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 though 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	$7,007
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.

MERCER
MAKE TOMORROW, TODAY

2016 HEALTH AND WELFARE BENEFIT PLAN RENEWAL REPORT

CLACKAMAS COUNTY

OCTOBER 21, 2015

MARSH & McLENNAN COMPANIES

CONTENTS

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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
Medical/Prescription/Vision Plans			
Providence Health Plan – General County[1]			
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	**6.0%**
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	**5.6%**
Providence Health Plan – POA[1]			
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	**-9.7%**
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	**-9.7%**
Kaiser Permanente HMO – General County (with hearing aids)[1]			
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	**-2.1%**
Kaiser Permanente HMO – POA[1]			
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	**-2.1%**

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

Vision Plan

VSP

General County			
12/12/12; $10/$30 copy; $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	**0.0%**
POA			
12/24/24; $10 copy; $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	**0.0%**

	Rates PEPM		
	2015	2016	% Change
Dental Plans			
Delta Dental of Oregon (formerly Moda/ODS)[2]			
Administration	$6.10	$6.18	**1.3%**
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	**22.1%**
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	**-3.6%**
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	**24.1%**
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	**-1.3%**
Kaiser Permanente[1]			
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	**5.9%**

	Rates PEPM		
	2015	2016	% Change
Life and AD&D – MetLife			
Basic Life (Rate per $1,000 benefit)			
Non-represented – General County Only	$0.211	$0.211	**0.0%**
Represented – General County and POA	0.197	0.197	**0.0%**
Group Universal Life	Age rated	Age rated	**0.0%**
Dependent Life per Employee (Rate per Family)			
$5,000 per Dependent – General County	$2.39	$2.39	**0.0%**
$2,000 per Dependent – POA	0.38	0.38	**0.0%**
Voluntary AD&D – General County Only (Rate per $1,000 benefit)			
Employee Only	$0.040	$0.040	**0.0%**
Employee and Family	0.060	0.060	**0.0%**
LTD – The Standard Insurance			
Self-Insured – General County			
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%**
Fully Insured – General County			
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%**
Fully Insured – Peace Officers			
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%**
Employee Assistance Plan (EAP) – The Standard Insurance – General County Only			
General Fee per Employee	$0.10	$0.10	**0.0%**
Flexible Spending Account – Flex Plan – General County Only			
Monthly Fee per Participant	$5.00	$5.00	**0.0%**
LTC – Unum – General County Only			
Monthly Rate per Participant	Age rated	Age rated	**0.0%**

[1]*Rates include the standard 2016 contract changes.*
[2]*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

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[1] 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.

[1] 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

Incentive Plan – General County	
Employee Only	$90.00
Employee + Spouse	182.00
Employee + Children	128.00
Employee + Family	219.00
Composite	171.00

Incentive Plan – POA	
Employee Only	$68.00
Employee + Spouse	134.00
Employee + Children	96.00
Employee + Family	163.00
Composite	134.00

50% Plan – General County Only	
Employee Only	$37.00
Employee + Spouse	74.00
Employee + Children	52.00
Employee + Family	87.00
Composite	72.00

Preventive Plan – General County Only	
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

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

Peace Officer Association

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

General County

Group Universal Life (Rates Per $1,000)		
Age	**Non-Smoker Rates**	**Smoker Rates**
< 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.

