Evelyn Minor-Lawrence
Director

DEPARTMENT OF HUMAN RESOURCES

PUBLIC SERVICES BUILDING
2051 Kaen Road | Oregon City, OR 97045

January 14, 2021

Board of County Commissioners
Clackamas County

Members of the Board:

Approval of 2021 Agreement amendment with Delta Dental for
Administrative Services for Clackamas County's Self-Funded Dental Benefits

Purpose/Outcomes	Approval of the Clackamas County Delta Dental Benefit Plan Administrative Services Agreement amendment for the 2021 plan years.
Dollar Amount and Fiscal Impact	The estimated fiscal impact for the Delta Dental 2021 plan year is: $4,414,282.45. This is in the current budget.
Funding Source	Department and retiree contributions
Duration	Effective January 1, 2021 – December 31, 2022
Previous Board Action/Review	This agreement received Board of County Commissioner's preliminary approval at the Board of County Commissioner's Policy Session on October 6, 2020.
Strategic Plan Alignment	Builds public trust through good government.
County Counsel Review	This Administrative Services Agreement amendment had been reviewed and approved by County Counsel on December 15, 2020.
Procurement Review	No, Procurement was not involved in the process of obtaining the contract amendment.
Contact Person	Kristi Durham, Human Resources, 503.742.5470
Contract No.	N/A

BACKGROUND:
At the Policy Session on October 6, 2020, the Board of County Commissioners approved the 2021 benefit plan renewals. The Delta Dental plan agreement amendment requires the board's signature.

County Counsel has reviewed and approved the plan agreement amendment.

RECOMMENDATION:
Staff recommends the Board approve the 2021 plan agreement amendment for Delta Dental.

Sincerely,

Kristi Durham, Benefits Manager
Department of Human Resources

ENDORSEMENT NO. 7

GROUP NO. 10000174

CLACKAMAS COUNTY

AGREEMENT dated January 1 2015 between **DELTA DENTAL PLAN OF OREGON** and **CLACKAMAS COUNTY** is hereby amended effective January 1, 2021 as follows:

1. The administrative fees in section 1.1 of Exhibit A shall be amended as follows:

   i. $6.62 per employee per month for dental administration, including processing claims from January 1, 2021 through December 31, 2021, if this Agreement is extended for a first year;
   ii. $6.69 per employee per month for dental administration, including processing claims from January 1, 2022 through December 31, 2022, if this Agreement is extended for a second year.

2. The member handbook(s) shall be deleted and shall be replaced with the attached.

Except as specifically provided herein, the terms, conditions, and provisions of said Agreement shall be unchanged by this Endorsement.

CLACKAMAS COUNTY (and any of its subsidiaries)	**DELTA DENTAL PLAN OF OREGON**
BY: ______________	BY: ______________
NAME: ______________	NAME: Scott Loftin
TITLE: ______________	TITLE: Senior Vice-President
DATE: ______________	DATE: October 30, 2020

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

888-374-8906 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 60667319 (6/20)

Delta Dental of Oregon & Alaska

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hổ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

(URDU) توجہ دیں: اگر آپ اردو بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d'assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta'e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA'AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala'au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

ADMINISTRATIVE SERVICES CONTRACT

This Administrative Services Contract (the "**Agreement**") is entered into between **Clackamas County** ("**Plan Sponsor**"), Plan Sponsor's group health plan known as the **Clackamas County Employee Dental Plan** (the "**Plan**"), and Oregon Dental Service ("**ODS**"). Plan Sponsor, Plan and ODS are sometimes referred to individually as the "**Party**" and collectively as the "**Parties**." This Agreement is effective **January 1, 2015** (the "**Effective Date**").

RECITALS

WHEREAS, Plan Sponsor has established and maintains the self-funded group health plan, the Plan, for Members;

WHEREAS, ODS provides certain ministerial administrative services to self-funded plans, including claims processing services; and

WHEREAS, Plan Sponsor and the Plan desire to retain ODS to furnish the administrative services described herein;

THEREFORE, in consideration of the mutual agreements and covenants contained in this Agreement and other good and valuable consideration the receipt of which is acknowledged, the Parties agree to the following:

SECTION 1. RELATIONSHIP OF PARTIES

1.1 ODS Acting in Ministerial Capacity Only

The Parties acknowledge and agree that ODS is acting solely in a ministerial capacity in performing ODS' duties and obligations under this Agreement and will have no discretionary authority or responsibility with respect to the administration of the Plan. While ODS may use ODS' reasonable business practices and ODS' reasonable understanding of the terms of the Plan in carrying out ODS' duties under this Agreement, ODS will have no discretionary authority and instead the Plan Administrator will have the ultimate responsibility for interpreting and administering the provisions of the Plan. The Plan Administrator means **Clackamas County**, who or which the Plan designates the Plan Administrator and named fiduciary for the Plan.

ODS will abide by all decisions of the Plan Administrator on all questions of substance and procedure concerning the Plan. ODS is not the Plan Administrator or a Plan-named fiduciary under the federal Employee Retirement Income Security Act of 1974, as amended (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the federal Health Insurance Portability and Accountability Act of 1996, as amended (HIPAA) or other applicable law. Throughout this Agreement, ERISA only applies when the Plan is part of an employee welfare benefit plan regulated under ERISA. ODS will not be responsible for advising Plan Sponsor or the Plan Administrator with respect to their fiduciary duties under this Agreement or for making any recommendations with respect to the investment of the Plan assets.

For the term of this agreement, the Plan has the meaning given to that term in the heading of this Agreement.

1.2 ODS IS NOT INSURING ANY PLAN LIABILITIES

ODS does not insure or underwrite any liability associated with the Plan and will have no financial risk or liability with respect to the provision of benefits under the Plan.

1.3 AUTHORITY

Plan Sponsor grants ODS the authority to serve as an agent of Plan Sponsor and Plan Administrator in carrying out ODS' duties under this Agreement, but only those ODS duties that are expressly stated in this Agreement or as mutually agreed in writing by the Parties.

1.4 PLAN SPONSOR RESPONSIBLE FOR ADOPTION OF PLAN

Plan Sponsor, and not ODS, has the sole and ultimate authority and responsibility for sponsoring, adopting, amending, designing and terminating the Plan.

1.5 PLAN ADMINISTRATOR AND FIDUCIARY

With respect to the Plan, the Plan Administrator is the plan administrator and the Plan-named fiduciary for purposes of § 402(a)(1) of ERISA (if applicable), COBRA, HIPAA and other applicable law, and, as such, is responsible and liable for administering all aspects of the Plan and all related regulatory compliance. The duties of Plan Sponsor, the Plan Administrator or both specifically include, but are not limited to, the following:

a. Ensure the Plan is in compliance with any applicable state and federal laws, including but not limited to ERISA, COBRA, HIPAA, the Internal Revenue Code and the Patient Protection and Affordable Care Act (PPACA);
b. Perform any applicable nondiscrimination testing;
c. Amend the Plan as necessary to ensure ongoing compliance with applicable law;
d. Provide Members copies of the Summary Plan Description (SPD), Member Handbook, Summary of Benefits and Coverage (SBC, when required), Summary of Material Modifications (SMM) and summary annual reports;
e. File any required tax or governmental returns (including but not limited to Form 5500 returns);
f. Respond to requests;
g. Execute and retain required Plan documentation.

For the purposes of this Agreement, Member means an individual entitled to receive benefits for Covered Services (including, but not limited to, application of an expense to Member Cost-Sharing, whether or not a payment under the Plan is made) under the terms of the Plan at the time the Covered Services are provided. Member Cost-Sharing includes deductibles, copayments, coinsurance and similar amounts for Covered Services that Member is responsible to pay under the Plan.

As discussed in section 1.5.d above, the Member Handbook is a written document that establishes eligibility, benefits and other legal requirements of the Plan available to Members. A Member Handbook will be prepared by ODS only if ODS expressly agrees to undertake that activity and subject to all other terms of this Agreement. A Summary Plan Description (SPD) is a written summary of the terms and benefits of the Plan available to Members.

1.6 Final Responsibility and Determinations

Plan Sponsor, the Plan Administrator, or both, will have the final responsibility and liability for payment of all benefits under the Plan. Plan Sponsor and the Plan Administrator will pay all expenses incident to the operation of the Plan. In its capacity as ERISA plan administrator, the Plan Administrator will be the final arbiter as to the interpretation of the Plan and the determination of eligibility for coverage and payment of benefits. All final determinations as to Member's entitlement to Plan benefits are to be made by Plan Sponsor, the Plan Administrator or both, including any determination upon an appeal of a denied claim for Plan benefits.

1.7 ODS is an Independent Contractor

ODS is and will remain an independent contractor with respect to the services being performed under the terms of this Agreement and will not for any purpose be deemed an employee of Plan Sponsor, the Plan or the Plan Administrator, and ODS will not be deemed to be a partner or to be governed by any legal relationship other than that of independent contractor. ODS does not assume any responsibility for the general policy design of the Plan, the adequacy of the funding thereof nor any act, omission or breach of duty by Plan Sponsor or the Plan Administrator.

1.8 Plan Acts Through Plan Administrator

Any actions, directions or representations made by the Plan Administrator to ODS may be considered the actions, directions or representations of the Plan.

SECTION 2. THE PLAN AND OTHER DOCUMENTS

2.1 Plan Adopted

The most current Member Handbook describing Plan benefits that have been adopted by Plan Sponsor are incorporated into this Agreement by reference. If Plan Sponsor changes or adds any benefits under the Plan, ODS will not be required to administer those changes or additions unless all of the following conditions have been met:

a. Plan Sponsor has provided advance notice to ODS of Plan Sponsor's intent to change or add benefits under the Plan;
b. ODS has provided Plan Sponsor advanced written notice of ODS' willingness and ability to adequately administer the changes or additions; and
c. When agreed upon by the Parties, any changes in the fees required by ODS to administer the changes or additions are included in a written amendment to the Fee Schedule as proposed by ODS.

2.2 Administrative Information

Plan Sponsor will furnish ODS with any and all instructions, contracts, information or documents deemed necessary by ODS to properly perform ODS' obligations under this Agreement. Such information will include, but not be limited to, copies of the Member Handbook and any and all amendments or successor documents. ODS, at the request of Plan Sponsor and as part of ODS' ministerial duties under this Agreement, may prepare and/or print a Member Handbook and other documents that communicate summary details of the Plan to Members. However, Plan Sponsor

retains ultimate authority as to the content, distribution and legal or regulatory requirements related to the Plan, including the Member Handbook.

2.3 Other Benefit Plans

If Plan Sponsor adopts additional self-funded benefit plans, Plan Sponsor may negotiate with ODS for the inclusion of such plans under this Agreement.

2.4 Interpretation

The terms and conditions of this Agreement govern over any conflicting or inconsistent terms in the Member Handbook.

SECTION 3. TERM OF AGREEMENT

3.1 Term

For the purposes of this agreement, Term means the period of time this Agreement remains in effect. The Agreement may renew for subsequent 12 month periods, each of which is referred to as a Term. If the Agreement is terminated early for any reason prior to the expiration of a full 12 month period, the shorter period between the first day of the Term and the date the Agreement is terminated is the Term.

The initial Term of this Agreement will commence on **January 1, 2015** and terminate on **December 31, 2015**, unless terminated sooner under Section 4.

3.2 Renewal

After the completion of the initial Term, this Agreement will automatically renew for additional 12-month periods on each subsequent anniversary of the Effective Date and subject to a revised Fee Schedule when proposed in advance by ODS, unless:

a. By or before the anniversary of the Effective Date, the Parties have not completed negotiation of and agreement to an amended Fee Schedule and any other amendments to this Agreement proposed by any Party; or
b. Any Party has given 30 days advance written notice prior to the anniversary of the Effective Date of the Party's intent not to renew the Agreement.

If, by the conclusion of any Term, the Parties have not completed the negotiations for, and execution of, a new Fee Schedule, but termination of this Agreement has not occurred, ODS at ODS' discretion may continue ODS' services under this Agreement using the last approved Fee Schedule, and the Fee Schedule subsequently agreed upon by the Parties will be in effect retroactively.

SECTION 4. TERMINATION AND MODIFICATION

4.1 TERMINATION WITHOUT CAUSE

Any Party may terminate this Agreement without cause upon 30 days prior written notice to the other Parties. Plan Sponsor may be subject to an Early Termination Fee as shown in the Fee Schedule.

4.2 TERMINATION FOR CAUSE

This Agreement terminates, and ODS' obligation to process claims and pay benefits will cease upon such termination, in accord with any of the following:

a. 30 days after written notice has been given by ODS to Plan Sponsor or the Plan, or by Plan Sponsor or the Plan to ODS, of the breach of material obligations under this Agreement; provided that such breach has not been cured within such 30 day period. Notwithstanding the foregoing, Plan Sponsor's default in any payment under this Agreement will be subject to termination under Section 4.2.b.;
b. Upon 3 business days written notice, in ODS' sole discretion, if Plan Sponsor fails to pay:
    i. Paid Claims to ODS by their due date or if Plan Sponsor does not pay any other payment due under this Agreement by its due date. Paid Claim means the amount ODS has paid on behalf of Member pursuant to this Agreement in response to a request for the payment of benefits under the Plan; or
    ii. Administrative fees, charges or other amounts due to ODS under the terms of this Agreement (including maintenance of the advance deposit, if applicable);
c. Upon 3 business days written notice, in ODS' sole discretion:
    i. If Plan Sponsor assigns this Agreement, unless such assignment had ODS' prior approval in writing; or
    ii. If Plan Sponsor is sold (including a sale of substantially all assets of Plan Sponsor) or merges, unless such sale or merger had ODS' prior approval in writing;
d. As of the effective date of any law, regulation or interpretation if any law or regulation is enacted which prohibits the continuance of this Agreement, or any existing law or regulation is interpreted by ODS to so prohibit the continuance of this Agreement;
e. If Plan Sponsor terminates the Plan, provided that Plan Sponsor will provide ODS with written notice 30 days prior to termination;
f. If the Plan is modified, unless this Agreement is amended to make such modified plan the Plan under this Agreement;
g. 10 days following the occurrence of any of the following if not reversed or cured prior to the expiration of the 10 day period:
    i. A finding or admission that Plan Sponsor or the Plan is insolvent;
    ii. The date that Plan Sponsor or the Plan files for the protection provided under any bankruptcy law;
    iii. The date that Plan Sponsor's or the Plan's creditors seek to have Plan Sponsor or the Plan declared bankrupt or placed under the protection of the Bankruptcy Court; or
    iv. The date that Plan Sponsor or Plan Sponsor's creditors or the Plan or the Plan's creditors seek to have a receiver appointed to manage Plan Sponsor's business or the Plan.

4.3 OTHER RIGHTS TO TERMINATE

ODS' right to terminate pursuant to Section 4 will be in addition to and not a limitation of any right to terminate (or right to offset) under any other provisions of this Agreement.

4.4 Late Payment and Reinstatement

Any payment received by ODS after termination of this Agreement will be deposited for security purposes only and will not be deemed to have been accepted for reinstatement or as an accord and satisfaction. This Agreement will be reinstated only upon the written endorsement of ODS.

4.5 Modification

Except as otherwise specifically provided in this Agreement, this Agreement may be modified only by a written agreement signed by an authorized representative of each Party.

SECTION 5. ODS' MINISTERIAL SERVICES

5.1 Claims Processing

During the Term of this Agreement and any period of Run-Out Claims Processing (as defined in the following paragraph), ODS will issue benefit payments and denials, along with explanations of benefits, in accordance with the terms of the Plan, ODS' dental and payment policies and any Participating Provider contracts for those claims Incurred between the Claims Incurred dates presented in the Fee Schedule. Incurred means the date upon which services or supplies have been provided to Member during the Term. For the purposes of this agreement, Participating Provider means any dentist or other health care provider as permissible under Plan benefits, licensed where required, performing services within the scope of its license, with whom ODS has entered into an agreement which allows Member to obtain dental care services according to certain pre-negotiated fees and other relevant terms.

Run-Out Claims Processing or Run-Out means ODS will continue to process claims and otherwise provide administrative services with regard to claims Incurred prior to the date of termination of this Agreement.

ODS will discontinue processing any and all claims upon termination of this Agreement and completion of any period of Run-Out, regardless of the Incurred date of the claim, as further provided in Section 8.1 of this Agreement. In evaluating claims, ODS will use ODS' claim processing system of edits and other applicable standards to determine whether claims are Covered Services.

Covered Services means the services, supplies, treatments or accommodations that are included within that term in the Member Handbook. If there is no Member Handbook, Covered Services means the services, supplies, treatments or accommodations for which benefits are provided under the Plan that ODS is required to administer under Section 2.1 (including, but not limited to, any services, supplies, treatments or accommodations to which Member Cost-Sharing is applied, regardless of whether a payment under the Plan is made).

5.2 General Administrative Services

ODS will:

a. Answer Member inquiries regarding eligibility, Plan benefits, status of benefit payments, complaints and requests for forms;

b. Upon request of Plan Sponsor, assist in the development and design of the Plan, both initially and in connection with benefit revisions, additions and extensions, although the design of the Plan is the sole responsibility of Plan Sponsor;
c. Upon the separate written request of the Plan Sponsor and subject to Section 2.2 and the payment of additional fees to be indicated by ODS, draft, prepare and print Member Handbooks and other Member materials;
d. Upon request of Plan Sponsor, assist with the enrollment of Members;
e. Maintain eligibility files based upon information provided by Plan Sponsor;
f. Issue identification cards to Plan Sponsor or Members;
g. Initiate reasonable overpayment, subrogation and similar right of reimbursement recovery efforts in accordance with ODS' standard business practices;
h. Provide Members with access to Participating Providers. Plan Sponsor will not attempt to establish or negotiate its own dental care provider contracted network;
i. Upon request of Plan Sponsor, prepare standard reports for use by the Plan in the financial management and administrative control of the Plan;
j. Conduct first and second level appeal reviews subject to federal regulations and the Terms of the Plan; and
k. Coordinate external review requests with Individual Review Organizations (IROs) subject to a fixed fee as indicated in the Fee Schedule, when so required by the terms of the Plan.

5.3 PROCESSING ERRORS

Claim processing errors may result from a number of causes, including retroactive termination, provider billing errors, claims processing mistakes, incorrect information from an Participating Provider or Member or other reasons. In addition, claims processing adjustments may result from a number of causes, including coordination of benefits recovery, third party liability recovery, audit or investigation findings and other reasons. If ODS becomes aware ODS has underpaid a claim or has misquoted Plan benefits to a member or Participating Provider or Member, for whatever reason, ODS will reprocess the claim and pay the appropriate amount, charging the amount as a claims expense to Plan Sponsor, except as precluded by Run-Out. If ODS becomes aware ODS has overpaid a claim, for whatever reason, ODS will reprocess the claim at the appropriate amount, attempt to recover appropriately and, if successful, credit Plan Sponsor with the amount less ODS' reasonable collection expenses. Plan Sponsor acknowledges that claim processing errors and adjustments occur in the normal course of business and that, as long as ODS makes reasonable attempts to correct the errors and make the adjustments, ODS has met ODS' obligation to Plan Sponsor and ODS will not be considered to be negligent under Section 9.2.c of this Agreement.

5.4 NONSTANDARD REPORTS

If Plan Sponsor or the Plan Administrator requests any nonstandard report and ODS, in its sole discretion, agrees to provide such report, ODS reserves the right to charge for nonstandard reports. Nonstandard reports shall be subject to a charge as indicated in the Fee Schedule, if any. All other charges for any nonstandard reports not specifically indicated in the Fee Schedule shall be agreed upon by the Parties in writing before the reports are prepared. Notwithstanding the foregoing, ODS will not prepare Incurred But Not Reported (IBNR) reports nor will ODS sign prepared financial statements.

SECTION 6. PLAN SPONSOR REQUIREMENTS

6.1 FEES

Plan Sponsor will pay ODS all administrative fees as set forth in the Fee Schedule and any other fees set forth in this Agreement or other applicable Exhibits. The Fee Schedule and any other Exhibits will be amended on an annual basis or as otherwise set forth in this Agreement.

6.2 AUTOMATIC FEE ADJUSTMENTS FOR INCREASE OF ADMINISTRATION

If, during any Term of the Agreement, ODS' administrative duties change or ODS' expenses of administration increase for the reasons stated below, ODS may provide reasonable notice to Plan Sponsor of an alternative Fee Schedule and such new Fee Schedule will go into effect automatically, unless otherwise determined by the Parties. For the purpose of this Section, ODS may adjust the Fee Schedule in the following situations:

a. ODS' costs increase due to legislative or regulatory changes;
b. ODS' costs increase due to a change in producer and/or consultant commissions;
c. ODS' costs increase due to mutually agreed upon benefit changes or additional ODS services; or
d. Plan enrollment increases or decreases by 10% or more at any time during the Term relative to the "Enrollment Assumption" listed in the Fee Schedule.

Upon reasonable notice to Plan Sponsor, such fee adjustment will apply as of the first month following the event identified above and continue for the remainder of the Term.

6.3 TAX FEES

ODS will bill Plan Sponsor for any and all federal and state taxes and/or fees, including taxes or fees which may be mandated or assessed on benefit payments made by ODS on behalf of the Plan. Any such fee will be billed monthly.

6.4 FUNDS FOR PAYMENT OF BENEFITS

Plan Sponsor will provide to ODS all funds necessary to pay Plan benefits.

6.5 CLAIMS BILLING

Based on the billing period, ODS will notify Plan Sponsor by an agreed-upon method (such as by electronic mail) of the amount of Paid Claims since the Effective Date (if this is the first such notification under this Agreement) or since the most recent previous notification (if this notification is other than the first under this Agreement). This notification is referred to as the "Claims Billing."

6.6 PAYMENT OF FUNDS

Plan Sponsor will pay to ODS the amount of each Claims Billing communicated to Plan Sponsor under Section 6.5 according to the terms set forth in the Fee Schedule.

6.7 Advance Deposit

Prior to the Effective Date of this Agreement, Plan Sponsor will pay to ODS an advance deposit as set out in the Fee Schedule. The advance deposit is calculated on the basis of the enrollment assumption documented in the Fee Schedule. Each time this Agreement is renewed for an additional Term, ODS will re-evaluate the enrollment assumption and advance deposit and, if necessary, Plan Sponsor will pay to ODS the amount needed to bring the advance deposit to the re-evaluated amount. After a final accounting by ODS following termination of this Agreement and completion of any period of Run-Out, ODS will refund the balance of the advance deposit remaining after offset of any amount owed to ODS for any reason. ODS will not pay interest on advanced deposits but is entitled to any earned interest from the advance deposit.

