HMO (Value)**

5. Add a \$250 Deductible
6. Out-of-Pocket Maximum increase from \$600 to \$1,000
7. Add a 10% Inpatient Hospital Coinsurance

Kaiser's underwriting worksheets for their renewal calculations are included in **Exhibit D** for reference.

**Exhibit E** contains the 2017 contract changes provided by Kaiser. The BRC and POA accepted the proposed 2017 benefit and administrative clarifications applicable to grandfathered plans.

See **Exhibit F** for the Kaiser 2017 benefit summaries.

The 2017 premium rates are shown below as per employee per month (PEPM), and include the required contract changes and PPACA fees for the plans:

**Medical/Prescription Drug/Vision Plans**

General County	
Employee Only	\$652.19
Employee + Spouse	1,304.38
Employee + Children	1,173.94
Employee + Family	1,956.57
Composite	1,411.77
<hr/>	
Peace Officers Association	<b>(STILL PENDING)</b>
Employee Only	\$665.98
Employee + Spouse	1,331.96
Employee + Children	1,198.76
Employee + Family	1,997.94
Composite	1,432.46

***Retirees – General County and Peace Officers (POA STILL PENDING)***

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a \$1000 deductible plan for early retirees and COBRA participants. The proposed rate increase of 8.4% for the General County and POA plans were accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan.

**Exhibit E** contains the 2017 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2017 benefit summaries.

The 2017 premium rates for the current \$1000 Deductible plan and Medicare plan are shown below as a per employee per month (PEPM). The premiums include the required contract changes and PPACA fees for the plans:

<u>\$1,000 Deductible Plan COBRA<sup>1</sup> and Early Retirees</u>	
General County	
Employee Only	\$502.27
Employee + Spouse	1,004.55
Employee + Children	904.09
Employee + Family	1,506.87
Peace Officers Association	
Employee Only	\$502.33
Employee + Spouse	1,004.66
Employee + Children	904.20
Employee + Family	1,507.04
Medicare (Parts A, B and D)	
Retiree Only (GC)	\$363.17
Retiree Only (POA)	\$357.62

## Vision Plans

### ***Vision Service Plan (VSP)***

The County elected to renew their vision plans with VSP for both General County and POA. The proposed rates for the 2017 plan year are provided below:

#### ***General County***

Employee Only	\$6.65
Employee + Spouse	13.30
Employee + Children	14.23
Employee + Family	22.74
Composite	16.00

#### ***Peace Officers Association (STILL PENDING)***

Employee Only	\$3.72
Employee + Spouse	7.44
Employee + Children	7.96
Employee + Family	12.73

<sup>1</sup> COBRA participants are charged an additional 2% administrative fee as allowed by law, which is not included in these rates.

Composite 10.00

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The above VSP rates are in a rate guarantee period of 24 months. The plan will next renew January 1, 2019.

See **Exhibit G** for the 2017 VSP benefit summaries.

## Dental Plans

### *Delta Dental of Oregon*

The Incentive Plan is available to all employees – General County and Peace Officers. The 50 Percent Plan and Preventive Plan are only available to General County employees. All three plans are self-funded and administered by Delta Dental of Oregon (Delta).

The County elected Delta Dental's proposed three-year rate guarantee. The administration fees year will be as follows:

Rates per Employee per Month	2017	2018	2019
Administration fee	\$6.30	\$6.40	\$6.49
% Change	1.9%	1.6%	1.4%

The County renewed the dental administration services with Delta effective January 1, 2017, with the following plan changes:

- Acceptance of the administrative changes that were provided with the renewal for all General County
- (STILL PENDING) Acceptance of the administrative changes that were provided with the renewal for all POA plans
- General County did not elect any benefit changes
- The POA did not elect any benefit changes **(POA STILL PENDING)**

There are no additional plan changes.

**Exhibit I** contains the Delta administrative contract changes for 2017 for General County and POA.

See **Exhibit J** for the 2017 Delta benefit summaries.

### *Underwriting*

Mercer projected a 2016 combined funding increase of 1.6% for the 2017 self-insured dental plans. The County elects to apply the individual plan funding adjustments to each plan. The break out of adjustments used for the 2017 plan year is provided in the underwriting calculation in **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from July 1, 2015, through June 30, 2016. An annual trend factor of 5.0% and 0% margin were used.