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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
NONREPRESENTED				
Providence Personal Option				
Employer	$614.65	$1,228.35	$1,108.65	$1,846.80
Employee	32.35	64.65	58.35	97.20
Providence Open Option				
Employer	630.80	1,261.60	1,138.10	1,895.25
Employee	33.20	66.40	59.90	99.75
Kaiser				
Employer	585.57	1,171.13	1,054.03	1,756.70
Employee	30.82	61.64	55.47	92.46
Medical Opt Out				
Cash Back	71.00	142.00	128.00	213.00
REPRESENTED				
Providence Personal Option				
Employer	579.56	1225.56	1099.56	1876.56
Employee	67.44	67.44	67.44	67.44
Providence Open Option				
Employer	587.56	1251.56	1121.56	1918.56
Employee	76.44	76.44	76.44	76.44
Kaiser				
Employer	548.70	1,165.08	1,041.81	1,781.47
Employee	67.69	67.69	67.69	67.69
Medical Opt Out				
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%)				
Nonrepresented				
Cash Back	$45.00	$88.00	$61.00	$107.00
Represented				
Cash Back	82.00	82.00	82.00	82.00
Dental Opt Out				
Nonrepresented				
Cash Back	72.00	143.00	100.00	172.00
Represented				
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
Providence Personal Option				
Employer	$502.00	$1,076.00	$963.00	$1,651.00
Employee	71.00	71.00	71.00	71.00
Providence Open Option				
Employer	512.40	1,097.40	981.40	1,683.40
Employee	71.60	71.60	71.60	71.60
Kaiser				
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
Dental Opt Out				
Cash Back	136.00	136.00	136.00	136.00

4

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

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
Most Recent 12 Months Ending		***July 2015***	
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
Projected Claims per Capita	**$1,224.85**	**$1,252.98**	**$1,240.98**
Claims Margin (%)	1.0%	1.0%	1.0%
Claims Margin ($ per Capita per Month)	$12.25	$12.53	$12.41
Projected Claims per Capita per Month + Margin	**$1,237.10**	**$1,265.51**	**$1,253.39**
Fixed Expenses			
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
Total Administration / Retention per Capita per Month	**$167.91**	**$167.91**	**$167.91**
Projected Total Cost per Capita per Month for Projection Period	**$1,405.02**	**$1,433.42**	**$1,421.30**
Budget per Capita per Month for Projection Period with Current Rates	**$1,302.54**	**$1,293.36**	**$1,297.48**
Needed Increase	**7.9%**	**10.8%**	**9.5%**

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
Most Recent 12 Months Ending		***July 2015***	
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
Projected Claims per Capita	**$1,159.78**	**$956.81**	**$1,129.36**
Claims Margin (%)	1.0%	1.0%	1.0%
Claims Margin ($ per Capita per Month)	$11.60	$9.57	$11.29
Projected Claims per Capita per Month + Margin	**$1,171.38**	**$966.38**	**$1,140.66**
Fixed Expenses			
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
Total Administration / Retention per Capita per Month	**$167.91**	**$167.91**	**$167.91**
Projected Total Cost per Capita per Month for Projection Period	**$1,339.29**	**$1,134.29**	**$1,308.57**
Budget per Capita per Month for Projection Period with Current Rates	**$1,429.60**	**$1,559.98**	**$1,449.55**
Needed Increase	**-6.3%**	**-27.3%**	**-9.7%**

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

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

	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.	Adding a $1,500 calendar year limited benefit. Services must be covered and are subject to prior authorization and medical necessity. 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. Transplant services continue to include a separate limited $5,000 lifetime travel expense benefit.	PHP change Optional but recommended
Prior Authorization List Updated	Not applicable.	Services added to the Prior Authorization list: 1. Travel expense reimbursement 2. Echocardiography services	PHP change Mandatory
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

Non-preventive Colonoscopies for Members Age 50+	Covered in full regardless of diagnosis when provided by in-network providers.	Non-preventive - Covered under outpatient services as referenced on the benefit summary. Preventive - Covered in full when provided by in-network providers. Colonoscopies for members under age 50 continue to be covered under outpatient services.	PHP change Optional

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.	Adding a $1,500 calendar year limited benefit. Services must be covered and are subject to prior authorization and medical necessity. 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. Transplant services continue to include a separate limited $5,000 lifetime travel expense benefit.	PHP change Optional but recommended
Prior Authorization List Updated	Not applicable.	Services added to the Prior Authorization list: 1. Travel expense reimbursement 2. Echocardiography services	PHP change Mandatory
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

Providence Health Plans – 2016 Benefit Summaries

Administered by PROVIDENCE Health Plan

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.