6.8 Subrogation and Right of Reimbursement

ODS will make its best efforts to identify and pursue potential subrogation and similar right of reimbursement recovery opportunities with regard to claims Incurred during the Term under the Plan, in accordance with ODS' standard business practices. Plan Sponsor will notify ODS of subrogation and right of reimbursement opportunities of which it becomes aware. A fixed percentage of subrogation and right of reimbursement recoveries will be withheld to cover ODS' costs of pursuit of such recoveries and is identified as the subrogation/right of reimbursement fee in the Fee Schedule, if any. This subrogation/right of reimbursement fee shall be in addition to any other fees and expenses that ODS is entitled to, or otherwise obligated to pay, out of any subrogation or similar right of reimbursement recovery.

Unless notified to the contrary by Plan Sponsor by or before the later of the termination date or the completion of any period of Run-Out, ODS will continue, after termination and completion of any Run-Out, to pursue Plan subrogation and similar right of reimbursement files that are then in its possession and will be entitled to withhold the subrogation/right of reimbursement fee from recoveries it obtains on those files. ODS' pursuit of recoveries under this provision, whether before or after the termination date and completion of any period of Run-Out, will continue only as long as ODS determines such recoveries are active and viable. The subrogation/right of reimbursement fee is calculated from the amount recovered, net of any attorney fees, costs, or other expenses that are paid to effectuate the recovery and net of any stop-loss reinsurance credited first to ODS. ODS will calculate and withhold the subrogation/right of reimbursement fee from each net recovery and then credit or remit the remaining net balance of the recovery to Plan Sponsor.

6.9 Late Fees

If administrative fees, claims or other invoices are not paid to ODS by the due date, ODS may in its discretion charge a late fee. Late fees are calculated from the date payment is due. See section 7.3 for additional information regarding late fees.

6.10 Information Necessary to Comply with Governmental Requirements

Plan Sponsor will provide the information necessary for ODS to comply with ODS' obligations under any federal or state law related to this Agreement, including but not limited to the social security numbers of Members, the working status of Members and tax identification number of Plan Sponsor, as required by the Medicare Secondary Payor reporting requirements applicable to third party administrators for group health plans under Section 111 of the Medicare, Medicaid and SCHIP Extension Act of 2007.

SECTION 7. ELIGIBILITY

7.1 Eligibility

Plan Sponsor shall administer eligibility terms and conditions in accordance with the Plan to determine only eligible employees and dependents are receiving benefits, including but limited to verification that employees apply for coverage within the established timeframe and correct effective dates are assigned to new Members, COBRA continuants and terminations. Plan Sponsor, not ODS, is responsible for determining, maintaining and remedying errors on Member eligibility records. If enrollment forms are not provided to ODS, Plan Sponsor will provide Member eligibility records to ODS in a form acceptable to ODS and upon an agreed frequency. Plan Sponsor agrees to comply with the terms and conditions for eligibility and enrollment set forth in the Plan.

Failure for Plan Sponsor to administer eligibility in accordance with the Plan may result in a denial of benefits under stop loss provisions, if applicable.

ODS will provide identification cards and will reissue cards as needed as a result of eligibility changes reflected on the cards. A request for a mass reissue of cards to Members is also available upon request with an associated fee, as described in the Fee Schedule or any other written agreement, to cover the cost of the cards and postage.

7.2 Commencement of Coverage

Member's coverage begins on the first day of the month (assuming eligibility, satisfaction of probationary periods, payment of the rate and other requirements of eligibility), and terminates on the last day of a month. Administrative fees are not pro-rated for partial months of coverage.

7.3 Billing and Payment

Payment of administrative fees by Plan Sponsor is due monthly. If payment is not received by the 15th of the month, ODS reserves the right to terminate this Agreement pursuant to Section 4.2. Failure to pay on time can result in late fees and/or a claims hold.

Payment of administrative fees is based on ODS-generated billings. If payment is adjusted by Plan Sponsor, detailed supporting documentation is needed for each adjustment prior to payment. Discrepancies will need to be included in the next payment.

7.4 Timely Information

Plan Sponsor acknowledges that ODS' ability to effectively perform the administrative services required by this Agreement depends upon Plan Sponsor's furnishing to ODS timely information in the form of properly completed applications and data for Members who are eligible for coverage and timely notice of those who terminate coverage. This information must be provided in a form acceptable to ODS.

7.5 No Liability if Information Not Timely

ODS will not be liable for non-performance or delay in the performance of this Agreement caused by or contributed to in whole or in part by the failure of Plan Sponsor to timely furnish any information necessary to determine eligibility for coverage or for adjudication of benefits. ODS reserves the right to hold the processing and payment of claims until necessary information is received from Plan Sponsor.

7.6 No Liability if Information Not Correct or Complete

ODS will not be liable for any claims payment errors based on incorrect or incomplete eligibility information. If ODS identifies such an error, and if Plan Sponsor requests that ODS pursue recovery of any overpayment based on the incorrect eligibility information ODS received, Plan Sponsor will pay ODS a fixed percentage of any recovery to cover ODS' costs of this pursuit and as identified in the fee Schedule, if any. This fee will be in addition to any other fees and expenses that ODS is entitled to, or otherwise obligated to pay, out of any recovery. Plan Sponsor will indemnify and hold harmless ODS for any and all liability ODS incurs as a result of its pursuit of overpayment errors based on incorrect or incomplete eligibility information.

To reduce the likelihood of incorrect or incomplete eligibility information, Plan Sponsor should regularly review ODS bills and membership lists to ensure records are accurate. ODS will supply monthly membership lists upon request by Plan Sponsor.

7.7 Retroactive Termination

Termination notices should be sent to ODS prior to the termination date when possible to reduce claims overpayments. However, retroactive termination will be allowed and must be in accordance with the PPACA when required to comply. Members may be terminated retroactively up to 12 months for billing and claims adjustments. ODS reserves the right to charge a fee for reprocessing retroactive claims as administrative fees do not cover the months for which claims are being reprocessed.

SECTION 8. DISPOSITION OF CLAIMS UPON TERMINATION

8.1 Termination of Administrative Services

The Parties agree that ODS will provide Run-Out Claim Processing services after the termination of this Agreement. ODS will continue to perform Run-Out Claim Processing services, however, only:

a. For the amount of time presented in the Fee Schedule (or any other written agreement of the Parties for Run-Out Claims Processing services);
b. For claims Incurred prior to the termination date;
c. If Plan Sponsor pays the Run-Out Claim Processing fees presented on the Fee Schedule (or any other written agreement of the Parties for Run-Out Claims Processing services) in a timely manner; and
d. If Plan Sponsor remits an advance deposit (or increases the existing amount of the deposit, if any) to ODS in advance and in an amount to be reasonably determined in ODS' sole discretion based upon ODS' estimate of claims Incurred but not paid and an estimate of the Run-Out administrative expenses, as calculated by ODS.

If Plan Sponsor breaches paragraph (c) or (d), all administrative services required of ODS under any term of this Agreement or otherwise, including but not limited to claims processing and payments, will immediately cease; except that, if ODS reasonably concludes that it is legally required to continue providing administrative services, Run-Out Claims Processing will continue and Plan Sponsor is obligated to pay ODS for its Run-Out Claims Processing services under the terms of this Agreement.

8.2 DISPOSITION OF CLAIMS AFTER TERMINATION

After termination of this Agreement and completion of any period of Run-Out, ODS will deny:

a. All claims under the Plan that are in the possession of ODS for which payment has not been issued, regardless of the date the claims were Incurred; and
b. All claims under the Plan that are received by ODS thereafter.

Plan Sponsor will pay ODS all benefit payments and administration charges that are due ODS and remain unreimbursed at the time of or after termination and completion of any period of Run-Out.

SECTION 9. INDEMNIFICATION AND LAWSUITS AGAINST THE PARTIES

9.1 CLAIMS DISPUTES

In the event a dispute arises with Member or other third party over Plan benefits or any action taken by ODS related to the payment of Plan benefits in the performance of ODS' duties under this Agreement (referred to in this Agreement as a Claim Dispute), the Parties agree to the following:

a. Notification of Dispute
When a Party reasonably determines that a Claim Dispute may arise, the Party will promptly notify the other Parties in writing as to the issues involved in the Claim Dispute.
b. Litigation Defense
If ODS is the party to any legal action related to or arising out of a Claim Dispute, ODS will defend itself against any such legal action (including, but not limited to, litigation, arbitration and/or mediation) brought by or on behalf of any Member or other third party, and ODS will have full discretionary authority in all matters related to the conduct, defense or settlement of any such action, including, but not limited to, the selection of counsel and pursuit of any counter- or cross-claim.

9.2 INDEMNIFICATION

The Parties agree to the following indemnification provisions:

a. Plan Sponsor and the Plan, jointly and severally, will indemnify, defend and hold harmless ODS, ODS affiliates and their respective directors, officers, employees (acting in the course of their employment, but not as claimant) and agents, for that portion of any liability, settlement and related expense (including the cost of legal defense through and including any appeals) resulting solely and directly from Plan Sponsor's or the Plan's breach of this Agreement, negligence, gross negligence, willful misconduct, criminal conduct, fraud or breach of a fiduciary responsibility related to or arising out of this Agreement.
b. Subject to Section 9.2.c, ODS will indemnify, defend and hold harmless Plan Sponsor and the Plan, their affiliates and their respective directors, officers, employees (acting in the course of their employment, but not as claimant) and agents, for that portion of any liability,

settlement and related expense (including the cost of legal defense through and including any appeals) resulting solely and directly from ODS' breach of this Agreement, negligence, gross negligence, willful misconduct, criminal conduct, fraud or breach of a fiduciary responsibility related to or arising out of this Agreement.

c. Notwithstanding anything herein to the contrary, Plan Sponsor and the Plan, jointly and severally, will remain obligated for:
   i. Indemnifying ODS from any claim or loss which results from Plan Sponsor's incorrect certification of Member eligibility;
   ii. The payment of all Plan benefits; and
   iii. The payment of all benefits, costs or damages when the acts giving rise to the liability were performed by Plan Sponsor or the Plan, or by ODS upon Plan Sponsor's or the Plan's express direction.

SECTION 10. GENERAL

10.1 Insurance

Each Party will obtain, at its own cost, and keep in force adequate policies providing comprehensive general liability and other insurance in amounts consistent with industry standards as may be necessary to insure Party and its agents and employees against any claim or claims for damages arising out of the performance of its obligations under this Agreement. If any Party procures one or more claims-made policies to satisfy its obligations under this Agreement, the Party will obtain any extended reporting endorsement ("tail coverage") required to continuously maintain such coverage in effect for all acts, omissions, events or occurrences during the Term of this Agreement, without limit or restriction as to the making of the claim or demand. Evidence of the insurance coverage required under this Section will be made available to any Party upon request. Self insurance shall meet the requirement of this section.

10.2 Joint Ownership of Certain Records; Confidentiality

For the purposes of this agreement, Proprietary Materials means ODS proprietary and confidential records, documents, lists, books, recorded information, data stored on data processing media, trade secrets, symbols, trademarks, service marks, systems, formats, programs, procedures, protocols, contract forms, pricing data, deidentified data, utilization information, fee schedules, reasonable and customary charges profiles, designs and business plans. Proprietary Materials specifically includes any data and information, including any data provided to Plan Sponsor or the Plan in the form of a data extract or otherwise, related to the composition of the ODS network of providers, the contracted (or "allowed" amounts) paid to Participating Providers, the terms of the agreement between ODS and the Participating Providers and the discounts to ODS offered by Participating Providers. Proprietary Materials also consist of any analyses, compilations, studies or other documents created on the basis of other Proprietary Materials.

The Parties agree that records and documents that constitute "protected health information" as that term is defined in 45 CFR 160.103 and that pertain to administration of the Plan will be and remain the joint property of the Plan and ODS. All Proprietary Materials are the sole property of ODS. ODS will have the right to protect the confidentiality of the Proprietary Materials and will not be required to make such Proprietary Materials available to anyone. Plan Sponsor agrees to maintain the confidentiality of any Proprietary Materials ODS provides, and Plan Sponsor will not provide any Proprietary Materials to any other person, including any data extracts or summary information, except to the extent such Proprietary Materials have been made available to the public without fault of Plan Sponsor. In the event of a termination of this Agreement, ODS will

cooperate with Plan Sponsor to provide copies of certain requested jointly owned information. Plan Sponsor or the Plan agrees to reimburse ODS for the reasonable cost of such assistance and copies.

10.3 Entire Agreement

This Agreement and its Exhibits supersede and replace all prior oral or written agreements, if any, between Plan Sponsor and ODS and is the entire agreement between the Parties.

Exhibit means the following when referenced collectively:

a. "Fee Schedule Exhibit" means the document with that Title that is attached to this Agreement and that contains the list of fees and other prices for ODS' services.
b. ""Reports" means the document with that Title that is attached to this Agreement and that contains the list or reports to be delivered by ODS to Plan Sponsor.
c. "HIPAA Exhibit" means the document with that Title that is attached to this Agreement and that contains the terms among the Parties that are required to comply with HIPAA.
d. "Designated Contact Person(s)" means the document with that Title that is attached to this Agreement and that contains the list of designated persons who are authorized to receive protected health information.

10.4 Non-Waiver

The failure or refusal of any Party to enforce or enjoin any breach or violation of any provision of this Agreement will not be a waiver of that Party's right to enforce any subsequent breach.

10.5 Audit Rights

During the Term of this Agreement, the period of Run-Out and for a period of 6 months following the Agreement's termination and completion of any period of Run-Out, Plan Sponsor or the Plan (or its designated claims auditing representative, if approved by ODS in writing) will have the right to initiate an examination of ODS' records. Examined records will relate only to Plan benefits. Any such audit will be conducted during regular business hours at ODS' offices and following 60 days prior written notice. Any examination of Members' health benefit payment records will be carried out in a manner specifically designed to protect the confidentiality of Members' medical information in compliance with all federal and state laws governing confidentiality and privacy of health information. All audits will be limited to information relating to the Term in which the audit is conducted and/or the immediately preceding Term and will be concluded within 18 months of the last day of the Term under audit. Plan Sponsor or the Plan will pay all expenses incurred by ODS, Plan Sponsor and the Plan relating to the audit, unless otherwise stated in a separate written audit agreement. ODS will not be required to disclose any information in violation of applicable law. ODS does not permit any extrapolation from a sample of claims to make determinations about the universe of claims processed as a whole.

Prior to commencement of any audit, Plan Sponsor, the Plan and its outside auditor, if any, will execute a written audit agreement with ODS which sets forth the terms and conditions of the audit according to ODS' most recent external audit policy. ODS reserves the right to deny access to a third party contingency fee auditor.

With regard to its contracts with Participating Providers and related information, the terms of which are not otherwise publicly available, ODS reserves the right to deny access to the contracts. At ODS' sole discretion, ODS will provide access to its contracts with Participating Providers only (i) for the purpose of ensuring that a claim was correctly paid by the claims processing system at the appropriately contracted rate, and (ii) only in a manner that ODS deems would protect the

confidential and/or proprietary information contained therein. This reservation of right pertains not only to the actual contracts but also to any data, reports or other information generated from which the terms of the contracts could be determined, which are considered Proprietary Material.

10.6 Severability

In the event any one or more of the terms, conditions or provisions contained in this Agreement or any application thereof is declared invalid, illegal or unenforceable in any respect by any arbitrator or court of competent jurisdiction, the validity, legality or enforceability of the remaining terms, conditions or provisions of this Agreement and any other application thereof will not in any way be affected or impaired thereby, and this Agreement will be construed as if such invalid, illegal or unenforceable provisions were not contained herein.

10.7 Restriction on Assignment

No Party will assign or transfer any of its rights, or delegate any of its duties or obligations hereunder, directly or indirectly, without the prior written consent of the other Parties. A Party may, with the prior written consent of the other Parties, assign this Agreement in its entirety to any person or entity, other than a direct competitor of a Party, which acquires the business of the assigning Party or with which the Party merges or is consolidated or affiliated, provided that the permitted assignee agrees in writing to be bound by the terms of this Agreement. Any attempted assignment, transfer or delegation in violation of this paragraph will be null and void.

10.8 Notices

Except for a revised Fee Schedule under Section 3.2 or an alternative Fee Schedule under Section 6.2 (which would be effective as provided in those sections) and except for endorsements or amendments to this Agreement (which would be effective on the endorsement or amendment effective date), all notices, requests, demands and other communications required or permitted to be given or made under the Agreement will be in writing and will be effective on the date of actual hard copy receipt (including by confirmed facsimile receipt or electronic mail), and will be sent to Plan Sponsor, the Plan or ODS, as the case may be, to such address, person or entity as set forth below, or as any Party will designate by notice to the other Parties in accordance herewith.

10.9 Binding Effect

This Agreement will be binding upon, inure to the benefit of and be enforceable by the Parties hereto and their respective successors and permitted assigns.

10.10 No Third Party Beneficiaries

Nothing in this Agreement, express or implied, is intended to confer on any person, other than the Parties hereto, any right or remedy of any nature whatsoever; and nothing in this Agreement will create, or be deemed to create, any rights, obligations or legal relationship between ODS and any Member.

10.11 Third Party Administrators

ODS recognizes that the Plan Administrator may choose to work with Third Party Administrators (TPAs) for handling of COBRA and retiree membership or for active eligibility processing. In these

situations, ODS will accept eligibility or payment from the TPA as if it were from the Plan Administrator provided information was received timely and accurately. However, ODS reserves the right to confer only with the Plan Administrator if the TPA process is causing accuracy concerns, processing challenges or timing delays.

10.12 Force Majeure

No Party will be deemed to be in violation of this Agreement if it is prevented from performing its obligations by events beyond its control including, without limitation, acts of God, war or insurrection, terrorism, flood or storm, strikes or rule or action of the government or agency. The Parties will make a good faith effort, however, to assure Members have access to Participating Provider services consistent with applicable law, despite such events.

10.13 Survival

All rights and obligations will cease upon termination or expiration of this Agreement, except for the rights and obligations set forth in Sections 6, 8, 9, 10.1 and 10.2.

10.14 Headings

The headings used in this Agreement are solely for convenience of reference, are not part of this Agreement and are not to be considered in construing or interpreting this Agreement.

10.15 Counterparts

This Agreement may be executed in one or more counterparts, each of which will be deemed an original and all of which together will constitute one and the same instrument.

10.16 Fidelity Bond

Plan Sponsor will provide a fidelity bond for fiduciaries and every person who handles funds or other property of the Plan if required by ERISA for the benefit of the Plan.

10.17 Bankruptcy

If bankruptcy, receivership or liquidation proceedings are commenced with respect to any Party hereto, and if this Agreement has not otherwise been terminated, then a non-filing Party may suspend all further performance of this Agreement pursuant to Section 365 of the Bankruptcy Code or any similar or successor provision of Federal or State law. Any such suspension of further performance by a non-filing Party pending the defaulting Party's assumption or rejection of this Agreement will not be a breach of this Agreement and will not affect the non-filing Party's right to pursue or enforce any of its rights under this Agreement or otherwise.

10.18 Class Actions

Plan Sponsor and ODS recognize that, from time to time, ODS, Plan Sponsor or the Plan may receive notice of a pending class action that seeks recovery on behalf of a class that may include ODS or Plan Sponsor (a Class Action). Notwithstanding any language to the contrary in this Agreement, ODS will have no duty to participate in the Class Action on behalf of Plan Sponsor or the Plan. ODS does not have a duty to notify Plan Sponsor or the Plan (or any plan) of receipt of notice of any Class Action. Plan Sponsor or the Plan may request that ODS provide information for a Class Action or

assist in pursuing a recovery for Plan Sponsor in a Class Action. ODS will have the sole discretion to accept or reject such a request. If accepted, ODS will be the appointed agent of the Plan and submit necessary claim information. The services provided will be subject to the payment of additional administrative fees and other related costs to ODS by Plan Sponsor.

10.19 Governing Law

Unless preempted by federal law, this Agreement will be governed, construed, performed and enforced in accordance with the laws of the State of Oregon.

10.20 Dispute Resolution

If a dispute should arise out of this Agreement or a breach thereof, the Parties will attempt in good faith to resolve the dispute informally through discussion, the exchange of documents or meetings following a Party's written notice of the existence and nature of the dispute.

If the Parties are unable to resolve the dispute within 30 days after the date of such written notice, they will, while continuing to attempt to resolve the dispute, also establish a procedure for mediation of the dispute in the event it is not resolved.

If the Parties are unable to resolve the dispute, or to agree to a procedure for mediation of the dispute, within 60 days after the date of the written notice of dispute, then the dispute will be submitted to mediation, initiated by written notice from a Party, in accordance with the model procedures of the International Institute for Conflict Prevention & Resolution.

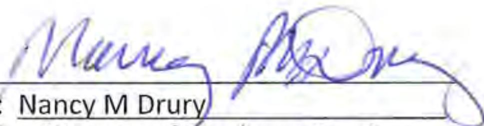
In the event the Parties are not able to resolve the dispute as described above, the Parties agree to binding arbitration in accordance with the commercial arbitration rules of the American Arbitration Association unless the Parties agree to another method of dispute resolution. The Arbitration will be conducted in Multnomah County, Oregon. The Parties agree that the arbitrator's award will be final and binding, may include an apportionment of attorney fees and costs, and may be enforced in any court having jurisdiction thereof.

Signature pages to follow.

This Agreement may be signed in counterparts. A fax transmission of a signature page will be considered an original signature page. At the request of a Party, each other Party will confirm a fax-transmitted signature page by delivering an original signature page to the requesting Party.

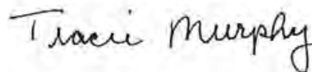
Plan Sponsor:

CLACKAMAS COUNTY



By: Nancy M Drury
Title: Director of Employee Services
Date: April 16, 2015

ODS:



By: Tracie Murphy
Title: Senior Vice-President
Date: March 4, 2015

Exhibit A

FEE SCHEDULE

1.1 Administrative Fees

i. $6.10 per employee per month for dental administration, including processing claims from January 1, 2015 through December 31, 2015, if this Agreement is extended for a second Term;
ii. $6.18 per employee per month for dental administration, including processing claims from January 1, 2016 through December 31, 2016, if this Agreement is extended for a third Term.