Mercer recommended and the County accepted the 2017 funding rates listed below. The below rates include all plan changes.

### **Self-Funded Dental Plans: Budgeting Rates per Employee per Month**

<b>Incentive Plan – General County</b>	
Employee Only	\$88.00
Employee + Spouse	178.00
Employee + Children	125.00
Employee + Family	214.00
Composite	167.00

<b>Incentive Plan – POA</b>	
	<b>(STILL PENDING)</b>
Employee Only	\$73.00
Employee + Spouse	143.00
Employee + Children	103.00
Employee + Family	174.00
Composite	143.00

<b>50% Plan – General County Only</b>	
Employee Only	\$38.00
Employee + Spouse	76.00
Employee + Children	53.00
Employee + Family	89.00
Composite	71.00

<b>Preventive Plan – General County Only</b>	
Employee Only	\$83.00
Employee + Spouse	168.00
Employee + Children	120.00
Employee + Family	203.00
Composite	160.00

### ***Kaiser Permanente***

The County has a fully insured dental plan through Kaiser that is available to all employees – General County. Kaiser proposed a 0.5% increase to the 2016 premium rates.

**The POA is still pending.**

**Exhibit E** contains the 2017 standard contract changes provided by Kaiser, which will be effective January 1, 2017.

See **Exhibit F** for the Kaiser 2017 benefit summaries.

The 2017 premium rates for Kaiser dental plan are shown below as per employee per month (PEPM), and include the contract changes for the plans:

***Dental Plan***

Employee Only	\$96.99
Employee + Spouse	192.04
Employee + Children	133.85
Employee + Family	229.86
Composite	179.88

**Life and Voluntary AD&D Insurance*****MetLife***

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. MetLife proposed a rate hold for all plans effective January 1, 2017, with a three-year rate guarantee. The below rates are effective through December 31, 2019. The County renewed the plans with MetLife effective January 1, 2017, with no change in benefits.

A summary of the rates effective January 1, 2017, through December 31, 2019, are as follows:

***General County***

<b>Basic Life</b>	
Non-Represented Employees	\$0.211/\$1,000
Represented Employees	\$0.197/\$1,000
<b>Dependent Life</b>	
\$5,000 per spouse/domestic partner or child	\$2.39 PEPM
<b>Voluntary Accidental Death and Dismemberment</b>	
Employee	\$0.040/\$1,000
Employee and Family (spouse/domestic partner or child)	\$0.060/\$1,000

***Peace Officer Association***

<b>Basic Life</b>	
Represented Employees	\$0.197/\$1,000
<b>Dependent Life</b>	
\$2,000 per spouse/domestic partner or child	\$0.38 PEPM

***General County***

<b>Group Universal Life (Rates Per \$1,000)</b>		
<b>Age</b>	<b>Non-Smoker Rates</b>	<b>Smoker Rates</b>
< 30	\$0.044	\$0.066
30-34	0.049	0.074
35-39	0.062	0.102
40-44	0.096	0.149
45-49	0.164	0.223
50-54	0.270	0.330
55-59	0.424	0.518
60-64	0.641	0.797



Group Universal Life (Rates Per \$1,000)		
Age	Non-Smoker Rates	Smoker Rates
65-69	1.186	1.269
70-74	1.986	1.986

The following levels and corresponding premium rates apply to covered dependent children:

Coverage Amount	\$2,000	\$4,000	\$6,000	\$8,000	\$10,000
Monthly Rate	\$0.118	\$0.236	\$0.354	\$0.472	\$0.59

## Long Term Disability Insurance

### *The Standard*

The County offers three LTD plans through Standard as follows:

- **Base LTD Plans**
  - **General County and POA.** This coverage is provided by the County without contributions from employees. The disability benefit is 60% of the first \$3,333 of monthly pre-disability income. The plan is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.
- **Buy-up LTD Plans**
  - **General County.** This plan offers General County employees the option of buying additional disability coverage, equal to 60% of the next \$5,000 of monthly pre-disability earnings above \$3,333 up to a maximum of \$8,333.
  - **Peace Officers.** This plan offers POA employees the option of buying additional disability coverage, equal to 60% of the next \$6,667 of monthly pre-disability earnings above \$3,333 up to a maximum of \$10,000.