- 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.
- 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)
Preventive Care	
• 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✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓
• Mammograms	Covered in full✓
• Colonoscopy; sigmoidoscopy	Covered in full✓
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓
Physician / Provider Services	
• Office visits	$20 / visit✓
• 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 / visit✓
• Phone and video visits (including Providence Health eXpress®)	$5 / visit✓
• Allergy shots, serums, infusions and injectable medications	$20 / visit✓
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Diagnostic Services	
• X-ray and lab services	Covered in full✓
• High-tech imaging services (such as PET, CT or MRI)	Covered in full✓
• Sleep studies	Covered in full✓
Emergency and Urgent Services	
• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$20 / visit✓
• Emergency medical transportation (air and/or ground)	20%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (limited to 30 days per calendar year)	20%
• Skilled nursing facility (limited to 60 days per calendar year)	20%

Benefit Highlights (continued)

	Copay or Coinsurance
Outpatient Services	
• 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 / visit✓
Maternity Services	
• Prenatal care	Covered in full✓
• Delivery and postnatal services	$150 / delivery✓
• Inpatient hospital/facility services	20%
• Routine newborn nursery care	20%✓
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%✓
• Diabetes supplies (lancets, test strips and needles)	20%✓
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	20%✓
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient and residential services	20%
• Day treatment, intensive outpatient, and partial hospitalization services	20%
• Applied behavior analysis	20%
• Outpatient provider visits	$20 / visit✓
Home Health and Hospice	
• Home health care	20%
• Hospice care	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.

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.

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

Administered by PROVIDENCE Health Plan

Your Benefit Summary

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

Copay	Maximum Calendar Year Benefit
$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.

- 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 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.

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Administered by PROVIDENCE Health Plan

Your Benefit Summary

Out-of-Area Dependent

Clackamas County - General County Employees

What You Pay	Calendar Year Out-of-Pocket Maximum
20% coinsurance	$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.

- 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
Preventive Care	
• 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
Physician / Provider Services	
• 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%
Diagnostic Services	
• X-ray and lab services	20%
• High-tech imaging services (such as PET, CT or MRI)	20%
• Sleep studies	20%
Emergency and Urgent Services	
• 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%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Outpatient Services	
• 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
Maternity Services	
• Prenatal care	Covered in full
• Delivery; postnatal care	20%
• Inpatient hospital/facility services	20%
• Routine newborn nursery care	20%
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%
• Diabetes supplies (lancets, test strips and needles)	20%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year)	20%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)	
• Inpatient and residential services	20%
• Day treatment, intensive outpatient, and partial hospitalization services	20%
• Applied behavior analysis	20%
• Outpatient provider visits	20%
Home Health and Hospice	
• Home health care	20%
• Hospice care	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.

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.

Contact us
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Your Benefit Summary

Open Option Plan

Clackamas County - General County Employees

Administered by PROVIDENCE Health Plan

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.

- 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 .
- 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:	
✓ No deductible needs to be met prior to receiving this benefit.	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)
Preventive Care		
• 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
Physician / Provider Services		
• 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%
Diagnostic Services		
• X-ray and lab services	10%✓	30%
• High-tech imaging services (such as PET, CT or MRI)	10%✓	30%
• Sleep studies	10%✓	30%
Emergency and Urgent Services		
• 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
Hospital Services		
• Inpatient/Observation care	10%	30%
• Rehabilitative care (30 days per calendar year)	10%	30%
• Skilled nursing facility (60 days per calendar year)	10%	30%
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	10%	30%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	10%	30%
Maternity Services		
• Prenatal care	Covered in full✓	30%
• Delivery and postnatal services	$150 / delivery✓	30%
• Inpatient hospital/facility services	10%	30%
• Routine newborn nursery care	10%✓	30%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	10%✓	30%
• Diabetes supplies (lancets, test strips and needles)	10%✓	30%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	10%✓	30%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	10%	30%
• Day treatment, intensive outpatient, and partial hospitalization services	10%	30%
• Applied behavior analysis	10%	30%
• Outpatient provider visits	$15 / visit✓	30%✓
Home Health and Hospice		
• Home health care	10%	30%
• Hospice care	Covered in full✓	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.