If paid in full up to the date of termination of this Agreement, the administrative fees shall cover services performed by ODS in paying claims during any period of Run-Out Claims Processing.

1.2 Producer Commission

This provision is not applicable to this Agreement.

1.3 Advance Deposit

$238,100

1.4 Claims Billing/Processing

This provision is to be negotiated by the Parties.

1.5 Custom or Mass Reissuing ID Cards

This provision is to be negotiated by the Parties at each occurrence.

1.6 Early Termination Fee

The difference between the penalty rate(s) outlined below and the administrative fees outlined in section 1.1, for each month this Agreement was in effect prior to such termination.

Penalty Rates:

a. Termination after the end of the initial Term, and prior to end of the second Term - $6.26 per employee per month. The difference is $0.16 and it applies only to the months this Agreement was in effect within the Term from January 1 to January 1 , 2015. The first and third Terms will not be considered for purposes of calculating the early termination fee.
b. Termination after the end of the second Term, and prior to end of the third Term - $6.39 per employee per month. The difference is $0.21 and it applies only to the months this Agreement was in effect within the Term from January 1 to January 1 , 2016. The first and second Terms will not be considered for purposes of calculating the early termination fee.

1.7 External Review

This provision is not applicable to this Agreement.

1.8 Nonstandard Reports

This provision is to be negotiated by the Parties at each occurrence.

1.9 Enrollment Assumption

The administrative fee payable by Plan Sponsor under this Agreement is based upon 100 percent of the number of covered employees contained in the Application or the number of covered employees reported to ODS to be eligible on the month prior to the last renewal date.

1.10 Subrogation/Right of Reimbursement Fee

Fee shall be equal to 25% of savings.

1.11 Run-Out Claims Processing Time Period

In no event will ODS be required to process claims received more than 12 months after the date of termination.

1.12 Member Handbooks and Other Member Materials

Fees are included in the administrative fees as stated in Section 1.1 of this Exhibit, except fees will be negotiated by the Parties upon special request for additional materials and delivery.

1.13 Late Fees

This provision is to be negotiated by the Parties at each occurrence.

Exhibit B

REPORTS

The following reports do not contain Protected Health Information:

Monthly Reports:

Activity Report – Standard
Distribution of Charges Report – Standard
Distribution of Paid Report - Standard
Savings Report – Standard
Tiered Enrollment Report – Standard

Exhibit C

REPORTS

Standard and Nonstandard Reports Including Protected Health Information;

None

Exhibit D

BUSINESS ASSOCIATE AGREEMENT

This Business Associate Agreement (the "Agreement") is entered into this 1st day of January, 2015 (the "Effective Date"), between Oregon Dental Service and its affiliates (the "Business Associate ") and Clackamas County (" Covered Entity") (collectively the "Parties").

RECITALS

WHEREAS, Covered Entity is subject to the Administrative Simplification requirements of the Health Insurance Portability and Accountability Act of 1996 and regulations promulgated thereunder, including the Standards for Privacy of Individually Identifiable Health Information and Security Standards for the Protection of Electronic Protected Health Information at 45 C.F.R. Parts 160 and 164 (collectively "Privacy and Security Regulations"). Covered Entity and Business Associate are further subject to the Health Information Technology for Economic and Clinical Health Act ("HITECH"), Title XIII of Division A of the American Recovery and Reinvestment Act of 2009 (ARRA) and regulations promulgated thereunder (the "Omnibus Rules"). The Privacy and Security Regulations and Omnibus Rules shall collectively be referred to as the "HIPAA Rules."

WHEREAS, Business Associate either 1) performs certain functions for, or on behalf of Covered Entity involving the creation, transmission, receipt, maintenance, use or disclosure of Protected Health Information ("PHI"); or 2) provides legal, actuarial, accounting, consulting, data aggregation, management, accreditation, administrative or financial services for Covered Entity involving the disclosure of PHI by Covered Entity or by another business associate of Covered Entity.

WHEREAS, the HIPAA Rules require Covered Entity to enter into an agreement with Business Associate in order to mandate certain protections for the privacy and security of PHI, and prohibit the disclosure of PHI from Covered Entity to Business Associate if such an agreement is not in place.

WHEREAS, the parties desire to enter into this agreement to protect PHI, and to amend any agreements between them, whether oral or written, with the execution of this Agreement.

NOW THEREFORE, in consideration of the mutual promises and agreements below and in order to comply with all legal requirements for the protection of this information, the parties agree as follows:

ARTICLE 1. DEFINITIONS

The following terms used in the Agreement shall have the same meaning as those terms in the HIPAA Rules at 45 CFR 160 and 164: Data Aggregation, Designated Record Set, Disclosure, Health Care Operations, Individual, Notice of Privacy Practices, Protected Health Information, Required by Law, Secretary, Subcontractor, and Use.

1.1 Breach: "Breach" means the unauthorized acquisition, access, use or disclosure of Protected Health Information ("PHI") where such breach compromises the security or privacy of such information.

1.2 Business Associate: "Business Associate" shall mean a person or entity providing certain functions, activities or services on behalf of Covered Entity involving the use and/or disclosure of Protected Health Information. This shall generally have the same meaning as the term "business associate" at 45 CFR 160.103 and in reference to the party to this agreement, shall mean Oregon Dental Service.

1.3 Covered Entity: "Covered Entity" means a (1) health plan; (2) health care clearinghouse; or (3) health care provider who transmits any health information in electronic form in connection with a transaction covered by HIPAA. This shall generally have the same meaning as the term "covered entity' at 45 CFR 160-103, and in reference to this agreement shall mean Clackamas County.

1.4 Health Insurance Portability and Accountability Act (HIPAA): "HIPAA" shall mean federal legislation effective in 1996 which addresses the requirements for the privacy of individually identifiable health information (IIHI) and Protected Health Information (PHI). As used herein, "HIPAA" shall also, where applicable, refer to the Standards for Electronic Transactions (45 C.F.R. Parts 160 and 162) and the Security Standards (45 C.F.R. Parts 160 and 164).

1.5 HIPAA Rules. "HIPAA Rules" shall mean the Privacy, Security, Breach Notification, and Enforcement Rules at 45 CFR Part 160 and 164.

1.6 HITECH Act: "HITECH Act" means the Health Information Technology for Economic and Clinical Health Act, found in the American Recovery and Reinvestment Act of 2009 at Division A, Title XIII and Division B, Title IV.

1.7 Minimum Necessary: "Minimum Necessary" means the disclosure of only that information which is required to accomplish the intended purpose of such use, disclosure or request. Where practicable, the information disclosed under the Minimum Necessary requirement shall be restricted to the limited data set as defined in 45 CFR 164.514(e)(2). This definition will be amended to reflect additional guidance as issued under HITECH should such guidance be provided as described in HITECH Section 13405 (b).

1.8 Privacy Rule: "Privacy Rule" shall mean the Standards for Privacy of Individually Identifiable Health Information at 45 CFR part 160 and part 164, subparts A and E.

1.9 Security Incident: "Security Incident" is further defined in 45 CFR.304 and means the attempted or successful unauthorized access, use, disclosure, modification, or destruction of information or interference with system operations in an information system.

1.10 Security Rule: "Security Rule" shall mean the Security Standards at 45 CFR part 160, and part 164, subparts A and C.

1.11 Unsecured PHI: '"Unsecured PHI" is further defined in Section 13402 of the HITECH Act and means Protected Health Information that is not secured through the use of a technology or methodology that renders PHI unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

ARTICLE 2. GENERAL PROVISIONS

2.1 Effect. This Business Associate Agreement supplements, modifies and amends any existing agreement between the parties involving the disclosure of Protected Health Information ("PHI") by Covered Entity to Business Associate, or the creation or receipt of PHI by Business Associate on behalf of Covered Entity. The terms and provisions of this Business Associate Agreement shall supersede any conflicting or inconsistent terms and provisions in any Agreement(s) between the parties, including all exhibits or other attachments thereto and all documents incorporated therein by reference. Without limiting the foregoing, any limitation or exclusion of damages provisions shall not be applicable to this Business Associate Agreement.

2.2 Amendment. Covered Entity and Business Associate agree to amend this Agreement to the extent necessary to allow either party to comply with HIPAA Rules and other applicable regulations or statutes. Business Associate agrees that it will fully comply with all such rules, regulations or statutes and that it will agree to amend this Agreement to incorporate any material required by such rules, statutes or regulations.

ARTICLE 3. OBLIGATIONS AND ACTIVITIES OF BUSINESS ASSOCIATE

3.1 Compliance with Security Regulations. Business Associate agrees that it will comply with the Security Regulations with respect to Electronic PHI and will use all appropriate safeguards to prevent the use or disclosure of PHI other than is pursuant to the terms and conditions of this Agreement. Business Associate further warrants that it shall implement as of the Effective Date, administrative, physical and technical safeguards that reasonably apply and appropriately protect the confidentiality, integrity and availability of any Electronic PHI that it creates receives, maintains, or transmits on behalf of Covered Entity. Upon request of Covered Entity, Business Associate shall promptly provide Covered Entity with information regarding such compliance.

3.2 Compliance with Privacy Regulations. To the extent that Business Associate is to carry out one or more of Covered Entity's obligations under the Privacy Regulations (Subpart E of 45 CFR Part 164) Business Associate agrees to comply with the requirements of the Privacy Regulations that apply to Covered Entity in the performance of such obligations.

3.3 Business Associate agrees to not use or further disclose PHI other than as permitted or required by this Agreement, or as required by law.

3.4 Report to Covered Entity any use or disclosure of PHI not provided for by the Agreement of which it becomes aware, including breaches of unsecured PHI as required at 45 CFR 164.410, and any security incident of which it becomes aware.

3.5 To the extent the Business Associate is to carry out one or more of the Covered Entity's obligations(s) under 45 CFR Part 164, comply with the requirements of Subpart E that apply to the Covered Entity in the performance of such obligations(s).

3.6 Business Associate agrees to make its internal practices, books and records relating to the use and disclosure of PHI received from, or created, or received by Business Associate on behalf of Covered Entity, available to the Secretary of Health and Human Services for purposes of determining Covered Entity and Business Associate's compliance with this Agreement and the HIPAA Rules.

ARTICLE 4. PERMITTED USES AND DISCLOSURES BY BUSINESS ASSOCIATE

4.1 Business Associate may only use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity as specified in the primary service Agreement.

4.2 Except as otherwise limited in this Agreement, Business Associate may use or disclose PHI to perform functions, activities, or services for or on behalf of Covered Entity, provided such use or disclosure would not violate the Privacy Rule if performed by Covered Entity.

4.3 Business Associate may use or disclose PHI as required by law.

4.4 Business Associate may use and disclose PHI:

a. For the proper management and administration of Business Associate;
b. To carry out Business Associate's legal responsibilities, and
c. As necessary for data aggregation purposes relating to the health care operations of Covered Entity as permitted by 45 CFR 164.504(e)(2)(i)(B), but only as separately authorized by Covered Entity in writing.

4.5 Business Associate acknowledges that, as between Business Associate and Covered Entity, all PHI shall be and remain the sole property of Covered Entity, including any and all forms thereof developed by Business Associate in the course of its fulfillment of its obligations pursuant to this Agreement.

4.6 Business Associate agrees that, to the extent Business Associate requests disclosure of PHI from Covered Entity, such request is only for the minimum necessary PHI for the accomplishment of Business Associate's purpose. For any disclosure or use of PHI, Business Associate shall determine and use the minimum necessary information only to accomplish the intended purpose of the use or disclosure. This provision shall automatically incorporate any guidance the Secretary issues pursuant to HITECH 13405 Regarding what constitutes "minimum necessary."

4.7 Business Associate is not authorized to de-identify PHI except as provided for in this Agreement. If provided for in this Agreement deidentification shall be done in accordance with 45 CFR 164.514 (a)-(c).

4.8 Business Associate shall maintain and retain PHI for the term of the Agreement and make such PHI available to Covered Entity as set forth in this Agreement.

ARTICLE 5. AGENTS, CONTRACTORS AND SUBCONTRACTORS

5.1 Business Associate shall ensure that any agent, contractor or subcontractor to whom Business Associate provides PHI received from, or created or received by Business Associate on behalf of Covered Entity agrees to be bound by the same restrictions, terms and conditions that apply through this Agreement to Business Associate with respect to such information.

5.2 Business Associate agrees to enter into a written contract with such agents, contractors or subcontractors to ensure that such agents, contractors, or subcontractors abide by the same restrictions and conditions that apply to the party when acting as a Business Associate with regard to PHI. Business Associate shall provide a copy of such contracts to Covered Entity upon request.

ARTICLE 6. INDIVIDUAL RIGHTS

6.1 Request to Access Records.

6.1.1 Within five (5) business days of a request by Covered Entity, Business Associate shall make available to Covered Entity the requested PHI to permit Covered Entity to respond to an individual's request for access to PHI for so long as such information is maintained in the Designated Record Set.

6.1.2 If Business Associate receives a request directly from an individual seeking access to or copies of PHI maintained by Business Associate for or on behalf of Covered Entity, Business Associate shall notify Covered Entity within five (5) business days and shall forward such request to Covered Entity. Notwithstanding the foregoing, Business Associate shall directly respond to such individual requests when and as directed by Covered Entity. Any denials of access to the PHI requested shall be the responsibility of Covered Entity.

6.2 Availability of Protected Health Information for Amendment. Within ten (10) business days of receipt of a request from Covered Entity for the amendment of an individual's PHI, Business Associate shall provide such information to Covered Entity for amendment and shall incorporate any such amendments in the PHI as required by 45 C.F.R. §164.526. Business Associate shall notify contractors and subcontractors who receive PHI of any such amendments.

6.3 Accounting of Disclosures. Within ten (10) business days of notice by Covered Entity to Business Associate that it has received a request for an accounting of disclosures of PHI, when such disclosures were made less than six (6) years prior to the date on which the accounting was requested, Business Associate shall make available to Covered Entity such information as is in Business Associate's possession and is required for Covered Entity to make the accounting required by 45 C.F.R. §164.528 At a minimum, Business Associate shall provide Covered Entity with the following information: (i) the date of the disclosure, (ii) the name of the entity or person who received the PHI, and if known, the address of such entity or person, (iii) a brief description of the PHI disclosed, and (iv) a brief statement of the purpose of such disclosure which includes an explanation of the basis for such disclosure. In the event the request for an accounting is delivered directly to Business Associate, Business Associate shall within two (2) business days forward such request to Covered Entity.

6.4. Record Keeping. Business Associate agrees to implement an appropriate record keeping process to enable it to comply with the HIPAA requirements applicable to it under this Agreement and the Privacy and Security Rules.

ARTICLE 7. PROHIBITION AGAINST SALE OR MARKETING OF PHI.

Except as otherwise provided in the HIPAA Rules, Business Associate shall not directly or indirectly receive remuneration in exchange for any PHI of an individual, or use or disclose PHI for any purpose related directly or indirectly to any marketing or marketing communication.

ARTICLE 8. REPORTING USES OR DISCLOSURES OF PHI NOT ALLOWED BY THIS AGREEMENT.

8.1 Business Associate shall report to Covered Entity any use or disclosure of PHI in violation of this agreement by Business Associate, its officers, directors, employees, contractors or by a third party to which Business Associate disclosed PHI pursuant to Article 5 of this Agreement. Notice of such use or disclosure shall be provided to Covered Entity in writing as soon as possible, but in no event later than five (5) business days from the date on which Business Associate discovers or is informed of the improper use or disclosure. Such notice shall include:

a. a description of the occurrence, including the date of the breach and the date of the discovery;
b. the name(s) of the individuals(s) whose PHI was used or disclosed;
c. the identity(ies) of the entity(ies)/person(s) to whom the use or disclosure was made;
d. description of the types of unsecured PHI that was disclosed;
e. the steps taken by Business Associate to correct the unauthorized use or disclosure.

8.2 Business Associate agrees to mitigate, to the extent practical, any harmful effect that is known to Business Associate resulting from any unauthorized acquisition, use or disclosure of unsecured PHI caused by Business Associate's violation of the requirements of this Agreement or its failure to properly secure PHI in accordance with guidelines published by the Department of Health and Human Services. As part of such mitigation activities, Business Associate shall discontinue and minimize the impact of any inappropriate use or disclosure.

8.3 Business Associate agrees to take prompt and appropriate corrective action to cure any deficiencies that caused the unauthorized use or disclosure and to implement additional actions intended to prevent other unauthorized disclosure.

ARTICLE 9. REPORTING OF A SECURITY INCIDENT

Business Associate shall report to Covered Entity any security incident of which it becomes aware in the following time and manner:

a. Any actual, successful security incident will be reported to Covered Entity in writing within five (5) business days of the date on which the Business Associate becomes aware of such security incident.
b. Any attempted, unsuccessful security incident of which Business Associate becomes aware will be reported to Covered Entity in writing, on a reasonable basis, at the written request of Covered Entity. If the Security Rule is amended to remove the requirement to report unsuccessful attempts at unauthorized access, this subsection shall no longer apply as of the effective date of the amendment of the Security Rule.

Any report required pursuant to this section shall: (i) identify the nature of the security incident; (ii) identify the PHI subject to the security incident; and (iii) identify what Business Associate has done or shall do to mitigate and correct any adverse effect of the security incident.

ARTICLE 10. REPORTING OF A BREACH OF UNSECURED PROTECTED HEALTH INFORMATION

In the event of a breach of Unsecured PHI, Business Associate will provide to Covered Entity:

a. A report including the identification of each individual whose unsecured PHI has been, or is reasonably believed by Business Associate to have been, accessed, acquired, or disclosed during such breach, contact information, nature/cause of the breach, PHI breached and the date or period of time during which the breach occurred.
b. The report must be provided to Covered Entity within five (5) business days from the date of the breach or the date the breach should have been known to have occurred.
c. Business Associate shall provide Covered Entity with any available information that Covered Entity is required to include in notification to the individual at the time of the report or promptly thereafter as such information becomes available. Upon report by Business Associate of a breach, Covered Entity will be responsible for notifying affected individuals, unless otherwise agreed upon by Business Associate to notify the affected individuals.

Business Associate is responsible for any and all costs related to notification of individuals or next of kin (if the individual is deceased) of any breach of Unsecured PHI reported by Business Associate to Covered Entity.

ARTICLE 11. OBLIGATIONS AND ACTIVITIES OF COVERED ENTITY

11.1 Covered Entity shall notify Business Associate of any limitation(s) in the Covered Entity notice of privacy practices in accordance with 45 CFR 164.520, to the extent that such limitation may affect Business Associate's use or disclosure of Protected Health Information.

11.2 Covered Entity shall notify Business Associate of any changes in, or revocation of, permission by Individual to use or disclose Protected Health Information, to the extent that such changes may affect Business Associate's use or disclosure of Protected Health Information.

11.3 Covered Entity shall notify Business Associate of any restriction to the use or disclosure of Protected Health Information that Covered Entity has agreed to in accordance with 45 CFR 164.522, to the extent that such restriction may affect Business Associate's use or disclosure of Protected Health Information.

ARTICLE 12. INDEMNIFICATION

12.1 Business Associate shall indemnify and hold harmless Covered Entity, its respective directors, officers, employees, representatives, shareholders, subsidiaries, and affiliates against any and all liabilities, losses, damages, penalties, fines, claims, demands, causes of action, proceedings and expenses (including reasonable attorneys' fees) asserted against, or suffered or incurred by Covered Entity, that result from or arise out of (i) Business Associate's negligence, recklessness or willful misconduct, (ii) Business Associate's failure to

perform any of its duties or obligations under this Agreement, or (iii) Business Associate's breach of any covenant under this Agreement. Notwithstanding the foregoing, in no event will either party be liable to the other party for any incidental, special, consequential, exemplary or reliance damages arising out of this Agreement.

12.2 Covered Entity shall indemnify and hold harmless Business Associate, its respective directors, officers, employees, representatives, shareholders, subsidiaries, and affiliates against any and all liabilities, losses, damages, penalties, fines, claims, demands, causes of action, proceedings and expenses (including reasonable attorneys' fees) asserted against, or suffered or incurred by Business Associate, that result from or arise out of (i) Covered Entity's negligence, recklessness or willful misconduct, (ii) Covered Entity's failure to perform any of its duties or obligations under this Agreement, or (iii) Covered Entity's breach of any covenant under this Agreement. Notwithstanding the foregoing, in no event will either party be liable to the other party for any incidental, special, consequential, exemplary or reliance damages arising out of this Agreement.

ARTICLE 13. NOTICE OF REQUEST FOR DATA

Business Associate agrees to notify Covered Entity within five (5) business days of Business Associate's receipt of any request or subpoena for PHI. To the extent that Covered Entity decides to assume responsibility for challenging the validity of such request, Business Associate agrees to cooperate fully with Covered Entity in such challenge.

ARTICLE 14. TERM and TERMINATION

14.1 Term. This Agreement shall commence as of the Effective Date set forth above and, unless earlier terminated as provided herein, shall continue in effect for the duration of the underlying agreement between the parties.

14.2 Termination for Cause.

14.2.1 In the event of a material breach or violation of this Agreement by Business Associate, Covered Entity will afford Business Associate an opportunity to cure the breach or end the violation. If Business Associate does not cure the breach or end the violation within thirty (30) days from the date of written notification from Covered Entity describing the breach or violation, Covered Entity may terminate this Agreement and the underlying agreement between the parties as necessary to comply with federal or state laws or regulations relating to the administrative simplification provisions of the HIPAA Rules. If termination of this Agreement and the underlying agreement between the parties is not feasible, in Covered Entity's sole discretion, Business Associate acknowledges that Covered Entity may report the breach or violation to the Secretary, notwithstanding any other provision of this Agreement or the underlying agreement to the contrary.

14.2.2 At the expense of Business Associate, Covered Entity may, in its sole discretion, cure any breach of Business Associate's obligation under this Agreement. Covered Entity shall give Business Associate notice of its election to cure any such breach and Business Associate shall cooperate fully in the efforts by Covered Entity to cure Business Associate's breach.