Both buy-up LTD benefit plans for the General County and Peace Officers are 100% paid by employees on a pretax basis. The Plans have two funding components – self-funded and fully insured. Both components are administered by Standard.

The benefits will remain unchanged for the 2017 plan year.

### *Fees and Premium Rates*

The County accepted the proposed Standard rate hold with a two-year rate guarantee with Standard. The next renewal will be January 1, 2019.

The 2017 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	\$0.19 per \$100 covered payroll
Administration Fees	
General	\$0.36 PEPM
New Claim	\$390 per claim
Open Claim	\$19 per open claim at month end
Incidental	As incurred

### Insured Plan

Base – General County	\$0.38/\$100
Buy-Up – General County	\$0.38/\$100
Base – Peace Officers	\$0.35/\$100
Buy-Up – Peace Officers	\$0.39/\$100

## Employee Assistance Plan

### *The Standard*

The County also receives services through an Employee Assistance Program (EAP) from Standard for employees covered by the long term disability plan. The rate will remain at \$0.10 per employee per month.

The County also purchases EAP coverage for part-time employees who are not covered under the LTD plan. The rate will remain at \$0.35 per employee per month.

## Flexible Spending Account Administrator

### *Navia Benefits Solutions*

The County uses Navia Benefits Solutions (Navia), formerly Flex-Plan Services, to provide FSA plans, which are available only to General County employees. The County is entering the third year of a 3-year rate guarantee with Navia effective January 1, 2017.

The 2017 fees remain the same as the 2016 fees, as follows:

### Fees per Participant per Month

Health Care FSA	\$5
Annual Maximum	\$2,500
Dependent Care FSA	\$5
Annual Maximum	\$5,000

## Long Term Care Insurance

### *Unum*

Unum insures the voluntary long term care (LTC) coverage for General County employees. There was a 20% rate increase for the 2017 plan year.

## 3

## Employee Contributions

### General County

For FOPPO, AFSCME and Employee's Association represented employees, the County will pay 95% of the renewal composite medical/ prescription/vision rate up to a collectively bargained capped composite amount.

The County will pay 95% of the tiered premium rates for nonrepresented employees.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
<b>NONREPRESENTED</b>				
<b>Providence Personal Option</b>				
Employer	\$646.95	\$1,294.85	\$1,167.55	\$1,945.60
Employee	34.05	68.15	61.45	102.40
<b>Providence Open Option</b>				
Employer	720.10	1,440.20	1,298.65	2,163.15
Employee	37.90	75.80	68.35	113.85
<b>Kaiser</b>				
Employer	619.58	1,239.16	1,115.24	1,858.74
Employee	32.61	65.22	58.70	97.83
<b>Medical Opt Out</b>				
Cash Back	75.00	149.00	134.00	224.00
<b>REPRESENTED</b>				
<b>Providence Personal Option</b>				
Employer	605.40	1,287.40	1,153.40	1,972.40
Employee	75.60	75.60	75.60	75.60
<b>Providence Open Option</b>				
Employer	513.14	1,271.14	1,122.14	2,032.14
Employee	244.86	244.86	244.86	244.86
<b>Kaiser</b>				
Employer	581.60	1,233.79	1,103.35	1,885.98
Employee	70.59	70.59	70.59	70.59
<b>Medical Opt Out</b>				
Cash Back	168.00	168.00	168.00	168.00

The County pays 100% of the premium for the Delta Dental of Oregon Incentive and Preventive dental plans and the Kaiser dental plan. The Delta Dental of Oregon Constant (50%) plan and Dental Opt Out cash back for all employees are as follows:

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
Delta Dental Of Oregon Constant (50%)				
<b>Nonrepresented</b>				
Cash Back	\$45.00	\$88.00	\$61.00	\$107.00
<b>Represented</b>				
Cash Back	82.00	82.00	82.00	82.00
Dental Opt Out				
<b>Nonrepresented</b>				
Cash Back	46.00	89.00	62.00	108.00
<b>Represented</b>				
Cash Back	83.00	83.00	83.00	83.00

**Peace Officers (STILL PENDING)**

The County pays 95% of the premium for the Providence medical plans. The County pays 100% of the premium for employees enrolled in the Kaiser medical plan.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
<b>Providence Personal Option</b>				
Employer	\$502.00	\$1,076.00	\$963.00	\$1,651.00
Employee	71.00	71.00	71.00	71.00
<b>Providence Open Option</b>				
Employer	512.40	1,097.40	981.40	1,683.40
Employee	71.60	71.60	71.60	71.60
<b>Kaiser</b>				
Employer	614.25	1,228.50	1,105.65	1,842.75
Employee	0.00	0.00	0.00	0.00

The County pays 100% of the premium for the Delta Dental of Oregon and Kaiser dental plans. The County removed the dental contribution for all employees. The Dental Opt Out cash back for all employees is as follows.