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.

Contact us

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All other areas: 800-878-4445
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Administered by PROVIDENCE Health Plan

Your Benefit Summary

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

Copay
$15

Maximum Calendar Year Benefit
$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.

- 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 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.

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Administered by PROVIDENCE Health Plan

Your Benefit Summary

Hearing Aid

Clackamas County - General County Employees on an Open Option Plan

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.

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

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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Administered by PROVIDENCE Health Plan

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.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at 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 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.

	Copay or Coinsurance		
Drug Coverage Category	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.
- 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 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.

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.

Contact us

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Your Benefit Summary

Personal Option Plan

Clackamas County POA

Administered by PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum
$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 at 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)
Physician / Provider Services	
• Office visits	$15 / visit
• Phone and video visits (including Providence Health eXpress®)	$5 / visit
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations; shots	Covered in full
• Maternity services: prenatal	Covered in full
• Maternity services: delivery and postnatal	$150 / delivery
• Allergy shots; serums; injectable medications	$15 / visit
• Inpatient hospital visits	Covered in full
• Surgery; anesthesia	Covered in full
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full
• Mammograms	Covered in full
Hospital Services	
• Inpatient care	Covered in full
• Observation care	Covered in full
• Maternity care	Covered in full
• Routine newborn nursery care	Covered in full
• Rehabilitative care (30 days per calendar year)	Covered in full
• Skilled nursing facility (60 days per calendar year)	Covered in full
Outpatient Diagnostic Services	
• X-ray; lab services	Covered in full
• Imaging services (such as PET, CT, MRI)	Covered in full
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$100
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit
• Emergency medical transportation	$50

Benefit Highlights (continued)

	Copay or Coinsurance
Other Covered Services	
• Outpatient rehabilitative services (30 visits per calendar year)	$15 / visit
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	Covered in full
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Home health care	Covered in full
• 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	Covered in full
-Formulary brand-name drugs	Covered in full
-Non-formulary brand-name drugs	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	Covered in full
• Residential services	Covered in full
• Applied behavior analysis	$15 / visit
• Outpatient provider visits	$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.

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

Contact us
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Your Benefit Summary

Out-of-Area Dependent
Clackamas County POA

Administered by PROVIDENCE Health Plan

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 penalities 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:
	Coinsurance
Physician / Provider Services	
• Office visits	20%
• 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 ®)	5%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full
• Vision and hearing screenings for children under 18	Covered in full
• Routine immunizations; shots	Covered in full
• Maternity services: prenatal	Covered in full
• Maternity services: delivery and postnatal	20%
• Allergy shots; serums; injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full
• Mammograms	Covered in full
Hospital Services	
• Inpatient care	20%
• Observation care	20%
• Maternity care	20%
• Routine newborn nursery care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Outpatient Diagnostic Services	
• X-ray; lab services	20%
• Imaging services (such as PET, CT, MRI)	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Emergency medical transportation	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.