14.2.3. Covered Entity may terminate this Agreement immediately upon written notice to Business Associate if Business Associate has breached a material term of this Agreement and cure is not possible.

14.3 Effect of Termination

14.3.1 Except as otherwise expressly provided in Section 14.2.3, upon termination of this Agreement for any reason, Business Associate shall return or destroy all PHI received from Covered Entity, or created or received by Business Associate on behalf of Covered Entity.

14.3.2 Upon termination of the Agreement for any reason, Business Associate, with respect to PHI received from Covered Entity, or created, maintained, or received by Business Associate on behalf of Covered Entity shall:

a. Retain only that PHI which is necessary for Business Associate to continue its proper management and administration or to carry out its legal responsibilities;
b. Return to Covered Entity, or if agreed to by Covered Entity, destroy the remaining Protected Health Information that the Business Associate still maintains in any form;

c. Continue to use appropriate safeguards and comply with the HIPAA Rules with respect to electronic PHI to prevent use or disclosure of the PHI, other than as provided for in this section for as long as Business Associate retains the PHI;

d. Not use or disclose the PHI retained by Business Associate other than for the purposes for which such PHI was retained and subject to the same conditions set out in Subsection 14.2.2 (a); and

e. Return to Covered Entity or if agreed to by Covered Entity, destroy the PHI retained by Business Associate when it is no longer needed by Business Associate for its proper management and administration or to carry out its legal responsibilities.

14.3.3 In the event of any termination of the Agreement, Business Associate shall, at the discretion of Covered Entity, return or destroy all PHI that Business Associate still maintains in any form and shall retain no copies. In the event that Business Associate determines that returning or destroying the PHI is infeasible, Business Associate shall provide to Covered Entity notification of the conditions that make return or destruction infeasible. Upon mutual agreement of the parties that return or destruction of PHI is infeasible, Business Associate shall extend the protections of this Agreement to such PHI for so long as Business Associate maintains such PHI.

ARTICLE 15. ELECTRONIC TRANSACTIONS AND CODE SETS

To the extent that the services performed by Business Associate pursuant to the Agreement involve transactions that are subject to the regulations governing electronic transactions and code set issued pursuant to HIPAA, Business Associate shall conduct such transactions in conformance with such regulations, as amended from time to time.

ARTICLE 16. INJUNCTIVE RELIEF

Business Associate hereby agrees that Covered Entity may suffer irreparable damage upon Business Associate's breach of this Agreement and that such damages shall be difficult to quantify. Business Associate hereby agrees that Covered Entity may file an action for injunctive relief to enforce the terms of this Agreement against Business Associate, in addition to any other remedy Covered Entity may have.

ARTICLE 17. MISCELLANEOUS

17.1 Statutory and Regulatory Reference. A reference in this Agreement to a section of any statute or regulation means the section as currently in effect or amended, and for which compliance is required.

17.2 Assignment. Business Associate may not sell, assign, transfer or otherwise convey any of its rights or delegate any of its duties under this Agreement without prior written consent of Covered Entity.

17.3 Survival. This Agreement will be binding upon and will inure to the benefit of the Parties to this Agreement and their respective permitted successors and assigns, subject to the transfer restrictions and expiration or termination provisions set forth in this Agreement

17.4 Interpretation. Any ambiguity in this Agreement shall be interpreted to permit compliance with the HIPAA rules.

17.5 Governing Law. This Agreement shall be governed by and construed in accordance with the laws of the State of Oregon.

17.6 No Agency. Nothing in this Agreement shall be construed to create (a) a partnership, joint venture or other joint business relationship between the parties or any of their affiliates, or (b) a relationship of employer and employee between the parties. Business Associate is an independent contractor, not an agent, to Covered Entity, and Covered Entity does not control the manner or means of Business Associates' performance under this Agreement, and nothing contained in this Agreement shall be intended to expand the scope or nature of the relationship.

17.7 No Third Party Beneficiaries. Nothing in this Agreement confers on any person other than Covered Entity and Business Associate and their respective successors and assigns, any right remedies obligations or liabilities.

17.7 Entire Agreement; Amendment. This Agreement represents the entire understanding between Business Associate and Covered Entity and there are no other representations, warranties and agreements between Business Associate and Covered Entity relating to the subject of this agreement, which can only be modified and renewed in writing, signed by an officer of both Business Associate and Covered Entity.

IN WITNESS WHEREOF, the Parties hereby agree that this Business Associate Agreement shall be considered fully executed.

Covered Entity

Clackamas County
2051 Kaen Rd Ste 310
Oregon City OR 97045

Signature

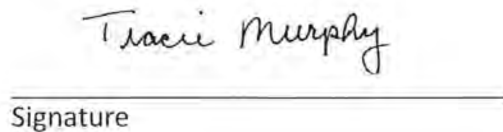
Nancy M. Drury
Printed Name

Director of Employee Services
Title

April 16, 2015
Date

Business Associate

Oregon Dental Service
601 SW 2nd Avenue
Portland OR 97204



Signature

Tracie Murphy
Printed Name

Senior Vice-President
Title

March 4, 2015
Date

Exhibit E

Designated Contact Person(s)

In accordance with CFR 164.504(f)(2)(iii)(B) of the HIPAA Privacy Rule, please designate the person(s) in the Plan's administration who is (are) designated to receive Protected Health Information (PHI):

_______ NEW As of (date): ____________________

_______ CHANGE As of (date): ____________________

Functions that the below individuals will be involved in:

_______ Receiving reports that include Protected Health Information (PHI)

_______ Customer Service activities on behalf of employees

Organization Name: ____

Name: Teri Burtis	Name: Nina Smith
Title: Human Resources Specialist	Title: Human Resources Analyst
Address: 2051 Kaen Rd, #310, Oregon City, OR, 97045	Address: 2051 Kaen Rd, #310, Oregon City, OR, 97045
Phone: 503-655-8203	Phone: 503-742-5472
Fax: 503-742-5468	Fax: 503-742-5468
Email: TBurtis@clackamas.us	Email: NSmith2@clackamas.us

Name: Billie Hurley	Name: Carolyn Williams
Title: Human Resources Analyst	Title: Benefits Manager
Address: 2051 Kaen Rd, #310, Oregon City, OR, 97045	Address: 2051 Kaen Rd, #310, Oregon City, OR, 97045
Phone: 503-742-5479	Phone: 503-742-5470
Fax: 503-742-5468	Fax: 503-742-5468
Email: BillieHur@clackamas.us	Email: CarolynW@clackamas.us

Name: Jennifer Joslin Brown	Name: Heather Pedersen
Title: Human Resources Analyst	Title: Compensation Manager
Address: 2051 Kaen Rd, #310, Oregon City, OR, 97045	Address: 2051 Kaen Rd, #310, Oregon City, OR, 97045
Phone: 503-742-5471	Phone: 503-742-5484
Fax: 503-742-5468	Fax: 503-742-5468
Email: JBrown1@clackamas.us	Email: HeatherPed@clackamas.us

Return form to: ODS
Attention: Privacy Office
601 SW Second Avenue
Portland, OR 97204

Oregon Group Dental Plan

Clackamas County
(General County Employees)
Delta Dental Premier Plan

Effective date: January 1, 2021
Group number: 10000174

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

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SECTION 1. WELCOME

This handbook describes the main features of the Group's dental plan (the "Plan"), but does not waive any of the conditions of the Plan as set out in the Plan Document.

The Plan is self-funded and the Group has contracted with Delta Dental Plan of Oregon (abbreviated as Delta Dental) to provide claims and other administrative services.

Members may direct questions to one of the numbers listed in section 2.1 or access tools and resources on Delta Dental's personalized member website, Member Dashboard, at www.deltadentalor.com. Member Dashboard is available 24 hours a day, 7 days a week allowing members to access plan information whenever it is convenient.

Delta Dental reserves the right to monitor telephone conversations and email communications between its employees and its members for legitimate business purposes as determined by Delta Dental.

The Group may change or replace this handbook at any time without the consent of any member. The most current handbook is available on Member Dashboard, accessed through the Delta Dental website. All plan provisions are governed by the Group's agreement with Delta Dental. This handbook may not contain every plan provision.

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SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to **Member Dashboard**)
www.DeltaDentalOR.com
Includes many helpful features, such as Find Care (use to find a participating dentist)

Dental Customer Service Department
Toll-free 888-217-2365
En Español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

Delta Dental
P.O. Box 40384
Portland, Oregon 97240

2.2 MEMBERSHIP CARD

After enrolling, members will receive ID (identification) cards that will include the group and identification numbers. Members will need to present the card each time they receive services. Members may go to Member Dashboard or contact Customer Service for replacement of a lost ID card.

2.3 NETWORK

See Network Information (section 3.1) for details about how networks work.

Dental network
Delta Dental Premier Network

2.4 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in section 14, section 16 and section 18.

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SECTION 3. USING THE PLAN

For questions about the Plan, members should contact Customer Service. This handbook describes the benefits of the Plan. It is the member's responsibility to review this handbook carefully and to be aware of the Plan's limitations and exclusions.

At a first appointment, members should tell the dentist that they have dental benefits administered by Delta Dental. Members will need to provide their subscriber identification number and Delta Dental group number to the dentist. These numbers are located on the ID card.

3.1 NETWORK INFORMATION

Delta Dental plans are easy to use and cost effective. If members choose a participating Delta Dental Premier dentist from the Delta Dental Premier Dental Directory (available on Member Dashboard by using Find Care), all of the paperwork takes place between Delta Dental and the dentist's office. 89% of all licensed dentists in Oregon are participating Delta Dental Premier dentists. For members outside Oregon, Delta Dental's national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

Members needing dental care may go to any dental office. However, there are differences in reimbursement by the Plan for participating Delta Dental Premier dentists and non-participating dentists or dental care providers. While a member may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

3.1.1 Non-Participating Dentists

Payment to a non-participating dentist or dental care provider is paid at the applicable coinsurance and is limited to the non-participating dentist fee schedule. The allowable fee in states other than Oregon will be that state's Delta Affiliate's non-participating dentist allowance. The member may have to pay the difference between the maximum allowed amount and the billed charge.

3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, Delta Dental provides a predetermination service. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the Plan's current benefits and returned to the dentist. The member and his or her dentist should review the information before beginning treatment.

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SECTION 4. EMPLOYEE GROUPS AND BENEFIT INFORMATION

The following is a list of Employee Groups, their benefit structure, and annual maximums. Members having questions concerning which group or category they are in, should contact the County's Risk and Benefits Division or call Delta Dental Customer Service Department.

Non-Represented
- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

Employees' Association
- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

Housing Authority Employees' Association
- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

AFSCME - DTD
- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

AFSCME WES
- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

FOPPO
- Incentive Plan
- $2,000 annual maximum*
- Adult and child Orthodontic benefit - $2,000 lifetime maximum.

AFSCME - CCOM
- Incentive Plan
- $2000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

Represented Employees
- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

Vector Control
- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

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Fair Board

- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

Job Share Employees (Option I)

- Incentive Plan
- $2,000 annual maximum*
- Child only Orthodontic benefit - $2,000 lifetime maximum.

All Employee Groups have the choice between the Incentive Plan with the benefits shown above and the Preventive or Constant Plan with the benefits shown below. A subscriber can change enrollment selection only during Open Enrollment or as a result of a qualified Family Status Change, see section 13.4.

- Preventive Plan (100-80-70 percent coverage)
- $2,000 annual maximum*
- Adult and child Orthodontic benefit - $3,000 lifetime maximum.

- Constant Plan (50% coverage)
- $2,000 annual maximum*
- No Orthodontic benefit available.

*Covered Class I services do not apply to annual maximum.

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SECTION 5. INCENTIVE PLAN

5.1 CLASS I, II AND III SERVICES

5.1.1 The program provides 70% toward covered Class I, II and III services the first year a member is eligible.

5.1.2 Payment increases by 10% each successive year. To qualify for this 10% increase, the member must visit the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment never drops below 70%.

5.1.3 Class I, II and III services will be covered at 100% at the end of three years, assuming at least one visit to the dentist each of these years.

5.2 CLASS IV SERVICES

5.2.1 The program provides 50% toward covered Class IV services. There is no "10% increase" provision.

Annual Maximum Payment (Class II, III, and IV Services Only) The maximum amount payable by the Plan for covered services received each year, or portion thereof, for each eligible employee and dependent(s). Please see the Section 4 titled "Employee Groups and Benefit Information" for the annual maximum for each group.

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SECTION 6. PREVENTIVE PLAN

6.1 CLASS I: 100% IS PROVIDED TOWARD COVERED CLASS I SERVICES.

6.2 CLASS II & III: 80% IS PROVIDED TOWARD COVERED CLASS II & III SERVICES.

6.3 CLASS IV: 70% IS PROVIDED TOWARD COVERED CLASS IV SERVICES.

6.4 DEDUCTIBLE: $50

Per member (not to exceed $100 per family) per year, or portion thereof.
Deductible applies to covered Class II, Class III and Class IV services.

Annual Maximum (Class II, III, and IV Services Only) The maximum amount payable by the Plan for covered services received each year, or portion thereof, for each eligible employee and dependent(s). Please see the Section 4 titled "Employee Groups and Benefit Information" for the annual maximum for each group. Members are responsible for expenses that exceed the annual maximum.

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SECTION 7. CONSTANT PLAN

7.1 CLASS I, II, III AND IV SERVICES

7.1.1 The program provides 50% payment toward covered Class I, II, III and IV services.

Annual Maximum (Class II, III, and IV Services Only) The maximum amount payable by the Plan for covered services received each year, or portion thereof, for each eligible employee and dependent(s). Please see the Section 4 titled "Employee Groups and Benefit Information" for the annual maximum for each group. Members are responsible for expenses that exceed the annual maximum.

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SECTION 8. BENEFITS AND LIMITATIONS

The Plan covers the services listed when performed by a dentist or dental care provider (licensed denturist or licensed hygienist), and only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). Delta Dental's dental consultants and dental director shall determine these standards.

Payment of covered expenses is always limited to the maximum plan allowance. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered under the medical portion of a member's plan will not be covered on this Plan except when related to an accident.

Covered dental services are outlined in 4 classes that start with preventive care and advance into basic and major dental procedures. Limitations may apply to these services, and are noted below. See section 10 for exclusions.

All annual or per year benefits or cost sharing accrue based on a calendar year (January 1 through December 31) or portion thereof. Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

Limitations may apply to these services, and are noted below. See section 10 for exclusions.

8.1 CLASS I COVERED SERVICES

8.1.1 Diagnostic

a. **Diagnostic Services:**
   i. Examination
   ii. Intra-oral x-rays to assist in determining required dental treatment.

b. **Diagnostic Limitations:**
   i. Periodic (routine) or comprehensive examinations or consultations are covered twice per year
   ii. Limited examinations or re-evaluations are covered twice per year
   iii. A separate charge for teledentistry is not covered. Teledentistry is included in the fees for overall patient management.
   iv. Complete series x-rays or a panoramic film is covered once in any 3-year period
   v. Supplementary bitewing x-rays are covered twice per year
   vi. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
   vii. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing

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8.1.2 Preventive

a. Preventive Services:

i. Prophylaxis (cleanings)
ii. Periodontal maintenance
iii. Topical application of fluoride
iv. Interim caries arresting medicament application
v. Sealants
vi. Space maintainers

b. Preventive Limitations:

i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year.† Additional periodontal maintenance is covered for members with periodontal disease. See section 8.2.4 for more information.
ii. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12.
iii. Topical application of fluoride is covered twice per year for members under age 19. For members age 19 and over, topical application of fluoride is covered twice per year if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
iv. Interim caries arresting medicament application is covered twice per tooth per year.
v. Sealant benefits are limited to the unrestored occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant per tooth during any 5-year period.

†Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see section 9.1).

8.2 CLASS II COVERED SERVICES

8.2.1 Restorative

a. Restorative Services:

i. Amalgam fillings and composite fillings for the treatment of decay
ii. Stainless steel crowns

b. Restorative Limitations:

i. Inlays are considered an optional service. An alternate benefit of a composite filling will be provided.
ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iii. Replacement of a stainless steel crown by the same dentist within a 2-year period of placement is not covered. The replacement is included in the charge for the original crown.
iv. Additional limitations when teeth are restored with crowns or cast restorations are in section 8.3.1.

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v. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered, except as provided under Class II, Miscellaneous (oral sedatives and nitrous oxide) or section 8.2.6

8.2.2 Oral Surgery

a. Oral Surgery Services:

i. Extractions (including surgical)
ii. Other minor surgical procedures

b. Oral Surgery Limitations:

i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
iii. A separate charge for post-operative care done within 30 days following an oral surgery is not covered. Post-operative care is included in the charge of the original surgery.
iv. Brush biopsy is covered twice per year. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

8.2.3 Endodontic

a. Endodontic Services:

i. Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

b. Endodontic Limitations:

i. A separate charge for cultures is not covered.
ii. A separate charge for pulp removal done with a root canal or root repair is not covered.
iii. A separate charge for pulp capping is not covered Pulp capping is considered to be included in the fee for the final restoration.
iv. Retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

8.2.4 Periodontic

a. Periodontic Services:

i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once every 6 months.
ii. Periodontal maintenance is covered under Class I, Preventive.
iii. A separate charge for post-operative care done within 6 months following periodontal surgery is not covered.
iv. Osseous surgery is covered for a maximum of 2 quadrants per visit.
v. Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.

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vi. Full mouth debridement is limited to once in a 2-year period and, if the member is age 19 or older, only if there has been no cleaning (prophylaxis, periodontal maintenance) within a 2-year period.

8.2.5 Miscellaneous

a. Miscellaneous Services:

i. Oral sedatives are available to eligible dependents through age 17.
ii. Nitrous oxide shall be a covered benefit for members age 18 and over.

8.2.6 Anesthesia Services

a. General anesthesia or IV sedation
Covered only:

i. In conjunction with covered surgical procedures performed in a dental office
ii. When necessary due to concurrent medical conditions

8.3 CLASS III COVERED SERVICES

8.3.1 Restorative

a. Restorative Services:

i. Cast restorations, such as crowns*, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 5-year period on any tooth. See 8.2.1 for limitations on buildups.
ii. Crowns for patients under age 16 are not covered. However, crowns for patients under age 16 may be covered upon review for medical necessity.
iii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
iv. If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

* **Note:** Crowns are covered at 70% under the Preventive Plan.

8.4 CLASS IV COVERED SERVICES

8.4.1 Prosthodontic

a. Prosthodontic Services:

i. Bridges
ii. Partial and complete dentures
iii. Denture relines

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iv. Repair of an existing prosthetic device
v. Implants and implant maintenance
vi. Surgical stent in conjunction with a covered surgical procedure

b. Prosthodontic Limitations:

i. A bridge or a full or partial denture will be covered once in a 5-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 5 years.
ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to being decayed or broken.
iv. Denture adjustments, repairs, and relines*:* A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines are covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
v. Tissue conditioning is covered no more than twice per denture in a 3-year period.
vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. Scaling and debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years, except when dentally necessary. The Plan will also cover:
    A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space in any 5-year period; or
    B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any 5-year period); or
    C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 5-year period.
    D. Implant-supported bridges are not covered if 1 or more of the retainers is supported by a natural tooth.
    E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 5 years.
vii. Fixed bridges or removable cast partial dentures are not covered for members under age 16.
viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.

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8.4.2 Other

a. **Other Services:**
   i. Athletic mouthguard
   ii. Nightguard (Occlusal guard)
   iii. Orthodontia for correcting malocclusioned teeth when necessity is established through an in-person clinical examination of the member

b. **Other Limitations:**
   i. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period for age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are excluded.
   ii. A nightguard (occlusal guard) is covered once every 5-year period at 100% up to $250 maximum with no deductible. Repair, reline and adjustment of occlusal guard is covered once every 12-month period. Over-the-counter nightguards are excluded.
   iii. **For Child Only Orthodontic Coverage:** Orthodontia is covered only for children. Treatment must begin prior to their 17th birthday. Refer to section 4 for plans with this benefit.
   iv. **For Adult and Child Orthodontic Coverage:** The plan covers orthodontia services for all enrolled members. Refer to section 4 for plans with this benefit.
   v. **Lifetime Maximum Payment for Orthodontic Services:** Please see section 4 for the lifetime maximum for your group. The plan will pay 50% toward covered orthodontic services, up to the maximum benefit
   vi. Pre-orthodontic treatment exam is part of the comprehensive orthodontic treatment plan.
   vii. Self-administered orthodontics are not covered.
   viii. Payment for orthodontia will end when treatment stops for any reason prior to completion, or upon termination of eligibility or of the Plan. If treatment began before the member was eligible under the Plan, the Plan will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.
   ix. Repair or replacement of an appliance furnished under the Plan is not covered
   x. A separate charge for a retainer, or the repair or replacement of an appliance furnished under the Plan is not covered
   xi. A separate charge for translation or sign language service is not covered. Translation or sign language service is included in the fees for overall patient management.
   xii. If the plan has a deductible, it does not apply to orthodontic services

8.5 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will be responsible for the remainder of the dentist's fee.

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SECTION 9. ORAL HEALTH, TOTAL HEALTH BENEFITS

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the body healthy. Studies have shown a relationship between periodontal disease, bacteria in the mouth, and various health problems including pre-term, low birth weight babies and diabetes.

9.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

The Plan has a program that provides additional cleanings (prophylaxis or periodontal maintenance) for members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in 0.

9.1.1 Diabetes

For members with diabetes, elevated blood sugar levels can have a negative effect on oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes.

Diabetic members are eligible for a total of 4 cleanings per year.

9.1.2 Pregnancy

Keeping the mouth healthy during a pregnancy is important for a member and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Data also suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant members are eligible for a cleaning in the third trimester of pregnancy regardless of when they had a previous cleaning.

9.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member can contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on Member Dashboard. Members with diabetes must include proof of diagnosis.

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SECTION 10. EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are not covered, even if otherwise dentally necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred or provided by a dentist or dental care provider.

Analgesics, Anesthesia and Medications
Prescribed drugs, premedications, and analgesics are excluded (except oral sedatives for eligible dependents through age 17 and nitrous oxide for members ages 18 and over).

Behavior Management
Additional services, time or assistance to control the actions of a member

Benefits Not Stated
Services or supplies not specifically described in this handbook as covered services

Congenital or Developmental Malformations
Including treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth).