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
<b>Dental Opt Out</b>				
Cash Back	136.00	136.00	136.00	136.00

# 4

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## Exhibits

- Exhibit A – Self-Funded Medical/Rx Underwriting (Providence Health Plan)
- Exhibit B – Providence Health Plan – 2017 Contract Changes
  - Exhibit B(1) – Non-Grandfathered – General County
  - Exhibit B(2) – Grandfathered – POA
- Exhibit C – Providence Health Plan – 2017 Benefit Summaries
- Exhibit D – Kaiser Permanente Medical and Dental Underwriting
- Exhibit E – Kaiser Permanente – 2017 Contract Changes
- Exhibit F – Kaiser Permanente – 2017 Benefit Summaries
- Exhibit G – VSP – 2017 Benefit Summaries
- Exhibit H – Self-funded Dental Underwriting Calculation
- Exhibit I – Delta Dental of Oregon – 2017 Contract Changes
- Exhibit J – Delta Dental of Oregon – 2017 Benefit Summaries
- Exhibit K – Carrier Information – A.M. Best Score

# EXHIBIT A

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## Self-Funded Medical/Rx Underwriting (Providence Health Plan)

## Clackamas County – General County

### Medical/Rx Projection for Jan 1, 2017 through Dec 31, 2017

	Open Option	Personal Option	GC Combined
<b>Most Recent 12 Months Ending</b>		<b>June 2016</b>	
Paid Claims Entered for Entire 12-Month Period	\$6,806,735	\$10,187,617	\$16,994,353
Stop Loss Credit	(177,980)	(1,193,484)	(1,371,464)
Historical Benefit Changes Adjustment	0.981	0.982	0.982
Adjusted Paid Claims during This Period	\$6,501,926	\$8,836,496	\$15,338,423
Average Setback Lives during This Period	463	557	1,020
Adjusted Paid Claims per Capita per Month	\$1,169.86	\$1,322.95	\$1,253.42
Annual Trend	7.0%	7.0%	7.0%
Number of Months of Trend	20	20	20
Trend Factor	1.120	1.120	1.120
<b>Projected Claims per Capita</b>	<b>\$1,310.25</b>	<b>\$1,481.70</b>	<b>\$1,403.83</b>
Claims Margin (%)	1.0%	1.0%	1.0%
Claims Margin (\$ per Capita per Month)	\$13.10	\$14.82	\$14.04
<b>Projected Claims per Capita per Month + Margin</b>	<b>\$1,323.35</b>	<b>\$1,496.52</b>	<b>\$1,417.87</b>
<b>Fixed Expenses</b>			
Providence Admin Fees - PEPM (Admin, Case Mgmt., Disease Mgmt.)	\$56.38	\$56.38	\$56.38
Stop Loss Premium - PEPM (estimated 20% increase)	132.07	132.07	132.07
Temporary Reinsurance Fee (HCR) - PEPM	0.00	0.00	0.00
<b>Total Administration / Retention per Capita per Month</b>	<b>\$188.45</b>	<b>\$188.45</b>	<b>\$188.45</b>
<b>Projected Total Cost per Capita per Month for Projection Period</b>	<b>\$1,511.80</b>	<b>\$1,684.97</b>	<b>\$1,606.32</b>
<b>Budget per Capita per Month for Projection Period with Current Rates</b>	<b>\$1,395.63</b>	<b>\$1,363.81</b>	<b>\$1,378.25</b>
<b>Needed Increase</b>	<b>8.3%</b>	<b>23.5%</b>	<b>16.5%</b>