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

Administered by PROVIDENCE Health Plan

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

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- 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:	
✓ No deductible needs to be met prior to receiving this benefit.	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)
Physician / Provider Services		
• Office visits	$10 / visit✓	20%✓
• Phone and video visits (including Providence Health eXpress®)	$5 / visit✓	Not covered
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	20%✓
• Vision and hearing screenings for children under 18	Covered in full✓	20%✓
• Routine immunizations; shots	Covered in full✓	20%✓
• Maternity services: prenatal	Covered in full✓	20%
• Maternity services: delivery and postnatal	$50 / delivery✓	20%
• Allergy shots; serums; injectable medications	Covered in full	20%
• Inpatient hospital visits	Covered in full	20%
• Surgery; anesthesia	Covered in full	20%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	20%✓
• Mammograms	Covered in full✓	20%
Hospital Services		
• 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✓	20%
• Rehabilitative care (30 days per calendar year)	Covered in full	20%
• Skilled nursing facility (60 days per calendar year)	Covered in full	20%
Outpatient Diagnostic Services		
• X-ray; lab services	Covered in full✓	20%
• Imaging services (such as PET, CT, MRI)	Covered in full✓	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year; deductible waived)	20%*	20%

* 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
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits)	$100✓	$100✓
• Urgent care services (for non-life threatening illness/minor injury)	$10 / visit✓	20%✓
• Emergency medical transportation	$50	$50
Other Covered Services		
• Outpatient rehabilitative services (30 visits per calendar year)	$10 / visit	20%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	$10 / visit	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Home health care	Covered in full	20%
• Hospice care	Covered in full✓	Covered in full✓
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓	Not covered
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	$10✓	Not covered
-Formulary brand-name drugs	$10✓	Not covered
-Non-formulary brand-name drugs	$10✓	Not covered
Mental Health / Chemical Dependency (To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient, residential services	Covered in full	20%
• Day treatment, intensive outpatient, and partial hospitalization services	Covered in full	20%
• Applied behavior analysis	$10 / visit✓	20%
• Outpatient provider visits	$10 / visit✓	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.

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.

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.

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.

Contact us

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Administered by PROVIDENCE Health Plan

Your Benefit Summary

Chiropractic Care Plan
Clackamas County - POA Active Employee Plans

Copay	Maximum Calendar Year Benefit
$10	$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.
- 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 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.

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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.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at 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 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.

	Copay or Coinsurance		
Drug Coverage Category	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.
- 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 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.

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.

Contact us

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Your Benefit Summary

Open Option Plan
Clackamas County Early Retirees, COBRA Participants & Temporary Employees

Administered by PROVIDENCE Health Plan

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.

- 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 .
- 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:	
✓ No deductible needs to be met prior to receiving this benefit.	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)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	50%✓
• Vision and hearing screenings for children under 18	Covered in full✓	50%✓
• Routine immunizations and shots	Covered in full✓	50%✓
• Colonoscopy (age 50+)	Covered in full✓	50%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits	$15 / visit✓	50%✓
• 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✓	50%✓
• Phone and video visits (including Providence Health eXpress®)	$5 / visit✓	Not covered
• Allergy shots, serums, infusions and injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Diagnostic Services		
• X-ray and lab services	30%✓	50%
• High-tech imaging services (such as PET, CT or MRI)	30%✓	50%
• Sleep studies	30%✓	50%
Emergency and Urgent Services		
• 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✓	50%✓
• 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)	30%	30%

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Hospital Services		
• Inpatient/Observation care	30%	50%
• Rehabilitative care (30 days per calendar year)	30%	50%
• Skilled nursing facility (60 days per calendar year)	30%	50%
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	30%	50%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	30%	50%
Maternity Services		
• Prenatal care	Covered in full✓	50%
• Delivery and postnatal services	$100 / delivery✓	50%
• Inpatient hospital/facility services	30%	50%
• Routine newborn nursery care	30%✓	50%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	30%	50%
• Diabetes supplies (lancets, test strips and needles)	30%✓	50%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	30%	50%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	30%	50%
• Day treatment, intensive outpatient, and partial hospitalization services	30%	50%
• Applied behavior analysis	30%	50%
• Outpatient provider visits	$15 / visit✓	50%✓
Home Health and Hospice		
• Home health care	30%	50%
• Hospice care	Covered in full✓	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.

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

Copay	Maximum Calendar Year Benefit
$25	$500 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.

- 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 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.

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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 at 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 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 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.