Coping
A thin covering over the visible part of a tooth, usually without anatomic conformity

Cosmetic Services
Services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion

Duplication and Interpretation of X-rays or Records

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures

Facility Fees
Including additional fees charged by the dentist for hospital, extended care facility or home care treatment

Gnathologic Recordings
Services to observe the relationship of opposing teeth, including occlusion analysis

Hypnosis

Illegal Acts
Services and supplies for treatment of an injury or condition caused by or arising directly from a member's illegal act. This includes any expense caused by or arising out of illegal acts related to riot, declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority.

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Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison

Instructions or Training
Including tobacco cessation counseling, plaque control and oral hygiene or dietary instruction

Localized Delivery of Antimicrobial Agents
Time released antibiotics to remove bacteria from below the gumline

Maxillofacial Prosthetics
Except for surgical stents as stated in section 8.4.1

Medications

Missed Appointment Charges

Never Events
Services and supplies related to never events. These are events that should never happen while receiving services in a dental office, including removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

Over the Counter
Including over the counter occlusal guards and athletic mouthguards

Periodontal Charting
Measuring and recording the space between a tooth and the gum tissue

Precision Attachments
Devices to stabilize or retain a prosthesis when seated in the mouth

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth, except nightguards (occlusal guards) or athletic mouthguards as provided in 8.4.2. Excluded services include increasing vertical dimension, equilibration, and periodontal splinting.

Self-Treatment
Services provided by a member to herself or himself

Service Related Conditions
Treatment of any condition caused by or arising out of a member’s service in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by the member’s military or veterans coverage.

Services on Tongue, Lip, or Cheek

Services Otherwise Available
Including those services or supplies:

a. compensable under workers' compensation or employer's liability laws
b. provided by any city, county, state or federal law, except for Medicaid coverage

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c. provided without cost to the member by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 13.3.2)

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ)

Treatment After Coverage Ends
The only exception is for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a member's eligibility ends. This exception is not applicable if the Group transfers its plan to another carrier.

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

a. not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
b. that are inappropriate with regard to standards of good dental practice
c. with poor prognosis

Treatment of Closed Fractures

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SECTION 11. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see section 12.5).

11.1 SUBSCRIBER

A person is eligible to enroll in the Plan if he or she:

a. is a permanent documented full time or part time employee, an employee in a job share position, a non-represented job share employee with benefit dollar allowance, or a retiree of Clackamas County
b. works for the Group on a regularly scheduled basis working the minimum number of hours per week required for that job position;
c. is not a seasonal, substitute, or temporary employee, or an agent, consultant, or independent contractor or leased worker
d. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
e. satisfies any orientation and/or eligibility waiting period

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under state or federal family and medical leave laws. Members should check with the Group's benefits manager to find out whether they qualify for this provision.

11.2 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are also subject to the Plan's child age limit. Foster children are eligible only while legally a foster child.

For purposes of determining eligibility, the following are considered children:

a. The biological, adopted or foster child of a subscriber or a subscriber's eligible spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent for the first 31 days of the newborn's life
d. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided

A subscriber's child who has sustained a disability making him or her physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous dental coverage. The incapacity must have started, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. The Plan will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Delta Dental at least 45 days before the child's 26th birthday:

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a. Recent medical or psychiatric progress notes and evaluations, referrals or consult notes
b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)
c. Relevant recent hospitalization records (e.g., history and physical, discharge summary) if applicable
d. Disability information from prior carrier

The Plan will make an eligibility determination based on documentation of the child's medical condition. Periodic review by Delta Dental will be required on an ongoing basis except in cases where the disability is certified to be permanent.

11.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group determines that the applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

11.4 NEW DEPENDENTS

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply from the date coverage is effective.

If a subscriber marries or registers a domestic partnership, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration.

If a subscriber files an Affidavit of Domestic Partnership with the Group, the domestic partner and his or her children are eligible for coverage.

A member's newborn child is eligible from birth. A subscriber's adopted child, or child placed for adoption or as a foster child is eligible on the date of placement. To enroll a new child, an online enrollment application must be submitted. The application and payment must be submitted within 31 days. If the application and payment is not received timely, the child will not be covered. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

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SECTION 12. ENROLLMENT

12.1 ENROLLING ELIGIBLE EMPLOYEES

Application for coverage may be submitted online for the eligible employee and any dependents to be enrolled must be filed with the Group within 15 days of becoming eligible to apply for coverage. Eligible employees can apply on the date of hire or the end of any required waiting period.

The subscriber must notify the Group of any change of address.

12.2 ENROLLING NEW DEPENDENTS

To enroll a new dependent, just complete the online enrollment application with the Group within 60 days of their eligibility. The subscriber must notify Delta Dental if family members are added or dropped from coverage, even if it does not affect premiums.

12.3 OPEN ENROLLMENT

If an eligible employee and/or any eligible dependents are not enrolled within 15 days of first becoming eligible, they must wait for the next open enrollment period to enroll unless:

a. The person qualifies for special enrollment as described in section 11.4
b. A court has ordered that coverage be provided for a spouse or minor child under a subscriber's insurance plan and a request for enrollment is made within 30 days after the court order is issued

Open enrollment occurs once a year at renewal.

12.4 SPECIAL ENROLLMENT RIGHTS

The special enrollment rights described in sections 12.4.1 and 12.4.2 apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a subscriber's dependent who loses other coverage or becomes eligible for a premium assistance subsidy
c. To both the eligible employee and his or her dependent if neither is enrolled under the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy

To enroll, an eligible employee must submit a complete and signed application and supporting documentation within the required timeframe.

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12.4.1 Loss of Other Coverage

If coverage is declined when initially eligible or at an open enrollment period because of other dental coverage, an eligible employee or any dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. He or she was covered under a group dental plan or had dental coverage at the time coverage was previously offered
b. He or she stated in writing at such time that coverage under a group dental plan or dental coverage was the reason enrollment was declined
c. He or she requests such enrollment not later than 60 days after the previous coverage ended
d. One of the following events has occurred:
    i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
    ii. His or her prior coverage ended as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        A. legal separation or divorce
        B. loss of dependent status per plan terms
        C. death
        D. end of employment or reduction in the number of hours of employment
        E. reaching the lifetime maximum on all benefits
        F. the plan stops offering coverage to a group of similarly situated persons
        G. moving out of an HMO service area that causes coverage to end and no other option is available under the plan
        H. termination of the benefit package option, and no substitute option is offered
    iii. The employer contributions toward his or her other active (not COBRA) coverage end. If employer contributions stop, the eligible employee or dependent does not have to end coverage to be eligible for special enrollment on a new plan.
    iv. His or her prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage ended due to loss of eligibility. Special enrollment must be requested within 60 days of the end of coverage.

12.4.2 Eligibility for Premium Subsidy

If an eligible employee or dependent covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.

12.4.3 Family Status Changes

Benefits are regulated by Section 125 of the Internal Revenue Code (IRC). This allows an eligible employee to change enrollment selections only during Open Enrollment and/or as a result of a qualified Family Status Change.

a. All enrollment changes must be completed through the Risk & Benefits Division
b. To make changes, the eligible employee must complete a Notice of Change in Family Status and required enrollment forms, and provide the required documentation within 60 days of the qualifying event. If the 60-day deadline is not met, the eligible employee will not be able to add any family members until the next Open Enrollment

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c. Changes are effective the first of the month following the Family Status Change or receipt of required forms and documents, whichever is later. Dental coverage for new children is automatic only for the first 31 days from the date of birth or adoption. Claims received after the 31st day will not be paid until enrollment forms are completed and processed

12.5 WHEN COVERAGE BEGINS

Coverage will begin on the first day of the month following two months of continuous employment.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group will begin on the first day of the month following receipt of the online enrollment forms.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption or as a foster child is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request, or coinciding with, but not before the loss of other coverage.

The necessary premium must also be paid for coverage to become effective.

12.6 WHEN COVERAGE ENDS

When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

12.6.1 Termination of the Group Plan

If the Plan is terminated for any reason, coverage ends for the members on the date the Plan ends.

12.6.2 Termination by Subscriber

A subscriber may end his or her coverage, or coverage for any enrolled dependent, only if there is a qualifying event. Qualifying events include marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

12.6.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage if the requirements for continuation of coverage are met (see section 15.2).

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12.6.4 Termination, Layoff or Reduction in Hours of Employment

Coverage ends on the last day of the month in which employment ends, unless a member chooses to continue coverage (see section 15).

If a subscriber is laid off and returns to active work within 6 months of being laid off, he or she and any eligible dependents may enroll in the Plan on the date of rehire and coverage will begin on that date.

If a subscriber experiences a reduction in hours that causes loss of coverage, and within 6 months the hours increase and the subscriber again qualifies for benefits, he or she and any eligible dependents may enroll in the group plan on the date the subscriber qualifies, and coverage will begin on that date provided the necessary premiums for coverage are paid.

The Group must notify Delta Dental that the subscriber is rehired or of an increase in hours and the necessary premiums for coverage must be paid. All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

An employee who has continuously participated in COBRA continuation coverage during a layoff, and is reinstated to employment within eighteen (18) months from layoff, will have the benefit waiting period waived. This applies to all lines of coverage and any type of layoff (economic or medical layoff).

12.6.5 Loss of Eligibility by Dependent

Coverage ends on the last day of the month in which the dependent's eligibility ends.

a. Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered or that a partnership no longer meets the requirements of the Affidavit of Domestic Partnership.
b. Coverage ends for an enrolled child on the last day of the month in which he or she turns age 26, or that a legal guardianship or foster relationship ends.

The subscriber must notify the Group and Delta Dental when a marriage, domestic partnership, foster child relationship or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends.

12.6.6 Rescission

The Plan may rescind a member's coverage back to the effective date, or deny claims at any time for fraud, material misrepresentation or concealment by a member which may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. The Plan reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. If the Plan ends coverage under this section, Delta Dental may, to the extent permitted by law, deny future enrollment of the members under any Delta Dental policy or contract or the contract of any affiliates.

12.6.7 Continuing Coverage

Information is in Continuation of Dental Coverage (section 15).

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SECTION 13. CLAIMS ADMINISTRATION & PAYMENT

13.1 SUBMISSION AND PAYMENT OF CLAIMS

13.1.1 Claim Submission

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to Delta Dental within 3 years after the date the expense was incurred.

13.1.2 Explanation of Benefits (EOB)

Delta Dental will report its action on a claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through Member Dashboard. The EOB will indicate if a claim has been paid, denied or accumulated toward satisfying any deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 13.1.1.

13.1.3 Claim Inquiries

Customer Service can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. The Plan will respond to an inquiry within 30 days of receipt.

13.1.4 Time Frames for Processing Claims

If a claim is denied, Delta Dental will send an EOB explaining the denial within 30 days after receiving the claim. If more time is needed to process the claim for reasons beyond Delta Dental's control, a notice of delay will be sent to the member explaining those reasons within 30 days after Delta Dental receives the claim. Delta Dental will then finish processing the claim and send an EOB to the member no more than 45 days after receiving the claim. If more information is needed to process the claim, the notice of delay will describe the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 13.1.1.

13.2 APPEALS

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

13.2.1 Definitions

For purposes of section 13.2, the following definitions apply:

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Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Delta Dental informing a person, of any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a person's eligibility to participate in the Plan and one resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or accidental injury.

Appeal is a written request by a member or his or her representative for Delta Dental to review an adverse benefit determination.

Utilization Review means a system of reviewing the dental necessity, appropriateness or quality of dental care services and supplies. An adverse benefit determination that the item or service is not dentally necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a dental judgment is a utilization review decision.

13.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date an adverse benefit determination is received to submit the first written appeal. If appeals are not submitted within the timeframes in these sections, the member will lose the right to any appeal.

13.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. Delta Dental's response time to an appeal is based on the nature of the claim as described below.

The timelines in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party (Delta Dental or the member) makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the specific reason to the other party when the issue arises.

Upon request and free of charge, the member may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

13.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal. Written comments, documents, records and other information relating to the claim for benefits may be submitted. Appeals are investigated by persons who were not involved in the original decision.

When an investigation is finished, Delta Dental will send a written notice of the decision to the member, including the reason for the decision. The investigation will be completed and notice sent within 30 days of receipt of the appeal.

13.2.5 Second Level Appeal

A member who disagrees with the decision on the first level appeal may ask for a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of

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Delta Dental's action on the first level appeal. Investigations and responses to a second level appeal

will be by persons who were not involved in the initial decisions. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. Delta Dental will notify the member in writing of the decision, including the basis for the decision,

13.3 Benefits Available from Other Sources

Sometimes dental expenses may be the responsibility of someone other than the Plan.

13.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when a member has dental coverage under more than one plan.

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

13.3.1.1 Order of Benefit Determination (Which Plan Pays First?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, (e.g., an employee, member of an organization, primary insured or retiree) then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.

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iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
    A. Custodial parent
    B. Spouse or domestic partner of the custodial parent
    C. Non-custodial parent
    D. Spouse or domestic partner of the non-custodial parent

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.
e. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse/domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee (i.e., one who is neither laid off nor retired) or as that employee's dependent determines its benefits before those of a plan that covers the member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

13.3.1.2 How COB Works

The **primary plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **secondary plan** (the plan that pays benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first.
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan

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will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.

c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that the Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

13.3.1.3 Effect on the Benefits of This Plan

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

13.3.1.4 Definitions

For purposes of section 13.3.1, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
e. Other arrangements of insured or self-insured group or group-type coverage

Plan does not include:

a. Fixed indemnity coverage
b. Accident-only coverage
c. Specified disease or specified accident coverage
d. School accident coverage
e. Medicare supplement policies
f. Medicaid policies
g. Coverage under other federal governmental plans, unless permitted by law

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Each contract or other arrangement for coverage described above is a separate plan. If a plan has 2 parts and COB rules apply to only one of the 2, each of the parts is treated as a separate plan.

Complying plan is a plan that follows these COB rules.

Non-complying plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

Allowable expense means a dental expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

a. The amount of the reduction by the primary plan because a member has not complied with the plan's requirements concerning second opinions or prior authorization, or because the member has a lower benefit due to not using an in-network provider
b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology
c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees
d. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

This Plan is the part of this plan funded by the Group and provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of this group dental plan providing dental benefits is separate from this Plan. A group dental plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Closed panel plan is a plan that provides dental benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

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Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

13.3.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by the Plan. The Plan does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section 13.3.3 for motor vehicle accident recovery). Because recovery from a third party may be difficult and take a long time, as a service to the member the Plan will pay a member's expenses based on the understanding and agreement that the Plan is entitled to be reimbursed from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party, as defined below.

The member agrees that the Plan has the rights described in section 13.3.2. The Plan may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of recovery or subrogation as discussed in this section. The Plan has discretion to interpret and construe these recovery and subrogation provisions.

13.3.2.1 Definitions:

For purposes of section 13.3.2, the following definitions apply:

Benefits means any amount paid by the Plan, or submitted for payment to or on behalf of a member. Bills, statements or invoices submitted by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Third Party means any person or entity responsible for the injury or illness, or the aggravation of an injury or illness, of a member. Third party includes any insurer of such person or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection (PIP) coverage and workers' compensation insurance.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member.

13.3.2.2 Subrogation

Upon payment by the Plan, the Plan has the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan's provisions.

13.3.2.3 Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply to all recovery, except for those related to motor vehicle accidents (see section 13.3.3 for motor vehicle recovery rights):

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a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that illness or injury.

b. The Plan is entitled to receive the amount of benefits it has paid for an illness or injury out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, the Plan is entitled to receive the amount of benefits it has paid whether the dental expenses are itemized or expressly excluded in the third party recovery.

c. If the Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

d. This right of recovery includes the full amount of the benefits paid or pending payment by the Plan, out of any recovery made by the member from the third party, including without limitation any and all amounts paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. The Plan's recovery rights will not be reduced due to the member's own negligence.

e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.

13.3.2.4 Additional Provisions

Members shall comply with the following and agree that Delta Dental may do one or more of the following, at its discretion:

a. The member shall cooperate with Delta Dental to protect the Plan's recovery rights, including by:

   i. Signing and delivering any documents Delta Dental reasonably requires to protect the Plan's rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
   ii. Providing any information to Delta Dental relevant to the application of the provisions of section 13.3.2 including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.
   iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member's provider.
   iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing the Plan's third party recovery rights.

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b. The member and his or her representatives are obligated to notify Delta Dental in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party.

c. By accepting payment of benefits by the Plan, the member agrees that the Plan has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 13.3.2.

e. Even without the member's written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 13.3.2.

f. Section 13.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.

g. If the member continues to receive treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

h. If the member or the member's representatives fail to do any of the above mentioned acts, then the Plan has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any sickness, illness, injury or dental/medical condition resulting from the event giving rise to, or the allegations in, the third party claim, except for claims related to motor vehicle accidents (see section 13.3.3). The Plan may notify dental providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

i. Coordination of benefits (where the member has dental/medical coverage under more than one plan or health insurance policy) is not considered a third party claim.

13.3.3 Motor Vehicle Accident Recovery

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Delta Dental and motor vehicle insurance has not yet paid, then the Plan will advance benefits. The Plan retains the right to repayment of any benefits paid from the proceeds of any settlement, judgment or other payment received by the member that exceeds the amount that fully compensates the member for their motor vehicle accident related injuries.

If the Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

The member shall do whatever is proper to secure, and may not prejudice, the rights of the Plan under this section.

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SECTION 14. MISCELLANEOUS PROVISIONS

14.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the member must give or authorize a provider to give Delta Dental any information needed to pay benefits. Delta Dental may release to or collect from any person or organization any needed information about the member.

14.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Delta Dental. Protected health information includes enrollment, claims, and medical and dental information. Delta Dental uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Delta Dental does not sell this information. The Notice of Privacy Practices provides more detail about how the Group uses members' information. Delta Dental, as the claims administrator, is required to adhere to these same practices Members can contact the Group if they have additional questions about the privacy of their information beyond what is provided in the Notice of Privacy Practices.

14.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Delta Dental or the Plan, except that the Plan shall pay amounts due under the Plan directly to a provider upon a member's written request.

14.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If the Plan makes a payment for a member to which he or she is not entitled, or pays a person who is not eligible for payments at all, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Plan's right to recovery includes the right to deduct the amount paid from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

14.5 CORRECTION OF PAYMENTS

If benefits that this Plan should have paid are instead paid by another plan, the Plan may reimburse the other plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the Plan's liability.

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14.6 CONTRACT PROVISIONS

The agreement between the Group and Delta Dental including this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the agreement plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

14.7 WARRANTIES

All statements made by the Group or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining coverage will void the coverage or reduce benefits unless contained in a written form and signed by the Group or the member, a copy of which has been given to the Group or member or the member's beneficiary.

14.8 LIMITATION OF LIABILITY

Delta Dental shall incur no liability whatsoever to any member concerning the selection of dentists to provide services. In performing or contracting to perform dental service, such dentists shall be solely responsible, and in no case shall Delta Dental be liable for the negligence of any dentist providing such services. Nothing contained in the agreement between the Group and Delta Dental shall be construed as obligating Delta Dental to provide dental services.

14.9 PROVIDER REIMBURSEMENTS

Dentists contracting with Delta Dental to provide services to members agree to look only to **the Plan** for payment of the part of the expense that is covered by the Plan and may not bill the member in the event the Plan fails to pay the dentist for whatever reason. The dentist may bill the member for applicable cost sharing or non-covered expenses except as may be restricted in the provider contract.

14.10 INDEPENDENT CONTRACTOR DISCLAIMER

Delta Dental and participating dentists are independent contractors. Delta Dental and participating dentists do not have a relationship of employer and employee nor of principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of a participating dentist's provision of dental care to members may be deemed or construed to exist between Delta Dental and participating dentists. A participating dentist is solely responsible for the dental care provided to any member, and Delta Dental does not control the detail, manner or methods by which a participating dentist provides care.

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14.11 NO WAIVER

Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If the Plan delays or fails to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive the Plan's rights to enforce the provisions of the Plan.

14.12 GROUP IS THE AGENT

The Group is the members' agent for all purposes under the Plan. The Group is not the agent of Delta Dental.

14.13 GOVERNING LAW

To the extent the Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the state of Oregon.

14.14 WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of the Plan must be filed in either state or federal court in the state of Oregon.

14.15 TIME LIMIT FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against the Plan by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 13.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

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SECTION 15. CONTINUATION OF DENTAL COVERAGE

The following sections on continuation of coverage may apply. Members should check with their employer's Risk & Benefits Division to find out whether they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

15.1 OREGON CONTINUATION FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

15.1.1 Introduction

The Plan offers enrolled spouses and domestic partners the opportunity to request a temporary extension of dental coverage for themselves and their dependents if coverage is lost due to a specific event identified in the following paragraphs.

55+ Oregon Continuation only applies to employers with 20 or more employees. The Plan will provide 55+ Oregon Continuation coverage to those members who elect it, subject to the following conditions:

a. The Plan will offer no greater rights than ORS 743B.343 to 743B.345 requires
b. The Plan will not provide 55+ Oregon Continuation coverage for members who do not comply with the requirements outlined below
c. The Group or its designated third party administrator is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group or its designated third party administrator fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. The Group shall be responsible for such premiums.

Note: In section 15.1 the term "domestic partner" refers only to a registered domestic partner, as defined in 017.

15.1.2 Eligibility

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber
b. The spouse or domestic partner is 55 years of age or older at the time of such event
c. The spouse or domestic partner is not eligible for Medicare

15.1.3 Notice and Election Requirements

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a member who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

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Notice of Death. Within 30 days of the death of the subscriber, the Group shall give the designated third party administrator, if any, written notice of the death and the mailing address of the eligible surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), the Group or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse or domestic partner that coverage can be continued, along with an election form. If the Group or its designated third party administrator does not provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or domestic partner must return the election form within 60 days after the form is mailed. If the election is not made within 60 days of the notification, the member will lose the right to continued benefits under this section.

15.1.4 Premiums

Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premiums shall be paid by the surviving, legally separated or divorced spouse or domestic partner to the Group or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

15.1.5 When Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following events:

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan ends, unless a different group plan is made available to members
c. The date the member becomes insured under any other group dental plan
d. The date the member remarries or registers another domestic partnership
e. The date the member becomes eligible for Medicare.