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

## Clackamas County – POA

### Medical/Rx Projection for Jan 1, 2017 through Dec 31, 2017

	Open Option	Personal Option	POA Combined
<b>Most Recent 12 Months Ending</b>		<b>June 2016</b>	
Paid Claims Entered for Entire 12-Month Period	\$4,786,725	\$678,046	\$5,464,771
Stop Loss Credit	0	0	0
Historical Benefit Changes Adjustment	1.000	1.000	1.000
Adjusted Paid Claims during This Period	\$4,786,725	\$678,046	\$5,464,771
Average Setback Lives during This Period	304	58	362
Adjusted Paid Claims per Capita per Month	\$1,312.74	\$974.20	\$1,258.48
Annual Trend	7.0%	7.0%	7.0%
Number of Months of Trend	20	20	20
Trend Factor	1.120	1.120	1.120
<b>Projected Claims per Capita</b>	<b>\$1,470.27</b>	<b>\$1,091.11</b>	<b>\$1,409.50</b>
Claims Margin (%)	1.0%	1.0%	1.0%
Claims Margin (\$ per Capita per Month)	\$14.70	\$10.91	\$14.09
<b>Projected Claims per Capita per Month + Margin</b>	<b>\$1,484.97</b>	<b>\$1,102.02</b>	<b>\$1,423.59</b>
<b>Fixed Expenses</b>			
Providence Admin Fees - PEPM (Admin, Case Mgmt., Disease Mgmt.)	\$56.38	\$56.38	\$56.38
Stop Loss Premium - PEPM (estimated 20% increase)	132.07	132.07	132.07
Temporary Reinsurance Fee (HCR) - PEPM	0.00	0.00	0.00
<b>Total Administration / Retention per Capita per Month</b>	<b>\$188.45</b>	<b>\$188.45</b>	<b>\$188.45</b>
<b>Projected Total Cost per Capita per Month for Projection Period</b>	<b>\$1,673.42</b>	<b>\$1,290.47</b>	<b>\$1,612.04</b>
<b>Budget per Capita per Month for Projection Period with Current Rates</b>	<b>\$1,291.03</b>	<b>\$1,360.74</b>	<b>\$1,302.03</b>
<b>Needed Increase</b>	<b>29.6%</b>	<b>-5.2%</b>	<b>23.8%</b>

All estimates are based upon the information available at a point in time, and are subject to unforeseen and random events. Therefore, any projection must be interpreted as having a likely range of variability from the estimate. Any estimate or projection may not be used or relied upon by any other party for any other purpose than for which it was issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.



# EXHIBIT B

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## Providence Health Plans – 2017 Contract Changes

## Exhibit B(1) – Non-Grandfathered Plans (General County)

## Exhibit B(2) – Grandfathered Plans (POA)

# EXHIBIT C

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## Providence Health Plans – 2017 Benefit Summaries

# EXHIBIT D

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## Kaiser Permanente Medical and Dental Underwriting

# EXHIBIT E

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## Kaiser Permanente – 2017 Contract Changes

# EXHIBIT F

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## Kaiser Permanente – 2017 Benefit Summaries

# EXHIBIT G

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## VSP – 2017 Benefit Summaries



# EXHIBIT H

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## Self-Funded Dental Plan Underwriting Calculation

## Clackamas County – Dental (2017)

### 2017 Preliminary Projection – Dental

	Self-Funded Dental				
	Incentive GC	Incentive POA	Constant (50%)	Preventive	Combined
<b>Most Recent 12 Months Ending</b>	<b>June 30, 2016</b>				
Mature Months	12	12	12	12	12
Paid Claims for Entire 12-Month Period	\$1,129,941	\$481,350	\$42,068	\$564,366	\$2,217,726
Stop loss/Pooling Credit	0	0	0	0	0
Historical Benefit Changes Adjustment	1.006	1.000	1.006	1.005	1.004
Adjusted Net Paid Claims during this Period	\$1,136,681	\$481,350	\$42,325	\$567,281	\$2,227,637
Average Enrollment Setback (1) Month	635	316	57	333	1,341
Adjusted Paid Claims per Capita per Month (PEPM)	\$149.17	\$126.94	\$61.88	\$141.96	\$138.43
Annual Trend	5.0%	5.0%	5.0%	5.0%	5.0%
Number of Months of Trend	19	19	19	19	19
Extended Trend Factor	1.081	1.081	1.081	1.081	1.081
Multiplicative Adjustments Not Related to Trend	1.000	1.000	1.000	1.000	1.000
<b>Projected Claims PEPM</b>	<b>\$161.22</b>	<b>\$137.19</b>	<b>\$66.88</b>	<b>\$153.43</b>	<b>\$149.61</b>
Claims Fluctuation Margin	0.0%	0.0%	0.0%	0.0%	0.0%
<b>Projected Claims PEPM with Margin</b>	<b>\$161.22</b>	<b>\$137.19</b>	<b>\$66.88</b>	<b>\$153.43</b>	<b>\$149.61</b>
2017 Moda Administration Fee	\$6.30	\$6.30	\$6.30	\$6.30	\$6.30
<b>Projected Total Cost (Claims+Margin+Admin) PEPM</b>	<b>\$167.52</b>	<b>\$143.49</b>	<b>\$73.18</b>	<b>\$159.73</b>	<b>\$155.91</b>
Current 2016 Budget, based on Current Rates	\$171.66	\$134.10	\$71.56	\$150.87	\$153.40
<b>Needed Increase to 2016 Rates</b>	<b>-2.4%</b>	<b>7.0%</b>	<b>2.3%</b>	<b>5.9%</b>	<b>1.6%</b>