	Copay or Coinsurance		
Drug Coverage Category	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.
- 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 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.

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 20 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.

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

Administered by PROVIDENCE Health Plan

Your Benefit Summary

Non-Medicare Eligible Retired Employees
Clackamas County

Important information about your plan

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

Retired Employee definition

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

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.

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.

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.

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.

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.

Contact us

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

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Administered by PROVIDENCE Health Plan

Your Benefit Summary

Men's Elective Sterilization
Clackamas County

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.

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.

Contact us

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TTY: 711

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www.ProvidenceHealthPlan.com/contactus

Your Benefit Summary

Domestic Partner Plus
Clackamas County

Administered by PROVIDENCE Health Plan

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.

Contact us

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EXHIBIT D

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	**Projected Claims Calculation**					
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			1.002740		
A8	Adjusted Claims					$392.231
A9	X Trend Factor	Annual Trend: 5.98%		1.11237		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$436.306
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
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	**Uncapped PMPM Premium Requirement**		**$651,319**	**$488.245**
E	**Capping**	**Increase**		
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	**Quoted Rate PMPM before Underwriter Adjustment**	**(2.10%)**	**652,506**	**489.135**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(2.10)%**	**652,506**	**489.135**
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	**Projected Claims Calculation**					
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			1.000040		
A8	Adjusted Claims					$391.175
A9	X Trend Factor	Annual Trend: 5.98%		1.11237		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$435.131
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
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	**Uncapped PMPM Premium Requirement**		**$129,873**	**$486.414**
E	**Capping**	**Increase**		
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	**Quoted Rate PMPM before Underwriter Adjustment**	**(2.10%)**	**126,535**	**473.915**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(2.10)%**	**126,535**	**473.915**
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	**Projected Claims Calculation**					
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	**Total Rate Calculation**			
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	**Uncapped PMPM Premium Requirement**		**$3,819**	**$381.873**
E	**Capping**	**Increase**		
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	**Quoted Rate PMPM before Underwriter Adjustment**	**(2.10%)**	**4,633**	**463.319**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(2.10)%**	**4,633**	**463.319**
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	**Projected Claims Calculation**					
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			0.763900		
A8	Adjusted Claims					$298.807
A9	X Trend Factor	Annual Trend: 5.98%		1.11237		
A10	Claims based PMPM	22.0 Months Midpoint to Midpoint				$332.384
A11	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.	PMPM$
D	**Total Rate Calculation**			
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	**Uncapped PMPM Premium Requirement**		**$5,742**	**$382.776**
E	**Capping**	**Increase**		
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	**Quoted Rate PMPM before Underwriter Adjustment**	**(2.10%)**	**6,949**	**463.258**
E5	X Underwriter Adjustment	1.00000		
E6	**Quoted Rate PMPM after Underwriter Adjustment**	**(2.10)%**	**6,949**	**463.258**
E7	Capping Adjustment		1,207	80.482

Rate Buildup

Region: Northwest
Group Name: Clackamas County
Contract Period: 01/01/2016 - 12/31/2016
Group Number(s): 01183-043, 045, 046, 047, 049, 050, 05
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

			Weight	Factor	Total$	PMPM$
A.	**Projected Claims Calculation**					
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	Annual Trend: 4.50%		1.0801		
A8	Claims Based PMPM	21 Months Midpoint to Midpoint				$54.31
A9	Credibility		100%			

Total Rate Calculation

		Factor	Mo. Prem.$	PMPM$
C.	**Total Rate Calculation**			
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		**$106,647**	**$63.48**
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
D4	**Quoted rate PMPM before UW Adj**	**5.7%**	**106,647**	**$63.48**
D5	x Underwriter Adjustment	1.0000		
D6	**Quoted rate PMPM after UW Adj**	**5.7%**	**106,647**	**$63.48**
D7	Capping Adjustment	0.0%	(0)	($0.00)