15.2 COBRA CONTINUATION COVERAGE

15.2.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. Certain church plans are exempted from COBRA. The Plan will provide COBRA continuation coverage to members who have experienced a qualifying event and who elect coverage under COBRA, subject to the following conditions:

a. The Plan will offer no greater COBRA rights than the COBRA statute requires
b. The Plan will not provide COBRA coverage for members who do not comply with the notice, election or other requirements outlined below

For purposes of section 15.2, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

15.2.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment), or a reduction in hours.

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Spouse. The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Divorce or legal separation from the subscriber
d. The subscriber becomes entitled to Medicare

If it can be established that a subscriber has eliminated coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the COBRA Administrator within 60 days of the divorce or legal separation, COBRA coverage may be available for the period after the divorce or legal separation.

Children. A child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Parents' divorce or legal separation
d. Subscriber becomes entitled to Medicare
e. Child ceases to be a child under the Plan

Domestic Partners. A subscriber, who at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the subscriber is not an eligible member under COBRA and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ends immediately when the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Retirees. If the Plan provides retiree coverage and the subscriber's former employer files a Chapter 11 bankruptcy proceeding, this may be a qualifying event for the retiree who loses coverage as a result, and for his or her covered dependents.

15.2.3 Other Coverage

The right to elect continuation coverage shall be available to persons who are covered under another group dental plan at the time of the election.

15.2.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage ends as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the County's Risk and Benefits Division if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce); and 4) the date the event occurred. Notice

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must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

Election Notice. Members will be notified of their right to continuation coverage within 14 days after the COBRA Administrator receives a timely qualifying event notice.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct) or reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental coverage will end.

A subscriber or the spouse may elect continuation coverage for eligible family members. Each family member also has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the subscriber does not.

If COBRA is elected, the Group will provide the same coverage as is available to similarly situated members under the Plan.

15.2.5 COBRA Premiums

Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). Subsequent payments are due on the first day of the month. There will be a grace period of 30 days to pay the premiums. The Plan will not send a bill for any payments due. The member is responsible for paying the applicable premiums when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

15.2.6 Length of Continuation Coverage

18-Month Continuation Period. When coverage is lost due to end of employment or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. When coverage is lost due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for members (other than the subscriber) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months before the termination or reduction of hours.

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Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death. Coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

15.2.7 Extending the Length of COBRA Coverage

An extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member does not provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started before the 61st day after the subscriber's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the Social Security Administration determination is within the 18-month period following the subscriber's termination of employment or reduction of hours. The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

a. The date of the Social Security Administration's disability determination
b. The date of the subscriber's termination of employment or reduction of hours
c. The date on which the member loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours

If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

If determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

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This extension is only available if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the event. If this notice is not provided to the COBRA Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 15.1).

15.2.8 Newborn or Adopted Child

If, a child is born to or placed for adoption or as a foster child with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (e.g., age). The subscriber or a family member must notify the COBRA Administrator within 31 days of the birth or placement to obtain coverage. If the COBRA Administrator is not notified in the required timeframe, the child will not be eligible for coverage.

15.2.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses, or domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules (see sections 11.4 and 12.2), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

15.2.10 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. Any required premiums are not paid in full on time
b. A member becomes covered under another group dental plan
c. A member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. The Group ceases to provide any group dental plan for its employees
e. During a disability extension period (section 15.2.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

COBRA coverage may also be cancelled for any reason the Plan would terminate coverage of a member not receiving COBRA coverage (such as fraud).

Questions about COBRA should be directed to the COBRA Administrator. The COBRA Administrator should be informed of any address changes.

15.3 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will end if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber asks to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active

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members. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Group if released under honorable conditions, but only if he or she returns to active employment:

a. On the first full business day following completion of military service for a leave of 30 days or less
b. Within 14 days of completing military service for a leave of 31 to 180 days
c. Within 90 days of completing military service for a leave of more than 180 days

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility waiting period. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Group).

15.4 FAMILY AND MEDICAL LEAVE

Subscribers should check with the Group to find out if they qualify for this coverage. If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

a. Affected members will remain eligible for coverage during a family and medical leave.
b. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any group eligibility waiting period under the Plan will not have to be re-served.
c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

15.5 LEAVE OF ABSENCE

A leave of absence is a period off work granted by the Group at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the Group A leave can be granted for any reason acceptable to the Group. If a subscriber is on leave for a family and medical leave-qualifying reason (see section 15.44), he or she remains eligible on the plan only for the period of the family and medical leave. The subscriber may not also continue or extend coverage under this leave of absence provision.

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If granted a leave of absence by the Group, a subscriber may continue coverage for up to the amount of times specified by the Group. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

15.6 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the Group, directly to the union or trust, and the union or trust must continue to pay the Group the premiums when due.

Continuation of coverage during a strike or lockout will not occur if:

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. A subscriber accepts full-time employment with another employer
c. A subscriber otherwise loses eligibility under the Plan

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SECTION 16. ERISA

Subscribers are entitled to certain rights and protections if the Plan is subject to the Employee Retirement Income Security Act of 1974 (ERISA). Members should ask the Group if this section is applicable.

16.1 PLAN ADMINISTRATOR AS DEFINED UNDER ERISA

Delta Dental is not the plan administrator or the named fiduciary of the Plan, as defined under ERISA. Contact the Group for more information.

16.2 INFORMATION ABOUT THE PLAN AND BENEFITS

Subscribers may examine, without charge, at the Group's office and at other specified locations, such as worksites, all documents governing the Plan, including insurance contracts, collective bargaining agreements (if applicable), updated summary plan description, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (if any). This information can be obtained by written request. The Group may charge a reasonable amount for the copies.

Subscribers are entitled to receive a summary of the Plan's annual financial report, if any is required by ERISA. The Group is required by law to furnish each subscriber with a copy of this summary annual report.

16.3 CONTINUATION OF GROUP DENTAL PLAN COVERAGE

Subscribers are entitled to continue dental care coverage for themselves or their dependents if coverage under the Plan is lost as a result of a qualifying event. Members may have to pay for such coverage. Members should review this handbook and the documents governing the Plan regarding the rules governing continuation coverage rights.

16.4 PRUDENT ACTIONS BY PLAN FIDUCIARIES

In addition to creating rights for members, ERISA imposes duties upon the people who are responsible for the operation of the Plan. The people who operate the Plan, called fiduciaries of the Plan, have a duty to do so prudently and in the interest of members. No one, including the employer or any other person, may fire or discriminate against a subscriber in any way to prevent him or her from obtaining a benefit or exercising rights under ERISA.

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16.5 ENFORCEMENT OF RIGHTS

If a claim for benefits is denied or no action is taken, in whole or in part, members have a right to receive an explanation, to obtain without charge copies of documents relating to the decision, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps members can take to enforce these rights. For instance, if a copy of plan documents or the latest annual report is requested from the Group and not received within 30 days, a member may file suit in federal court. In such a case, the court may require the Group to provide the materials and pay the member up to $110 a day until he or she receives the materials, unless the materials were not sent because of reasons beyond the control of the Group. If a claim for benefits is denied or no action is taken, in whole or in part, a member may file suit in state or federal court after exhausting the appeal process required by the Plan (see section 13.2). In addition, a member who disagrees with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order may file suit in federal court.

If plan fiduciaries misuse the Plan's money, or if a member is discriminated against for asserting his or her rights, the member may seek assistance from U.S. Department of Labor or may file suit in federal court. The court will decide who should pay court costs and legal fees. If the member is successful, the court may order the person who has been sued to pay these costs and fees. If the member loses, the court may order him or her to pay these costs and fees, (e.g., if it finds the claim is frivolous).

16.6 ASSISTANCE WITH QUESTIONS

For questions about this section or a member's rights under ERISA, or for assistance obtaining documents from the Group, members should contact one of the following:

Employee Benefits Security Administration
Seattle District Office
300 Fifth Avenue, Suite 1110
Seattle, Washington 98104
206-757-6781

Office of Outreach, Education and Assistance
US Department of Labor
200 Constitution Avenue N.W.
Washington D.C., 20210
866-444-3272

Information and assistance is also available through their website: dol.gov/agencies/ebsa Members may obtain publications about their rights and responsibilities under ERISA by calling the Office of Outreach, Education and Assistance.

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SECTION 17. DEFINITIONS

Affidavit of Domestic Partnership is a signed document that attests the subscriber and one other eligible person meet the criteria in the affidavit to be unregistered domestic partners.

Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

Amalgam is a silver-colored material used in restoring teeth.

Anterior refers to teeth located at the front of the mouth (tooth chart in section 1818).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in section 1818).

Bridge is also called a fixed partial denture. A bridge replaces one or more missing teeth using a pontic (false tooth or teeth) permanently attached to the adjacent teeth. Retainer crowns (crowns placed on adjacent teeth) are considered part of the bridge.

Broken A tooth is considered broken when a piece or pieces of the tooth have been completely separated from the rest of the tooth. A tooth with cracks is not considered broken.

Cast Restoration includes crowns, inlays, onlays, and any other restoration to fit a specific member's tooth that is made at a laboratory or dental office and cemented into the tooth.

Coinsurance means the percentages of covered expenses to be paid by a member.

Composite is a tooth-colored material used in restoring teeth.

Cost Sharing is the share of costs a member must pay when receiving a covered service, including deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for non-participating providers or the cost of non-covered services.

Covered Service is a service that is specifically described as a benefit of the Plan.

Debridement is the removal of excess plaque. A periodontal 'pre-cleaning' procedure done when there is too much plaque for the dentist to perform an exam.

Deductible is the amount of covered expenses that are paid by a member before benefits are payable by the Plan.

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Delta Dental is the claims administrator of the Plan. A reference to Delta Dental as paying claims or issuing benefits means that Delta Dental processes the claim and the Group reimburses Delta Dental for any benefit issued.

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Dentally Necessary means services that, in the judgment of Delta Dental:

a. are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
b. are appropriate with regard to standards of good dental practice in the service area
c. have a good prognosis
d. are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately

The fact that a dentist may recommend or approve a service or supply does not, of itself, make the charge a covered expense.

Dentist means a licensed dentist, to the extent that he or she is operating within the scope of his or her license as required under law within the state of practice.

Denture Repair is a procedure done to fix a complete, immediate, or partial denture. This includes adding a tooth to a partial denture, replacing a broken tooth in a denture, or fixing broken framework and/or base.

Dependent means any person who is or may become eligible for coverage under the terms of the Plan because of a relationship to a subscriber.

Domestic Partner refers to a registered domestic partner and an unregistered domestic partner as follows:

a. **Registered Domestic Partner** means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.
b. **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Group's affidavit of domestic partnership.

Eligible Employee, means an employee or former employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see section 11.1).

Emergency Services means services for a dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. Includes services to treat the following conditions: acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked out tooth.

The **Group** is Clackamas County, the organization that has contracted with Delta Dental to provide claims and other administrative services. It also means the Plan Sponsor.

Group Health Plan means any plan, fund or program established and maintained by the Group for the purpose of providing healthcare for its employees or their dependents through insurance, reimbursement or otherwise. This dental benefit plan is a group health plan.

Implant is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jaw bone and supports a single crown, fixed bridge, or partial or full denture.

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Implant Abutment is an attachment used to connect an implant and an implant supported prosthetic device.

Implant Supported Prosthetic is a crown, bridge or removable partial or full denture that is supported by or attached to an implant.

Limited Exam is an examination of a specific oral health problem or complaint.

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers. For a participating Delta Dental Premier dentist, the maximum amount is the dentist's filed or contracted fee with Delta Dental. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to Delta Dental's Dental Consultant who determines a comparable code to the one billed. For non-participating dentists or dental care providers, the maximum amount is based on a non-participating dentist fee schedule. When using a non-participating dentist or dental care provider, any amount above the MPA is the member's responsibility.

Member means a subscriber or dependent of a subscriber who has enrolled for coverage under the terms of the Plan.

Non-participating Dentist or Dental Provider means a licensed dental provider who has not agreed to the terms and conditions established by Delta Dental that participating Delta Dental Premier dentists have agreed to.

Participating Delta Dental Premier Dentist means a licensed dentist who has agreed to provide services in the Delta Dental Premier network in accordance with terms and conditions established by Delta Dental and has satisfied Delta Dental that he or she is in compliance with such terms and conditions.

Periodic Exam is a routine exam (check-up), commonly performed every 6 months.

Periodontal Maintenance is a periodontal procedure for members who have previously been treated for periodontal disease. In addition to cleaning the visible surfaces of the teeth (as in prophylaxis) surfaces below the gum-line are also cleaned. This is a more comprehensive service than a regular cleaning (prophylaxis).

The **Plan** is the dental benefit plan sponsored and funded by the Group and Delta Dental is contracted to provide claims and other administrative services.

Plan Sponsor means the Group.

Pontic is an artificial tooth that replaces a missing tooth and is part of a bridge.

Posterior refers to teeth located toward the back of the mouth (tooth chart in section 1818).

Prophylaxis is cleaning and polishing of all teeth.

Reline means the process of resurfacing the tissue side of a denture with new base material.

Restoration is the treatment that repairs a broken or decayed tooth. Restorations include, but are not limited to, fillings and crowns.

2021 DRAFT

Retainer is a tooth used to support a prosthetic device (bridges, partial dentures or overdentures). Also see **Implant Abutment.**

Subscriber means any employee or former employee who is enrolled in the Plan.

Veneer is a layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A **chairside veneer** is a restoration created in the dentist's office. A **laboratory veneer** is a restoration that is created (cast) at a laboratory. Chairside and laboratory veneers may be paid at different benefit levels.

Waiting Period means the period that must pass before a person is eligible to enroll for benefits under the terms of the Plan.

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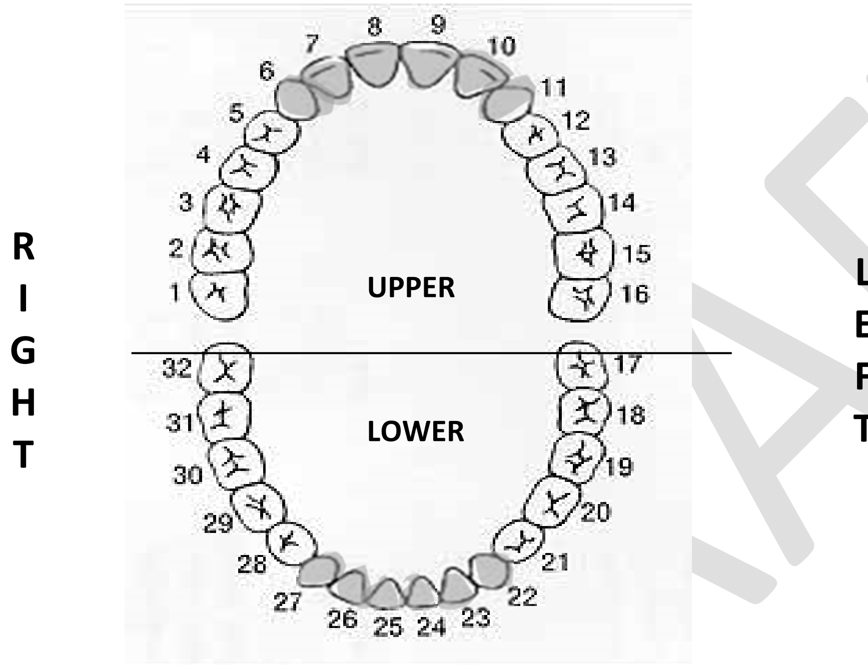
SECTION 18. TOOTH CHART

The Permanent Arch



Anterior teeth are shaded gray.

The Permanent Arch		
Tooth #		Description of Tooth
Upper	Lower	
1	17	3rd Molar (wisdom tooth)
2	18	2nd Molar (12-yr molar)
3	19	1st Molar (6-yr molar)
4	20	2nd Bicuspid (2nd premolar)
5	21	1st Bicuspid (1st premolar)
6	22	Cuspid (canine/eye tooth)
7	23	Lateral Incisor
8	24	Central Incisor
9	25	Central Incisor
10	26	Lateral Incisor
11	27	Cuspid (canine/eye tooth)
12	28	1st Bicuspid (1st premolar)
13	29	2nd Bicuspid (2nd premolar)
14	30	1st Molar (6-yr molar)
15	31	2nd Molar (12-yr molar)
16	32	3rd Molar (wisdom tooth)

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

888-374-8906 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 60667319 (10/19)

DELTA DENTAL
Delta Dental of Oregon & Alaska

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hổ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d’assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ប្រុងប្រយ័ត្ន៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta’e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA’AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala’au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

Delta Dental of Oregon & Alaska

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For help, call us directly at 888-217-2365
(En Español: 877-299-9063)

P.O. Box 40384
Portland, OR 97240

Oregon Group Dental Plan

Clackamas County
(Peace Officers Association)
Delta Dental Premier Plan

Effective date: January 1, 2021
Group number: 10000174

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

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SECTION 1. WELCOME

This handbook describes the main features of the Group's dental plan (the "Plan"), but does not waive any of the conditions of the Plan as set out in the Plan Document.

The Plan is self-funded and the Group has contracted with Delta Dental Plan of Oregon (abbreviated as Delta Dental) to provide claims and other administrative services.

Members may direct questions to one of the numbers listed in section 2.1 or access tools and resources on Delta Dental's personalized member website, Member Dashboard, at www.deltadentalor.com. Member Dashboard is available 24 hours a day, 7 days a week allowing members to access plan information whenever it is convenient.

Delta Dental reserves the right to monitor telephone conversations and email communications between its employees and its members for legitimate business purposes as determined by Delta Dental.

The Group may change or replace this handbook at any time without the consent of any member. The most current handbook is available on Member Dashboard, accessed through the Delta Dental website. All plan provisions are governed by the Group's agreement with Delta Dental. This handbook may not contain every plan provision.

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SECTION 2. MEMBER RESOURCES

2.1 CONTACT INFORMATION

Delta Dental Website (log in to **Member Dashboard**)
www.DeltaDentalOR.com
Includes many helpful features, such as Find Care (use to find a participating dentist)

Dental Customer Service Department
Toll-free 888-217-2365
En Español 877-299-9063

Telecommunications Relay Service for the hearing impaired
711

Delta Dental
P.O. Box 40384
Portland, Oregon 97240

2.2 MEMBERSHIP CARD

After enrolling, members will receive ID (identification) cards that will include the group and identification numbers. Members will need to present the card each time they receive services. Members may go to Member Dashboard or contact Customer Service for replacement of a lost ID card.

2.3 NETWORK

See Network Information (section 3.1) for details about how networks work.

Dental network
Delta Dental Premier Network

2.4 OTHER RESOURCES

Additional member resources providing general information about the Plan can be found in section 11 and section 13.

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SECTION 3. USING THE PLAN

For questions about the Plan, members should contact Customer Service. This handbook describes the benefits of the Plan. It is the member's responsibility to review this handbook carefully and to be aware of the Plan's limitations and exclusions.

At a first appointment, members should tell the dentist that they have dental benefits administered by Delta Dental. Members will need to provide their subscriber identification number and Delta Dental group number to the dentist. These numbers are located on the ID card.

3.1 NETWORK INFORMATION

Delta Dental plans are easy to use and cost effective. If members choose a participating Delta Dental Premier dentist from the Delta Dental Premier Dental Directory (available on Member Dashboard by using Find Care), all of the paperwork takes place between Delta Dental and the dentist's office. 89% of all licensed dentists in Oregon are participating Delta Dental Premier dentists. For members outside Oregon, Delta Dental's national affiliation with Delta Dental Plans Association provides offices and/or contacts in every state. Also, dental claims incurred any place in the world may be processed in Oregon.

Members needing dental care may go to any dental office. However, there are differences in reimbursement by the Plan for participating Delta Dental Premier dentists and non-participating dentists or dental care providers. While a member may choose the services of any dentist, Delta Dental does not guarantee the availability of any particular dentist.

3.1.1 Non-Participating Dentists

Payment to a non-participating dentist or dental care provider is paid at the applicable coinsurance and is limited to the non-participating dentist fee schedule. The allowable fee in states other than Oregon will be that state's Delta Affiliate's non-participating dentist allowance. The member may have to pay the difference between the maximum allowed amount and the billed charge.

3.2 PREDETERMINATION OF BENEFITS

For expensive treatment plans, Delta Dental provides a predetermination service. The dentist may submit a predetermination request to get an estimate of what the Plan would pay. The predetermination will be processed according to the Plan's current benefits and returned to the dentist. The member and his or her dentist should review the information before beginning treatment.

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SECTION 4. DEFINITIONS

Affidavit of Domestic Partnership is a signed document that attests the subscriber and one other eligible person meet the criteria in the affidavit to be unregistered domestic partners.

Alveoloplasty is the surgical shaping of the bone of the upper or the lower jaw. It is performed most commonly in conjunction with the removal of a tooth or multiple teeth to have the gums heal smoothly for the placement of partial denture or denture.

Amalgam is a silver-colored material used in restoring teeth.

Anterior refers to teeth located at the front of the mouth (tooth chart in section 13).

Bicuspid is a premolar tooth, between the front and back teeth (tooth chart in section 13).

Bridge is also called a fixed partial denture. A bridge replaces one or more missing teeth using a pontic (false tooth or teeth) permanently attached to the adjacent teeth. Retainer crowns (crowns placed on adjacent teeth) are considered part of the bridge.

Broken A tooth is considered broken when a piece or pieces of the tooth have been completely separated from the rest of the tooth. A tooth with cracks is not considered broken.

Cast Restoration includes crowns, inlays, onlays, and any other restoration to fit a specific member's tooth that is made at a laboratory or dental office and cemented into the tooth.

Coinsurance means the percentages of covered expenses to be paid by a member.

Composite is a tooth-colored material used in restoring teeth.

Cost Sharing is the share of costs a member must pay when receiving a covered service, including deductible, copayments or coinsurance. Cost sharing does not include premiums, balance billing amounts for non-participating providers or the cost of non-covered services.

Covered Service is a service that is specifically described as a benefit of the Plan.

Debridement is the removal of excess plaque. A periodontal 'pre-cleaning' procedure done when there is too much plaque for the dentist to perform an exam.

Deductible is the amount of covered expenses that are paid by a member before benefits are payable by the Plan.