# EXHIBIT I

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## Delta Dental of Oregon – 2017 Contract Changes

# EXHIBIT J

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## Delta Dental of Oregon – 2017 Benefit Summaries

# EXHIBIT K

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## Carrier Information – A.M. Best Score



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Attachment 3

Clackamas County General County – Plan Options FINAL

# Clackamas County

## General County - Plan Options

Effective January 1, 2017

October 18, 2016

	Fully Insured	Self-Funded	
	Kaiser	PHP (Personal)	PHP (Open)
2017 Composite Rate that Causes County to Hit Cap of \$1,440.14:	<b>\$1,516.00</b>	<b>\$1,516.00</b>	<b>\$1,516.00</b>
Negotiated 2017 County Contribution Cap:	<b>\$1,440.14</b>	<b>\$1,440.14</b>	<b>\$1,440.14</b>
Employee Portion:	<b>\$75.86</b>	<b>\$75.86</b>	<b>\$75.86</b>
Renewal Composite if No Plan Changes Made:	<b>\$1,446.64</b>	<b>\$1,664.00</b>	<b>\$1,712.00</b>
\$ Savings Needed to Reduce 2017 Composite to \$1,516:	<b>\$69.36</b>	<b>(\$148.00)</b>	<b>(\$196.00)</b>
Current 2016 Composite:	<b>\$1,334.27</b>	<b>\$1,436.00</b>	<b>\$1,476.00</b>

General County Plan Design	As-Is			Value		Base	Buy-Up		
	Kaiser	Personal	Open	Kaiser		Personal	Open	Open	
Deductible	\$0	\$500	\$500	\$250	(34.87)	\$1,000	(60.00)	\$750	(24.00)
Out-of-Pocket Maximum	\$600	\$1,500	\$2,500	\$1,000	Included	\$3,000	(53.00)	\$2,500	-
Office Visit Copayment	\$10	\$20	\$15	\$10	-	\$25	(8.00)	\$20	(7.00)
Inpatient Hospital Coinsurance	0%	20%	10%	10%	Included	20%	-	10%	-
Emergency Room Copayment	\$75	\$100	\$100	\$75	-	\$100	-	\$100	-
Lab & X-ray Coinsurance	0%	0%	10%	0%	-	10%	(7.00)	0%	7.00
Outpatient Coinsurance (copay for Kaiser)	\$10	20%	10%	\$10	-	20%	-	10%	-
Alternative Care Annual Maximum	\$1,500	\$2,000	\$2,000	\$1,500	-	\$2,000	-	\$2,000	-
Alternative Care Copayment	\$10/\$25	\$20	\$15	\$10/\$25	-	\$25	(3.00)	\$20	(3.00)
Pharmacy (Rx) Retail Copayment	\$10/\$20	\$15/\$30	\$15/\$30	\$10/\$20	-	\$10/\$10 /50%<\$200 /50%<\$200	-	\$15/\$30	-
Pharmacy (Rx) Mail Order Copayment	2x Retail	2x Retail	2x Retail	2x Retail	-	2x Retail	(21.00)	2x Retail	-
Vision - Exam	\$10	\$10	\$10	\$10	-	\$10	-	\$10	-
Vision - Hardware Allowance	\$250 / 24 mo	\$130 / 12 mo	\$130 / 12 mo	\$250 / 12 mo	Included	\$130 / 12 mo	-	\$130 / 12 mo	-
Renewal Composite	\$1,446.64	\$1,664.00	\$1,712.00	\$1,446.64		\$1,664.00		\$1,712.00	
Option Composite	\$1,446.64	\$1,664.00	\$1,712.00	\$1,411.77		\$1,512.00		\$1,685.00	
Employer Renewal Contribution	\$1,374.30	\$1,440.14	\$1,440.14	\$1,341.18		\$1,436.40		\$1,440.14	
Overall Percentage Increase	8.4%	15.9%	16.0%	5.8%		5.3%		14.2%	
Employee Current Contribution	\$67.69	\$67.44	\$76.44	\$67.69		\$67.44		\$76.44	
Employee New Contribution	<b>\$72.33</b>	<b>\$223.86</b>	<b>\$271.86</b>	<b>\$70.59</b>		<b>\$75.60</b>		<b>\$244.86</b>	
Difference	\$4.64	\$156.42	\$195.42	\$2.90		\$8.16		\$168.42	