EXHIBIT E

Kaiser Permanente – 2016 Contract Changes

2016 CONTRACT CHANGES CLACKAMAS COUNTY

Jennifer Pittman, Executive Account Manager

KAISER PERMANENTE®

Clackamas County 2016 Contract Changes

Contract Change	Current (2015)	New (2016)	Rationale	Rate Impact
Student Out of Area Coverage	Student Out-of-Area: 20% coinsurance, $1,200 Benefit Maximum. Does not accumulate to Out-of-Pocket Maximum.	Dependent child: 10 OV, 10 X-ray/Lab, 10 Prescriptions. 20% coinsurance for all services. Benefit accumulates to Out-of-Pocket Maximum. **no student verification needed*	ACA mandate to remove dollar limits and accumulate to the Out-of-Pocket Maximum, as benefit covers Essential Health Benefits.	Enhancement *$.02 increase to PMPM*
Physical, Occupational, Speech Therapies	Subject to deductible.	Not subject to deductible, copays apply	Member experience, steers members to the most appropriate medical care.	Enhancement *Increases rates by less that 0.01%*
Pediatric and Adult Vision Hardware	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 *No rate impact*
Mental Health Service Exclusions and Limitations	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 *No rate impact*

Clackamas County 2016 Contract Changes, cont.

Contract Change	Current (2015)	New (2016)	Rationale	Rate Impact
Port Wine Stain Treatment (on the face)	Treatment *only* 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 *No rate impact*
Detained or Confined Members	Services arranged by criminal justice officials (unless emergency) listed as excluded.	These services are not excluded.	OR state legislation	Enhancement *No rate impact*
Genetic Testing	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 *No rate impact*
Unlicensed Providers	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 *No rate impact*

EXHIBIT F

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
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	$10
Specialty Care	$10
Urgent Care	$10
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0 per department visit
Medications (outpatient)	**You pay**
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
Maternity Care	**You pay**
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
Inpatient Hospital Services	$0
Hospital Services	**You pay**
Ambulance Services (per transport)	$75
Emergency department visit	$75 (Waived if admitted)
Inpatient Hospital Services	$0
Outpatient Services (other)	**You pay**
Outpatient surgery visit	$10
Chemotherapy/radiation therapy visit	$10
Durable medical equipment, external prosthetic devices, and orthotic devices	$0

342MMC-14/7-14

Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$10
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	**You pay**
Outpatient Services (Group visit ½ copay)	$10
Inpatient hospital & residential Services	$0
Mental Health Services	**You pay**
Outpatient Services (Group visit ½ copay)	$10
Inpatient hospital & residential Services	$0
Alternative Care	**You pay**
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.
Vision Services	**You pay**
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

- 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

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

Facilities and Services: 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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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
Office visits	**You pay**
Routine preventative physical exam	$0
Primary Care	$10
Specialty Care	$10
Urgent Care	$10
Tests (outpatient)	**You pay**
Preventive Tests	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
CT, MRI, PET scans	$0 per department visit
Medications (outpatient)	**You pay**
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
Maternity Care	**You pay**
Scheduled prenatal care and first postpartum visit	$0
Laboratory	$0
X-ray, imaging, and special diagnostic procedures	$0
Inpatient Hospital Services	$0
Hospital Services	**You pay**
Ambulance Services (per transport)	$75
Emergency department visit	$75 (Waived if admitted)
Inpatient Hospital Services	$0
Outpatient Services (other)	**You pay**
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
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	$0
Chemical Dependency Services	**You pay**
Outpatient Services (Group visit ½ copay)	$10
Inpatient hospital & residential Services	$0
Mental Health Services	**You pay**
Outpatient Services (Group visit ½ copay)	$10
Inpatient hospital & residential Services	$0
Alternative Care	**You pay**
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.
Vision Services	**You pay**
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