Delta Dental refers to Delta Dental Plan of Oregon. Delta Dental Plan of Oregon is a business name used by Oregon Dental Service, a not-for-profit dental healthcare service contractor. Delta Dental is the claims administrator of the Plan. A reference to Delta Dental as paying claims or issuing benefits means that Delta Dental processes the claim and the Group reimburses Delta Dental for any benefit issued.

Dentally Necessary means services that, in the judgment of Delta Dental:

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a. are established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
b. are appropriate with regard to standards of good dental practice in the service area
c. have a good prognosis
d. are the least costly of the alternative supplies or levels of service that can be safely provided. For example, coverage would not be allowed for a crown when a filling would be adequate to restore the tooth appropriately

The fact that a dentist may recommend or approve a service or supply does not, of itself, make the charge a covered expense.

Dentist means a licensed dentist, to the extent that he or she is operating within the scope of his or her license as required under law within the state of practice.

Denture Repair is a procedure done to fix a complete, immediate, or partial denture. This includes adding a tooth to a partial denture, replacing a broken tooth in a denture, or fixing broken framework and/or base.

Dependent means any person who is or may become eligible for coverage under the terms of the Plan because of a relationship to a subscriber.

Domestic Partner refers to a registered domestic partner and an unregistered domestic partner as follows:

a. **Registered Domestic Partner** means a person joined with the subscriber in a partnership that has been registered under the laws of any federal, state or local government.
b. **Unregistered Domestic Partner** means a person who has entered into a partnership with the subscriber that meets the criteria in the Group's affidavit of domestic partnership.

Eligible Employee, means an employee or former employee of the Group who meets the eligibility requirements to be enrolled on the Plan (see section 8.1).

Emergency Services means services for a dental condition manifesting itself by acute symptoms of sufficient severity requiring immediate treatment. Includes services to treat the following conditions: acute infection, acute abscess, severe tooth pain, unusual swelling of the face or gums or a knocked out tooth.

The **Group** is Clackamas County, the organization that has contracted with Delta Dental to provide claims and other administrative services. It also means the Plan Sponsor.

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Implant is an artificial, permanent tooth root replacement used to replace a missing tooth or teeth. It is surgically placed into the upper or lower jaw bone and supports a single crown, fixed bridge, or partial or full denture.

Implant Abutment is an attachment used to connect an implant and an implant supported prosthetic device.

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Implant Supported Prosthetic is a crown, bridge or removable partial or full denture that is supported by or attached to an implant.

Limited Exam is an examination of a specific oral health problem or complaint.

Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse providers. For a participating Delta Dental Premier dentist, the maximum amount is the dentist's filed or contracted fee with Delta Dental. If the database does not contain a fee for a particular procedure in a particular area, the claim is referred to Delta Dental's Dental Consultant who determines a comparable code to the one billed. For non-participating dentists or dental care providers, the maximum amount is based on a non-participating dentist fee schedule. When using a non-participating dentist or dental care provider, any amount above the MPA is the member's responsibility.

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The **Plan** is the dental benefit plan sponsored and funded by the Group and Delta Dental is contracted to provide claims and other administrative services.

Plan Sponsor means the Group.

Pontic is an artificial tooth that replaces a missing tooth and is part of a bridge.

Posterior refers to teeth located toward the back of the mouth (tooth chart in section 13).

Prophylaxis is cleaning and polishing of all teeth.

Reline means the process of resurfacing the tissue side of a denture with new base material.

Restoration is the treatment that repairs a broken or decayed tooth. Restorations include, but are not limited to, fillings and crowns.

Retainer is a tooth used to support a prosthetic device (bridges, partial dentures or overdentures). Also see **Implant Abutment.**

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Subscriber means any employee or former employee who is enrolled in the Plan.

Veneer is a layer of tooth-colored material attached to the surface of an anterior tooth to repair chips or cracks, fix gaps and change the shape and size of teeth. A **chairside veneer** is a restoration created in the dentist's office. A **laboratory veneer** is a restoration that is created (cast) at a laboratory. Chairside and laboratory veneers may be paid at different benefit levels.

Waiting Period means the period that must pass before a person is eligible to enroll for benefits under the terms of the Plan.

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SECTION 5. BENEFITS AND LIMITATIONS

The Plan covers the services listed when performed by a dentist or dental care provider (licensed denturist or licensed hygienist), and only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). Delta Dental's dental consultants and dental director shall determine these standards.

Payment of covered expenses is always limited to the maximum plan allowance. In no case will benefits be paid for services provided beyond the scope of a dentist's or dental care provider's license, certificate or registration. Services covered under the medical portion of a member's plan will not be covered on this Plan except when related to an accident.

Covered dental services are outlined in 4 classes that start with preventive care and advance into basic and major dental procedures. Limitations may apply to these services, and are noted below. See section 77 for exclusions.

All annual or per year benefits or cost sharing accrue based on a calendar year (January 1 through December 31) or portion thereof. Frequency limitations are calculated from the previous date of service or initial placement, unless otherwise specified.

Deductible: $0

Annual maximum plan payment limit: $1,500

Per member per year, or portion thereof.

All covered services except and orthodontia apply to the annual maximum plan payment limit.

Members are responsible for expenses that exceed the annual maximum plan payment limit.

5.1 CLASS I

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE IN THE FIRST YEAR A MEMBER IS COVERED

Payment increases by 10% each successive year. To qualify for this increase, the member must visit the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment will never drop below the starting percentage.

Class I services will be paid at 100% at the end of 3 years, assuming at least one visit to the dentist each of these years.

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5.1.1 Diagnostic

a. Diagnostic Services:

i. Examination
ii. Intra-oral x-rays to assist in determining required dental treatment.

b. Diagnostic Limitations:

i. Periodic (routine) or comprehensive examinations or consultations are covered twice per year
ii. Limited examinations or re-evaluations are covered twice per year
iii. A separate charge for teledentistry is not covered. Teledentistry is included in the fees for overall patient management.
iv. Complete series x-rays or a panoramic film is covered once in any 5-year period
v. Supplementary bitewing x-rays are covered once in any 12-month period
vi. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered
vii. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing

5.1.2 Preventive

a. Preventive Services:

i. Prophylaxis (cleanings)
ii. Periodontal maintenance
iii. Topical application of fluoride
iv. Interim caries arresting medicament application
v. Sealants
vi. Space maintainers

b. Preventive Limitations:

i. Prophylaxis (cleaning) or periodontal maintenance is covered twice per year.† Additional periodontal maintenance is covered for members with periodontal disease. See section 8.2.4 for more information.
ii. Adult prophylaxis is only covered for members age 12 and over. Child prophylaxis is covered for members under age 12.
iii. Topical application of fluoride is covered twice per year for members under age 19. For members age 19 and over, topical application of fluoride is covered twice per year if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
iv. Interim caries arresting medicament application is covered twice per tooth per year.
v. Sealant benefits are limited to the unrestored occlusal surfaces of permanent molars. Benefits will be limited to one sealant per tooth during any 5-year period.
vi. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth or missing permanent teeth are not covered.

†Additional cleaning benefit is available for members with diabetes and members in their third trimester of pregnancy. To be eligible for this additional benefit, members must be enrolled in the Oral Health, Total Health program (see section 6.1).

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5.2 Class II

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE IN THE FIRST YEAR A MEMBER IS COVERED

Payment increases by 10% each successive year. To qualify for this increase, the member must visit the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment will never drop below the starting percentage.

Class II services will be paid at 100% at the end of 3 years, assuming at least one visit to the dentist each of these years.

5.2.1 Restorative

a. Restorative Services:

i. Amalgam fillings and composite fillings for the treatment of decay
ii. Stainless steel crowns

b. Restorative Limitations:

i. Inlays are considered an optional service. An alternate benefit of a composite filling will be provided.
ii. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
iii. Replacement of a stainless steel crown by the same dentist within a 2-year period of placement is not covered. The replacement is included in the charge for the original crown.
iv. Additional limitations when teeth are restored with crowns or cast restorations are in section 5.3.1.
v. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered, except as provided in section 5.2.5

5.2.2 Oral Surgery

a. Oral Surgery Services:

i. Extractions (including surgical)
ii. Other minor surgical procedures

b. Oral Surgery Limitations:

i. A separate, additional charge for alveoloplasty done in conjunction with surgical removal of teeth is not covered.
ii. Surgery on larger lesions or malignant lesions is not considered minor surgery.
iii. A separate charge for post-operative care done within 30 days following an oral surgery is not covered. Post-operative care is included in the charge of the original surgery.
iv. Brush biopsy is covered twice per year. Benefits are limited to the sample collection and do not include coverage for pathology (lab) services.

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5.2.3 Endodontic

a. Endodontic Services:

i. Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

b. Endodontic Limitations:

i. A separate charge for cultures is not covered.
ii. A separate charge for pulp removal done with a root canal or root repair is not covered.
iii. A separate charge for pulp capping is not covered Pulp capping is considered to be included in the fee for the final restoration.Retreatment of the same tooth by the same dentist within a 2-year period of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

5.2.4 Periodontic

a. Periodontic Services:

i. Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

b. Periodontic Limitations:

i. Periodontal scaling and root planing is limited to once every 6 months.
ii. Periodontal maintenance is covered under Class I, Preventive.
iii. A separate charge for post-operative care done within 6 months following periodontal surgery is not covered.
iv. Osseous surgery is covered for a maximum of 2 quadrants per visit.
v. Additional periodontal surgical procedures by the same dentist to the same site within a 3-year period of an initial periodontal surgery are not covered.
vi. Full mouth debridement is limited to once in a 2-year period and, if the member is age 19 or older, only if there has been no cleaning (prophylaxis, periodontal maintenance) within a 2-year period.

5.2.5 Anesthesia Services

a. General anesthesia or IV sedation
Covered only:

i. In conjunction with covered surgical procedures performed in a dental office
ii. When necessary due to concurrent medical conditions

5.3 CLASS III

COVERED SERVICES PAID AT 70% OF THE MAXIMUM PLAN ALLOWANCE IN THE FIRST YEAR A MEMBER IS COVERED

Payment increases by 10% each successive year. To qualify for this increase, the member must visit the dentist at least once during the year. Failure to do so will cause a 10% reduction in payment for the next year, although payment will never drop below the starting percentage.

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Class III services will be paid at 100% at the end of 3 years, assuming at least one visit to the dentist each of these years.

5.3.1 Restorative

a. Restorative Services:

i. Cast restorations, such as crowns*, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

b. Restorative Limitations:

i. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See 5.2.1 for limitations on buildups.
ii. Crowns for patients under age 16 are not covered. However, crowns for patients under age 16 may be covered upon review for medical necessity.
iii. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and the member is responsible for paying the difference.
iv. If a tooth can be restored by an amalgam or composite filling, but another type of restoration is selected by the member or dentist, covered expense will be limited to a composite. Crowns are only a benefit if the tooth cannot be restored by a routine filling.
v. Re-cement or re-bond of a crown, inlay, or veneer, by the same dentist, is limited to once per lifetime.

* **Note:** Crowns are covered at 70% under the Preventive Plan.

5.4 CLASS IV

COVERED SERVICES PAID AT 50% OF THE MAXIMUM PLAN ALLOWANCE

There is no 10% increase provision.

5.4.1 Prosthodontic

a. Prosthodontic Services:

i. Bridges
ii. Partial and complete dentures
iii. Denture relines
iv. Repair of an existing prosthetic device
v. Implants and implant maintenance
vi. Surgical stent in conjunction with a covered surgical procedure

b. Prosthodontic Limitations:

i. A bridge or a full or partial denture will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.

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ii. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
iii. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of members age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture retainer teeth unless the tooth requires a cast restoration due to being decayed or broken.
iv. Denture adjustments, repairs, and relines*:* A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines are covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
v. Tissue conditioning is covered no more than twice per denture in a 3-year period.
vi. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. Scaling and debridement of an implant is covered once in a 2-year period. Implant maintenance is limited to once every 3 years, except when dentally necessary. The Plan will also cover:
    A. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
    B. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (once in any 7-year period); or
    C. The final implant-supported bridge retainer and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space over the lifetime of the implant.
    D. Implant-supported bridges are not covered if 1 or more of the retainers is supported by a natural tooth.
    E. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.
vii. Fixed bridges or removable cast partial dentures are not covered for members under age 16.
viii. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. The member is responsible for paying the difference.

5.4.2 Other

a. Other Services:
i. Athletic mouthguard
ii. Orthodontia for correcting malocclusioned teeth when necessity is established through an in-person clinical examination of the member

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b. Other Limitations:

i. An athletic mouthguard is covered once in any 12-month period for members age 15 and under and once in any 2-year period for age 16 and over. These time periods are calculated from the previous date of service. Over-the-counter athletic mouthguards are excluded.

ii. Orthodontia is covered only for children. Treatment must begin prior to their 17th birthday.

iii. Lifetime maximum of $3,000 per member for orthodontic services. This maximum is not included in the annual maximum plan payment limit. Any deductible is waived.

iv. Pre-orthodontic treatment exam is part of the comprehensive orthodontic treatment plan.

v. Self-administered orthodontics are not covered.

vi. Payment for orthodontia will end when treatment stops for any reason prior to completion, or upon termination of eligibility or of the Plan. If treatment began before the member was eligible under the Plan, the Plan will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

vii. Repair or replacement of an appliance furnished under the Plan is not covered

viii. A separate charge for a retainer, or the repair or replacement of an appliance furnished under the Plan is not covered

ix. A separate charge for translation or sign language service is not covered. Translation or sign language service is included in the fees for overall patient management.

5.5 GENERAL LIMITATION – OPTIONAL SERVICES

If a more expensive treatment than is functionally adequate is performed, the Plan will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will be responsible for the remainder of the dentist's fee.

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SECTION 6. ORAL HEALTH, TOTAL HEALTH BENEFITS

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the body healthy. Studies have shown a relationship between periodontal disease, bacteria in the mouth, and various health problems including pre-term, low birth weight babies and diabetes.

6.1 ORAL HEALTH, TOTAL HEALTH BENEFITS

The Plan has a program that provides additional cleanings (prophylaxis or periodontal maintenance) for members based on this evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in 0.

6.1.1 Diabetes

For members with diabetes, elevated blood sugar levels can have a negative effect on oral health. Diabetes increases the risk of cavities, gum disease, tooth loss, dry mouth and infection. Poor oral health can make diabetes more difficult to manage. Infections may cause blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes.

Diabetic members are eligible for a total of 4 cleanings per year.

6.1.2 Pregnancy

Keeping the mouth healthy during a pregnancy is important for a member and the baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Data also suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant members are eligible for a cleaning in the third trimester of pregnancy regardless of when they had a previous cleaning.

6.2 HOW TO ENROLL

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member can contact Customer Service or complete and return the Oral Health, Total Health enrollment form found on Member Dashboard. Members with diabetes must include proof of diagnosis.

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SECTION 7. EXCLUSIONS

In addition to the limitations and exclusions described elsewhere in the Plan, the following services, procedures and conditions are not covered, even if otherwise dentally necessary, if they relate to a condition that is otherwise covered by the Plan, or if recommended, referred or provided by a dentist or dental care provider.

Analgesics
Substances used for the purpose of pain relief

Anesthesia or Sedation
Local anesthetics, nitrous oxide, general anesthesia and/or IV sedation except as stated in section 5.2.5

Behavior Management
Additional services, time or assistance to control the actions of a member

Benefits Not Stated
Services or supplies not specifically described in this handbook as covered services

Congenital or Developmental Malformations
Including treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia and fluorosis (discoloration of teeth).

Coping
A thin covering over the visible part of a tooth, usually without anatomic conformity

Cosmetic Services
Services and supplies for the primary purpose of improving or changing appearance, such as tooth bleaching and enamel microabrasion

Duplication and Interpretation of X-rays or Records

Experimental or Investigational Procedures
Including expenses incidental to or incurred as a direct consequence of such procedures

Facility Fees
Including additional fees charged by the dentist for hospital, extended care facility or home care treatment

Gnathologic Recordings
Services to observe the relationship of opposing teeth, including occlusion analysis

Hypnosis

Illegal Acts
Services and supplies for treatment of an injury or condition caused by or arising directly from a member’s illegal act. This includes any expense caused by or arising out of illegal acts related to riot, declared or undeclared war, including civil war, martial law, insurrection, revolution,

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invasion, bombardment or any use of military force or usurped power by any government, military or other authority.

Inmates
Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison

Instructions or Training
Including tobacco cessation counseling, plaque control and oral hygiene or dietary instruction

Localized Delivery of Antimicrobial Agents
Time released antibiotics to remove bacteria from below the gumline

Maxillofacial Prosthetics
Except for surgical stents as stated in section 5.4.1

Medications

Missed Appointment Charges

Never Events
Services and supplies related to never events. These are events that should never happen while receiving services in a dental office, including removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

Orthodontia
Except as provided for children

Over the Counter
Including over the counter occlusal guards and athletic mouthguards

Periodontal Charting
Measuring and recording the space between a tooth and the gum tissue

Precision Attachments
Devices to stabilize or retain a prosthesis when seated in the mouth

Rebuilding or Maintaining Chewing Surface; Stabilizing Teeth
Including services only to prevent wear or protect worn or cracked teeth, except athletic mouthguards as provided in 5.4.2. Excluded services include increasing vertical dimension, equilibration, nightguards (occlusal guards) and periodontal splinting.

Self-Treatment
Services provided by a member to herself or himself

Service Related Conditions
Treatment of any condition caused by or arising out of a member's service in the armed forces of any country or as a military contractor or from an insurrection or war, unless not covered by the member's military or veterans coverage.

Services on Tongue, Lip, or Cheek

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Services Otherwise Available
Including those services or supplies:

a. compensable under workers' compensation or employer's liability laws
b. provided by any city, county, state or federal law, except for Medicaid coverage
c. provided without cost to the member by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under the Plan
d. provided under separate contracts that are used to provide coordinated coverage for covered persons in a group and are considered parts of the same plan

Taxes

Third Party Liability Claims
Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party (see section 10.3.2)

TMJ
Treatment of any disturbance of the temporomandibular joint (TMJ)

Treatment After Coverage Ends
The only exception is for Class III services that were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after a member’s eligibility ends. This exception is not applicable if the Group transfers its plan to another carrier.

Treatment Before Coverage Begins

Treatment Not Dentally Necessary
Including services:

a. not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under the Plan
b. that are inappropriate with regard to standards of good dental practice
c. with poor prognosis

Treatment of Closed Fractures

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SECTION 8. ELIGIBILITY

The date a person becomes eligible may be different than the date coverage begins (see section 9.5).

8.1 SUBSCRIBER

A person is eligible to enroll in the Plan if he or she:

a. is a permanent documented full time or part time employee, an employee in a job share position, a non-represented job share employee with benefit dollar allowance, or a retiree of Clackamas County
b. works for the Group on a regularly scheduled basis working the minimum number of hours per week required for that job position;
c. is not a seasonal, substitute, or temporary employee, or an agent, consultant, or independent contractor or leased worker
d. is paid on a regular basis through the payroll system, has federal taxes deducted from such pay, and is reported to Social Security
e. satisfies any orientation and/or eligibility waiting period

Subscribers are eligible to remain enrolled if they are on an approved leave of absence under state or federal family and medical leave laws. Members should check with the Group's benefits manager to find out whether they qualify for this provision.

8.2 DEPENDENTS

A subscriber's legal spouse or domestic partner is eligible for coverage. A subscriber's children are eligible until their 26th birthday. Children eligible due to a court or administrative order are also subject to the Plan's child age limit. Foster children are eligible only while legally a foster child.

For purposes of determining eligibility, the following are considered children:

a. The biological, adopted or foster child of a subscriber or a subscriber's eligible spouse or domestic partner
b. Children placed for adoption with a subscriber. Adoption paperwork must be provided
c. A newborn child of an enrolled dependent for the first 31 days of the newborn's life
d. Children related to a subscriber by blood or marriage for whom the subscriber is the legal guardian. A court order showing legal guardianship must be provided

A subscriber's child who has sustained a disability making him or her physically or mentally incapable of self-support at even a sedentary level may be eligible for coverage even though he or she is over 26 years old. To be eligible, the child must be unmarried and principally dependent on the subscriber for support and have had continuous dental coverage. The incapacity must have started, and the information below must be received, before the child's 26th birthday. Social Security Disability status does not guarantee coverage under this provision. The Plan will determine eligibility based on commonly accepted guidelines. To avoid a break in coverage, it is recommended that the following information be submitted to Delta Dental at least 45 days before the child's 26th birthday:

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a. Recent medical or psychiatric progress notes and evaluations, referrals or consult notes
b. Relevant test results (e.g., lab, imaging, neuro-psychiatric testing, etc.)
c. Relevant recent hospitalization records (e.g., history and physical, discharge summary) if applicable
d. Disability information from prior carrier

The Plan will make an eligibility determination based on documentation of the child's medical condition. Periodic review by Delta Dental will be required on an ongoing basis except in cases where the disability is certified to be permanent.

8.3 QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Plan will cover a child of an eligible employee who has a right to enrollment due to a qualified medical child support order (QMCSO). The Plan has detailed procedures for determining whether an order qualifies as a QMCSO. A copy of such procedures is available from the Group without charge.

The child's coverage under the Plan will be effective as of the first day of the month following the date that the Group determines that the applicable order qualifies as a QMCSO and that the child is eligible for enrollment in the Plan.

8.4 NEW DEPENDENTS

A new dependent may cause a premium increase. Premiums will be adjusted accordingly and will apply from the date coverage is effective.

If a subscriber marries or registers a domestic partnership, the spouse or domestic partner and his or her children are eligible to enroll as of the date of the marriage or registration.

If a subscriber files an Affidavit of Domestic Partnership with the Group, the domestic partner and his or her children are eligible for coverage.

A member's newborn child is eligible from birth. A subscriber's adopted child, or child placed for adoption or as a foster child is eligible on the date of placement. To enroll a new child, an online enrollment application must be submitted. The application and payment must be submitted within 31 days. If the application and payment is not received timely, the child will not be covered. Proof of legal guardianship will be required for coverage of a grandchild beyond the first 31 days from birth.