Attachment 4

2017 Rate Sheet

CLACKAMAS COUNTY - 2017

MEDICAL	NONREPRESENTED				REPRESENTED			
	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family
<b>Kaiser</b>								
Employer	619.58	1,239.16	1,115.24	1,858.74	581.60	1,233.79	1,103.35	1,885.98
Employee	32.61	65.22	58.70	97.83	70.59	70.59	70.59	70.59
	<u>652.19</u>	<u>1,304.38</u>	<u>1,173.94</u>	<u>1,956.57</u>	<u>652.19</u>	<u>1,304.38</u>	<u>1,173.94</u>	<u>1,956.57</u>
Composite Equivalent				1,411.77			95%	1,411.77
Employer								<u>1,341.18</u>
Employee								70.59
<b>Providence Open Option/VSP Vision</b>								
Employer	720.10	1,440.20	1,298.65	2,163.15	513.14	1,271.14	1,122.14	2,032.14
Employee	37.90	75.80	68.35	113.85	244.86	244.86	244.86	244.86
	<u>758.00</u>	<u>1,516.00</u>	<u>1,367.00</u>	<u>2,277.00</u>	<u>758.00</u>	<u>1,516.00</u>	<u>1,367.00</u>	<u>2,277.00</u>
Composite Equivalent				1,685.00				1,685.00
Employer							max cap	<u>1,440.14</u>
Employee								244.86
<b>Providence Personal Option/VSP Vision</b>								
Employer	646.95	1,294.85	1,167.55	1,945.60	605.40	1,287.40	1,153.40	1,972.40
Employee	34.05	68.15	61.45	102.40	75.60	75.60	75.60	75.60
	<u>681.00</u>	<u>1,363.00</u>	<u>1,229.00</u>	<u>2,048.00</u>	<u>681.00</u>	<u>1,363.00</u>	<u>1,229.00</u>	<u>2,048.00</u>
Composite Equivalent				1,512.00				1,512.00
Employer							max cap	<u>1,436.40</u>
Employee								75.60
<b>Medical Opt Out - Cash Back</b>	75.00	149.00	134.00	224.00	168.00	168.00	168.00	168.00