- 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

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

Facilities and Services: 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

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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
Skilled Nursing Facility Services	**You pay**
Inpatient skilled nursing Services (up to 100 days per Calendar Year)	20% Coinsurance after Deductible
Chemical Dependency Services	**You pay**
Outpatient Services (Group visit ½ copay)	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Mental Health Services	**You pay**
Outpatient Services (Group visit ½ copay)	$25
Inpatient hospital & residential Services	20% Coinsurance after Deductible
Alternative Care	**You pay**
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.
Vision Services	**You pay**
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

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

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- Vitamins and supplements
- Alternative and chiropractic care

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For one Member per Calendar Year	$1,000
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Out-of-Pocket Maximum (Note: Deductible amounts and Services not subject to the Deductible do not count toward your Out-of-Pocket Maximum.)	
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CT, MRI, PET scans	$0 per department visit
Medications (outpatient)	**You pay**
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EXHIBIT G

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** 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** 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**.

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[1]. Visit **vsp.com** to find a VSP provider who carries these brands.

VSP® Vision care for life

See why we're consumers' #1 choice in vision care[2].

Contact us. **800.877.7195**
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
	Your Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses			
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 equivalent frame allowance at Costco Optical	$0	Every calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	$0	Every calendar year
Lens Enhancements	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements	$30 $30 $30	Every calendar year
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every calendar year
Diabetic Eyecare Plus Program	• 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.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Visit **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 $70	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 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** | **vsp.com**

[1]Brands/Promotion subject to change.

[2]Blueocean Market Intelligence National Vision Plan Member Research, 2014

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- **Great Eyewear.** It's easy to find the perfect frame at a price that fits your budget.

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See why we're consumers' #1 choice in vision care[2].

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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
Your Coverage with a VSP Provider			
WellVision Exam	• Focuses on your eyes and overall wellness	$10	Every calendar year
Prescription Glasses		$0	See frame and lenses
Frame	• $130 allowance for a wide selection of frames • $150 allowance for featured frame brands • 20% savings on the amount over your allowance • $70 equivalent frame allowance at Costco Optical		Every other calendar year
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	$0	Every other calendar year
Lens Enhancements	• Average savings of 20-25% on lens enhancements		Every other calendar year
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every other calendar year
Diabetic Eyecare Plus Program	• 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.	$20	As needed
Extra Savings	**Glasses and Sunglasses** • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam.		
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		

Your Coverage with Out-of-Network Providers

Visit **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 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** | **vsp.com**

[1]Brands/Promotion subject to change.

[2]Blueocean Market Intelligence National Vision Plan Member Research, 2014

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 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.

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** to find a VSP doctor that specializes in pediatric eyecare.

Visit **vsp.com** for more details on your child's vision benefit and the exclusive savings and promotions for VSP members.

Contact us.
vsp.com | 800-877-7195

*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., J.Am. 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** 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
Your Coverage with a VSP Choice Doctor only; Not available at Retail providers			
WellVision Exam®	• A thorough eye exam that tests for childhood eye health and vision issues, like nearsightedness, amblyopia (lazy eye), and strabismus (cross-eye)	$0	Every calendar year
Prescription Glasses			
Frame	• 1 Frame from our exclusive Otis & Piper Eyewear Collection	$0	Every calendar year
Lenses	• Single vision, lined bifocal, lined trifocal, or lenticular lenses • Polycarbonate, scratch-resistant coating, and UV protection	$0	Every calendar year
Lens Enhancements	• Average savings of 20% - 25% on lens enhancements		Every calendar year

Contacts (Instead of glasses)	• Contact lens exam and a minimum three-month's supply of contact lenses are fully covered.
	  • Standard (one pair annually)
	  • Monthly (six-month supply)
	  • Bi-weekly (three-month supply)
	  • Dailies (three-month supply)
	• Ask your VSP doctor which contacts qualify for your child's plan.
		$0	Every calendar year

Extra Savings	**Glasses and Sunglasses** • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP doctor within 12 months of your last WellVision Exam		
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities		
Your Coverage with Other Providers			
Visit 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 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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