CLACKAMAS COUNTY - 2017

		NONREPRESENTED				REPRESENTED			
<b>DENTAL</b>									
<b>Kaiser</b>									
Employer		96.99	192.04	133.85	229.86	96.99	192.04	133.85	229.86
Employee		-	-	-	-	-	-	-	-
		<u>96.99</u>	<u>192.04</u>	<u>133.85</u>	<u>229.86</u>	<u>96.99</u>	<u>192.04</u>	<u>133.85</u>	<u>229.86</u>
	Composite:				179.88				179.88
<b>MODA Preventive</b>									
Employer		83.00	168.00	120.00	203.00	83.00	168.00	120.00	203.00
Employee		-	-	-	-	-	-	-	-
		<u>83.00</u>	<u>168.00</u>	<u>120.00</u>	<u>203.00</u>	<u>83.00</u>	<u>168.00</u>	<u>120.00</u>	<u>203.00</u>
	Composite:				160.00				160.00
<b>MODA Incentive</b>									
Employer		88.00	178.00	125.00	214.00	88.00	178.00	125.00	214.00
Employee		-	-	-	-	-	-	-	-
		<u>88.00</u>	<u>178.00</u>	<u>125.00</u>	<u>214.00</u>	<u>88.00</u>	<u>178.00</u>	<u>125.00</u>	<u>214.00</u>
	Composite:				167.00				167.00
<b>MODA 50%</b>									
Employer		97.64	192.64	133.85	230.82	146.68	184.68	161.68	197.68
Employee Cash Back		(45.00)	(88.00)	(61.00)	(107.00)	(82.00)	(82.00)	(82.00)	(82.00)
FICA/PERS		(14.64)	(28.64)	(19.85)	(34.82)	(26.68)	(26.68)	(26.68)	(26.68)
		<u>38.00</u>	<u>76.00</u>	<u>53.00</u>	<u>89.00</u>	<u>38.00</u>	<u>76.00</u>	<u>53.00</u>	<u>89.00</u>
	Composite:				71.00				71.00
<b>Dental Opt Out</b>									
Employer		60.97	117.96	82.17	143.14	110.01	110.01	110.01	110.01
Employee Cash Back		(46.00)	(89.00)	(62.00)	(108.00)	(83.00)	(83.00)	(83.00)	(83.00)
FICA/PERS		(14.97)	(28.96)	(20.17)	(35.14)	(27.01)	(27.01)	(27.01)	(27.01)
		<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>	<u>-</u>
<b>WELLNESS/EAP</b>									
Employer Paid		2.20	4.40	4.00	6.60	2.20	4.40	4.00	6.60



**CLACKAMAS COUNTY - 2017**

	<b>Elected/ Nonrep</b>	<b>Nonrep Housing Authority</b>	<b>EA</b>	<b>HA/EA</b>	<b>DTD</b>	<b>WES</b>	<b>FOPPO</b>	<b>C-COM (Non- Dispatch)</b>	<b>C-COM (Dispatch)</b>
<b>LONGEVITY</b>									
5 - 9 Years	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%
10-14 Years	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%
15-19 Years	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%
20-24 Years	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%
25-30 Years	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.0%	3.0%	3.0%
30+ Years	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.5%	3.5%	3.5%
<b>VACATION ACCRUALS (MONTHLY)**</b>									
< 5 Years	12.7	12.7	8.7	8.7	8.7	8.7	8.7	10.7	19.1
Annual Maximum Carryover	280	280	250	250	250	218	240	240	240
5 - 9 Years	14.0	14.0	10.7	10.7	10.7	10.7	10.7	12.7	21.1
Annual Maximum Carryover	280	280	250	250	250	218	240	240	240
10-14 Years	16.0	16.0	12.7	12.7	12.7	12.7	12.7	14.7	23.1
Annual Maximum Carryover	280	280	250	250	250	258	240	280	280
15-19 Years	18.0	18.0	14.7	14.7	14.7	14.7	14.7	16.0	24.4
Annual Maximum Carryover	280	280	250	250	250	258	240	280	280
20+ Years	19.3	19.3	16.7	16.7	16.7	16.7	16.7	16.7	25.1
Annual Maximum Carryover	280	280	250	250	250	258	250	280	280
<b>VACATION SELLBACK ACCRUALS (MONTHLY)**</b>									
Accrual (all years of service)	16	16	12	12	12	12	12		
Annual Maximum Carryover	280	280	250	250	250	250	250		
<b>SICK LEAVE</b>									
Monthly accrual	8	8	8	8	8	8	8	8	8
No Maximum Carryover									
<b>HOLIDAYS</b>									
Regular	9	9	9	10	9	9	9	9	3
Personal (Floating Holiday)	1	1	1	0	1	1	2	1	0

Note: Elected Officials do not receive longevity pay, nor do they accrue vacation, sick leave or Personal Holidays.

\*\*Employees hired prior to 01/01/01 have a choice between the regular Vacation plan and the Vacation Sell Back plan.

Employees hired on or after 01/01/01 are enrolled in the Vacation Sell Back plan (except CCOM & POA).

Employees may sell one week of vacation each calendar year as long as they have taken at least one week of vacation during that year.

CCOM Dispatch employees earn additional vacation time in lieu of most holidays.