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SECTION 9. ENROLLMENT

9.1 ENROLLING ELIGIBLE EMPLOYEES

Application for coverage may be submitted online for the eligible employee and any dependents to be enrolled must be filed with the Group within 15 days of becoming eligible to apply for coverage. Eligible employees can apply on the date of hire or the end of any required waiting period.

The subscriber must notify the Group of any change of address.

9.2 ENROLLING NEW DEPENDENTS

To enroll a new dependent, just complete the online enrollment application with the Group within 60 days of their eligibility. The subscriber must notify Delta Dental if family members are added or dropped from coverage, even if it does not affect premiums.

9.3 OPEN ENROLLMENT

If an eligible employee and/or any eligible dependents are not enrolled within 15 days of first becoming eligible, they must wait for the next open enrollment period to enroll unless:

a. The person qualifies for special enrollment as described in section 8.4
b. A court has ordered that coverage be provided for a spouse or minor child under a subscriber's insurance plan and a request for enrollment is made within 30 days after the court order is issued

Open enrollment occurs once a year at renewal.

9.4 SPECIAL ENROLLMENT RIGHTS

The special enrollment rights described in sections 9.4.1 and 9.4.2 apply:

a. To an eligible employee who loses other coverage or becomes eligible for a premium assistance subsidy
b. To a subscriber's dependent who loses other coverage or becomes eligible for a premium assistance subsidy
c. To both the eligible employee and his or her dependent if neither is enrolled under the Plan, and either loses other coverage or becomes eligible for a premium assistance subsidy

To enroll, an eligible employee must submit a complete and signed application and supporting documentation within the required timeframe.

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9.4.1 Loss of Other Coverage

If coverage is declined when initially eligible or at an open enrollment period because of other dental coverage, an eligible employee or any dependents may enroll in the Plan outside of the open enrollment period if the following criteria are met:

a. He or she was covered under a group dental plan or had dental coverage at the time coverage was previously offered
b. He or she stated in writing at such time that coverage under a group dental plan or dental coverage was the reason enrollment was declined
c. He or she requests such enrollment not later than 60 days after the previous coverage ended
d. One of the following events has occurred:
    i. His or her prior coverage was under a COBRA continuation provision and the coverage under such provision was exhausted
    ii. His or her prior coverage ended as a result of loss of eligibility for the coverage. Examples of when coverage under a plan may be lost include:
        A. legal separation or divorce
        B. loss of dependent status per plan terms
        C. death
        D. end of employment or reduction in the number of hours of employment
        E. reaching the lifetime maximum on all benefits
        F. the plan stops offering coverage to a group of similarly situated persons
        G. moving out of an HMO service area that causes coverage to end and no other option is available under the plan
        H. termination of the benefit package option, and no substitute option is offered
    iii. The employer contributions toward his or her other active (not COBRA) coverage end. If employer contributions stop, the eligible employee or dependent does not have to end coverage to be eligible for special enrollment on a new plan.
    iv. His or her prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage ended due to loss of eligibility. Special enrollment must be requested within 60 days of the end of coverage.

9.4.2 Eligibility for Premium Subsidy

If an eligible employee or dependent covered under Medicaid or CHIP becomes eligible for a premium assistance subsidy, and special enrollment is requested within 60 days of the determination of eligibility, they may enroll in the Plan outside of the open enrollment period.

9.4.3 Family Status Changes

Benefits are regulated by Section 125 of the Internal Revenue Code (IRC). This allows an eligible employee to change enrollment selections only during Open Enrollment and/or as a result of a qualified Family Status Change.

a. All enrollment changes must be completed through the Risk & Benefits Division
b. To make changes, the eligible employee must complete a Notice of Change in Family Status and required enrollment forms, and provide the required documentation within 60 days of the qualifying event. If the 60-day deadline is not met, the eligible employee will not be able to add any family members until the next Open Enrollment

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c. Changes are effective the first of the month following the Family Status Change or receipt of required forms and documents, whichever is later. Dental coverage for new children is automatic only for the first 31 days from the date of birth or adoption. Claims received after the 31st day will not be paid until enrollment forms are completed and processed

9.5 WHEN COVERAGE BEGINS

Coverage will begin on the first day of the month following two months of continuous employment.

Coverage for new dependents through marriage, registration of a domestic partnership, or the filing of an Affidavit of Domestic Partnership with the Group will begin on the first day of the month following receipt of the online enrollment forms.

Coverage for a newborn is effective on the date of the newborn's birth. Coverage for a child newly adopted or placed for adoption or as a foster child is effective on the date of adoption or placement. Court ordered coverage is effective on the first day of the month following the date the Group determines that an applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.

Coverage for those enrolling during open enrollment begins on the date the Plan renews. All other plan provisions will apply. Coverage under special enrollment due to loss of coverage or eligibility for premium subsidy begins on the first day of the month following receipt of the special enrollment request, or coinciding with, but not before the loss of other coverage.

The necessary premium must also be paid for coverage to become effective.

9.6 WHEN COVERAGE ENDS

When the subscriber's coverage ends, coverage for all enrolled dependents also ends.

9.6.1 Termination of the Group Plan

If the Plan is terminated for any reason, coverage ends for the members on the date the Plan ends.

9.6.2 Termination by Subscriber

A subscriber may end his or her coverage, or coverage for any enrolled dependent, only if there is a qualifying event. Qualifying events include marriage, divorce and birth. Coverage ends on the last day of the month through which premiums are paid.

9.6.3 Death

If a subscriber dies, coverage for any enrolled dependents ends on the last day of the month in which the death occurs. Enrolled dependents may extend their coverage if the requirements for continuation of coverage are met (see section 12.22).

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9.6.4 Termination, Layoff or Reduction in Hours of Employment

Coverage ends on the last day of the month in which employment ends, unless a member chooses to continue coverage (see section 12).

If a subscriber is laid off and returns to active work within 6 months of being laid off, he or she and any eligible dependents may enroll in the Plan on the date of rehire and coverage will begin on that date.

If a subscriber experiences a reduction in hours that causes loss of coverage, and within 6 months the hours increase and the subscriber again qualifies for benefits, he or she and any eligible dependents may enroll in the group plan on the date the subscriber qualifies, and coverage will begin on that date provided the necessary premiums for coverage are paid.

The Group must notify Delta Dental that the subscriber is rehired or of an increase in hours and the necessary premiums for coverage must be paid. All plan provisions will resume at re-enrollment whether or not there was a lapse in coverage. Upon re-enrollment in the Plan, any waiting period required by the Plan will not have to be re-served.

An employee who has continuously participated in COBRA continuation coverage during a layoff, and is reinstated to employment within eighteen (18) months from layoff, will have the benefit waiting period waived. This applies to all lines of coverage and any type of layoff (economic or medical layoff).

9.6.5 Loss of Eligibility by Dependent

Coverage ends on the last day of the month in which the dependent's eligibility ends.

a. Coverage ends for an enrolled spouse on the last day of the month in which a decree of divorce or annulment is entered (regardless of any appeal), and for an enrolled domestic partner on the last day of the month in which a judgment of dissolution or annulment of the domestic partnership has been entered or that a partnership no longer meets the requirements of the Affidavit of Domestic Partnership.
b. Coverage ends for an enrolled child on the last day of the month in which he or she turns age 26, or that a legal guardianship or foster relationship ends.

The subscriber must notify the Group and Delta Dental when a marriage, domestic partnership, foster child relationship or guardianship ends.

Enrolled dependents may have the right to continue coverage in their own names when their coverage under the Plan ends.

9.6.6 Rescission

The Plan may rescind a member's coverage back to the effective date, or deny claims at any time for fraud, material misrepresentation or concealment by a member which may include but is not limited to enrolling ineligible persons on the Plan, falsifying or withholding documentation or information that is the basis for eligibility or employment, and falsification or alteration of claims. The Plan reserves the right to retain premiums paid as liquidated damages, and the member shall be responsible for the full balance of any benefits paid. If the Plan ends coverage under this section, Delta Dental may, to the extent permitted by law, deny future enrollment of the members under any Delta Dental policy or contract or the contract of any affiliates.

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9.6.7 Continuing Coverage

Information is in Continuation of Dental Coverage (section 12).

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SECTION 10. CLAIMS ADMINISTRATION & PAYMENT

10.1 SUBMISSION AND PAYMENT OF CLAIMS

10.1.1 Claim Submission

A claim is not payable until the service or supply has actually been received. In no event, except absence of legal capacity or in the case of a Medicaid claim, is a claim valid if submitted later than 12 months from the date the expense was incurred. Claims submitted by Medicaid must be sent to Delta Dental within 3 years after the date the expense was incurred.

10.1.2 Explanation of Benefits (EOB)

Delta Dental will report its action on a claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through Member Dashboard. The EOB will indicate if a claim has been paid, denied or accumulated toward satisfying any deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

If a member does not receive an EOB or an email indicating that an EOB is available within a few weeks of the date of service, this may indicate that Delta Dental has not received the claim. To be eligible for reimbursement, claims must be received within the claim submission period explained in section 10.1.1.

10.1.3 Claim Inquiries

Customer Service can answer questions about how to file a claim, the status of a pending claim, or any action taken on a claim. The Plan will respond to an inquiry within 30 days of receipt.

10.1.4 Time Frames for Processing Claims

If a claim is denied, Delta Dental will send an EOB explaining the denial within 30 days after receiving the claim. If more time is needed to process the claim for reasons beyond Delta Dental's control, a notice of delay will be sent to the member explaining those reasons within 30 days after Delta Dental receives the claim. Delta Dental will then finish processing the claim and send an EOB to the member no more than 45 days after receiving the claim. If more information is needed to process the claim, the notice of delay will describe the information needed, and the party responsible for providing the additional information will have 45 days to submit it. Once the additional information is received, processing of the claim will be completed within 15 days. Submission of information necessary to process a claim is subject to the Plan's claim submission period explained in section 10.1.1.

10.2 APPEALS

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service.

10.2.1 Definitions

For purposes of section 10.2, the following definitions apply:

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Adverse Benefit Determination means a letter or an Explanation of Benefits (EOB) from Delta Dental informing a person, of any of the following: a denial, reduction or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a person's eligibility to participate in the Plan and one resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or accidental injury.

Appeal is a written request by a member or his or her representative for Delta Dental to review an adverse benefit determination.

Utilization Review means a system of reviewing the dental necessity, appropriateness or quality of dental care services and supplies. An adverse benefit determination that the item or service is not dentally necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a dental judgment is a utilization review decision.

10.2.2 Time Limit for Submitting Appeals

A member has **180 days** from the date an adverse benefit determination is received to submit the first written appeal. If appeals are not submitted within the timeframes in these sections, the member will lose the right to any appeal.

10.2.3 The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. Delta Dental's response time to an appeal is based on the nature of the claim as described below.

The timelines in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party (Delta Dental or the member) makes it impossible to comply with the requirements. Whoever is unable to comply must give notice of the specific reason to the other party when the issue arises.

Upon request and free of charge, the member may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits.

10.2.4 First Level Appeals

An appeal must be submitted in writing. If necessary, Customer Service can help with filing an appeal. Written comments, documents, records and other information relating to the claim for benefits may be submitted. Appeals are investigated by persons who were not involved in the original decision.

When an investigation is finished, Delta Dental will send a written notice of the decision to the member, including the reason for the decision. The investigation will be completed and notice sent within 30 days of receipt of the appeal.

10.2.5 Second Level Appeal

A member who disagrees with the decision on the first level appeal may ask for a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of Delta Dental's action on the first level appeal. Investigations and responses to a second level appeal

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will be by persons who were not involved in the initial decisions. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a first level appeal. Delta Dental will notify the member in writing of the decision, including the basis for the decision,

10.3 Benefits Available from Other Sources

Sometimes dental expenses may be the responsibility of someone other than the Plan.

10.3.1 Coordination of Benefits (COB)

Coordination of benefits applies when a member has dental coverage under more than one plan.

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, then any other plans pay. The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

10.3.1.1 Order of Benefit Determination (Which Plan Pays First?)

The first of the following rules that applies will govern:

a. **Non-dependent/Dependent.** If a plan covers the member as other than a dependent, (e.g., an employee, member of an organization, primary insured or retiree) then that plan will determine its benefits before a plan that covers the member as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the member as a dependent and primary to the plan covering the member as other than a dependent (e.g. a retired employee), then the order of benefits between the 2 plans is reversed.
b. **Dependent Child/Parents Married or Living Together.** If the member is a dependent child whose parents are married or are living together whether or not they have ever been married or domestic partners, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the birthday rule.)
c. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or domestic partners, then the following rules apply:
    i. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
    ii. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.

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iii. If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows: The plan covering the
    A. Custodial parent
    B. Spouse or domestic partner of the custodial parent
    C. Non-custodial parent
    D. Spouse or domestic partner of the non-custodial parent

d. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (b. or c.) above shall determine the order of benefits as if those persons were the parents of the child.
e. **Dependent Child Covered by Parent and Spouse/Domestic Partner.** For a dependent child covered under the plans of both a parent and a spouse/domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
f. **Active/Retired or Laid Off Employee.** The plan that covers a member as an active employee (i.e., one who is neither laid off nor retired) or as that employee's dependent determines its benefits before those of a plan that covers the member as a laid off or retired employee or as that employee's dependent. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
g. **COBRA or State Continuation Coverage.** If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering the member as an employee, member of an organization, primary insured, or retiree or as a dependent of the same, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.
h. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary plan and the plan that covered the member for the shorter period of time is the secondary plan.
i. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid if it had been the primary plan.

10.3.1.2 How COB Works

The **primary plan** (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The **secondary plan** (the plan that pays benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

a. If this Plan is primary, it will provide its benefits first.
b. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This Plan

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will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.

c. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that the Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.

10.3.1.3 Effect on the Benefits of This Plan

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

10.3.1.4 Definitions

For purposes of section 10.3.1, the following definitions apply:

Plan means any of the following that provides benefits or services for medical or dental care or treatment. If separate contracts are used to provide coordinated coverage for covered persons in a group, the separate contracts are considered parts of the same plan and there is no COB among those separate contracts.

Plan includes:

a. Group or individual insurance contracts and group-type contracts
b. HMO (health maintenance organization) coverage
c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan
d. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
e. Other arrangements of insured or self-insured group or group-type coverage

Plan does not include:

a. Fixed indemnity coverage
b. Accident-only coverage
c. Specified disease or specified accident coverage
d. School accident coverage
e. Medicare supplement policies
f. Medicaid policies
g. Coverage under other federal governmental plans, unless permitted by law

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Each contract or other arrangement for coverage described above is a separate plan. If a plan has 2 parts and COB rules apply to only one of the 2, each of the parts is treated as a separate plan.

Complying plan is a plan that follows these COB rules.

Non-complying plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

Allowable expense means a dental expense, including cost sharing, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service instead of cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

The following are examples of expenses that are not allowable expenses:

a. The amount of the reduction by the primary plan because a member has not complied with the plan's requirements concerning second opinions or prior authorization, or because the member has a lower benefit due to not using an in-network provider
b. Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by 2 or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology
c. Any amount in excess of the highest of the negotiated fees, if a member is covered by 2 or more plans that provide benefits or services on the basis of negotiated fees
d. If a member is covered by one plan that calculates its benefits on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

This Plan is the part of this plan funded by the Group and provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of this group dental plan providing dental benefits is separate from this Plan. A group dental plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

Closed panel plan is a plan that provides dental benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

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Custodial parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

10.3.2 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of an illness or injury for which such costs were paid by the Plan. The Plan does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section 10.3.3 for motor vehicle accident recovery). Because recovery from a third party may be difficult and take a long time, as a service to the member the Plan will pay a member's expenses based on the understanding and agreement that the Plan is entitled to be reimbursed from any recovery the member may receive for any benefits it paid that are or may be recoverable from a third party, as defined below.

The member agrees that the Plan has the rights described in section 10.3.2. The Plan may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of recovery or subrogation as discussed in this section. The Plan has discretion to interpret and construe these recovery and subrogation provisions.

10.3.2.1 Definitions:

For purposes of section 10.3.2, the following definitions apply:

Benefits means any amount paid by the Plan, or submitted for payment to or on behalf of a member. Bills, statements or invoices submitted by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Third Party means any person or entity responsible for the injury or illness, or the aggravation of an injury or illness, of a member. Third party includes any insurer of such person or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection (PIP) coverage and workers' compensation insurance.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member.

10.3.2.2 Subrogation

Upon payment by the Plan, the Plan has the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan's provisions.

10.3.2.3 Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply to all recovery, except for those related to motor vehicle accidents (see section 10.3.3 for motor vehicle recovery rights):

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a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that illness or injury.

b. The Plan is entitled to receive the amount of benefits it has paid for an illness or injury out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, the Plan is entitled to receive the amount of benefits it has paid whether the dental expenses are itemized or expressly excluded in the third party recovery.

c. If the Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

d. This right of recovery includes the full amount of the benefits paid or pending payment by the Plan, out of any recovery made by the member from the third party, including without limitation any and all amounts paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. The Plan's recovery rights will not be reduced due to the member's own negligence.

e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.

10.3.2.4 Additional Provisions

Members shall comply with the following and agree that Delta Dental may do one or more of the following, at its discretion:

a. The member shall cooperate with Delta Dental to protect the Plan's recovery rights, including by:

   i. Signing and delivering any documents Delta Dental reasonably requires to protect the Plan's rights, including a Third Party Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
   ii. Providing any information to Delta Dental relevant to the application of the provisions of section 10.3.2 including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include dental/medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments.
   iii. Notifying Delta Dental of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Delta Dental by the member's provider.
   iv. Taking such actions as Delta Dental may reasonably request to assist it in enforcing the Plan's third party recovery rights.

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b. The member and his or her representatives are obligated to notify Delta Dental in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party.

c. By accepting payment of benefits by the Plan, the member agrees that the Plan has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.

d. The member agrees that Delta Dental may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section 10.3.2.

e. Even without the member's written authorization, Delta Dental may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section 10.3.2.

f. Section 10.3.2 applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.

g. If the member continues to receive treatment for an illness or injury after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

h. If the member or the member's representatives fail to do any of the above mentioned acts, then the Plan has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any sickness, illness, injury or dental/medical condition resulting from the event giving rise to, or the allegations in, the third party claim, except for claims related to motor vehicle accidents (see section 10.3.3). The Plan may notify dental providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

i. Coordination of benefits (where the member has dental/medical coverage under more than one plan or health insurance policy) is not considered a third party claim.

10.3.3 Motor Vehicle Accident Recovery

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Delta Dental and motor vehicle insurance has not yet paid, then the Plan will advance benefits. The Plan retains the right to repayment of any benefits paid from the proceeds of any settlement, judgment or other payment received by the member that exceeds the amount that fully compensates the member for their motor vehicle accident related injuries.

If the Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

The member shall do whatever is proper to secure, and may not prejudice, the rights of the Plan under this section.

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SECTION 11. MISCELLANEOUS PROVISIONS

11.1 RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the member must give or authorize a provider to give Delta Dental any information needed to pay benefits. Delta Dental may release to or collect from any person or organization any needed information about the member.

11.2 CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is very important to Delta Dental. Protected health information includes enrollment, claims, and medical and dental information. Delta Dental uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. Delta Dental does not sell this information. The Notice of Privacy Practices provides more detail about how the Group uses members' information. Delta Dental, as the claims administrator, is required to adhere to these same practices Members can contact the Group if they have additional questions about the privacy of their information beyond what is provided in the Notice of Privacy Practices.

11.3 TRANSFER OF BENEFITS

Only members are entitled to benefits under the Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on Delta Dental or the Plan, except that the Plan shall pay amounts due under the Plan directly to a provider upon a member's written request.

11.4 RECOVERY OF BENEFITS PAID BY MISTAKE

If the Plan makes a payment for a member to which he or she is not entitled, or pays a person who is not eligible for payments at all, the Plan has the right to recover the payment from the person paid or anyone else who benefited from it, including a provider. The Plan's right to recovery includes the right to deduct the amount paid from future benefits it would provide for a member even if the mistaken payment was not made on that member's behalf.

11.5 CORRECTION OF PAYMENTS

If benefits that this Plan should have paid are instead paid by another plan, the Plan may reimburse the other plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the Plan's liability.

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11.6 CONTRACT PROVISIONS

The agreement between the Group and Delta Dental including this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the agreement plus any endorsements or amendments shall supersede all other communications, representations or agreements, either verbal or written between the parties. If any term, provision, agreement or condition is held by a court of competent jurisdiction to be invalid or unenforceable, the remainder of the provisions shall remain in full force and effect and shall in no way be affected, impaired or invalidated.

11.7 WARRANTIES

All statements made by the Group or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining coverage will void the coverage or reduce benefits unless contained in a written form and signed by the Group or the member, a copy of which has been given to the Group or member or the member's beneficiary.

11.8 LIMITATION OF LIABILITY

Delta Dental shall incur no liability whatsoever to any member concerning the selection of dentists to provide services. In performing or contracting to perform dental service, such dentists shall be solely responsible, and in no case shall Delta Dental be liable for the negligence of any dentist providing such services. Nothing contained in the agreement between the Group and Delta Dental shall be construed as obligating Delta Dental to provide dental services.

11.9 PROVIDER REIMBURSEMENTS

Dentists contracting with Delta Dental to provide services to members agree to look only to **the Plan** for payment of the part of the expense that is covered by the Plan and may not bill the member in the event the Plan fails to pay the dentist for whatever reason. The dentist may bill the member for applicable cost sharing or non-covered expenses except as may be restricted in the provider contract.

11.10 INDEPENDENT CONTRACTOR DISCLAIMER

Delta Dental and participating dentists are independent contractors. Delta Dental and participating dentists do not have a relationship of employer and employee nor of principal and agent. No relationship other than that of independent parties contracting with each other solely for the purpose of a participating dentist's provision of dental care to members may be deemed or construed to exist between Delta Dental and participating dentists. A participating dentist is solely responsible for the dental care provided to any member, and Delta Dental does not control the detail, manner or methods by which a participating dentist provides care.

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11.11 NO WAIVER

Any waiver of any provision of the Plan or any performance under the Plan must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If the Plan delays or fails to exercise any right, power or remedy provided in the Plan, including a delay or omission in denying a claim, that shall not waive the Plan's rights to enforce the provisions of the Plan.

11.12 GROUP IS THE AGENT

The Group is the members' agent for all purposes under the Plan. The Group is not the agent of Delta Dental.

11.13 GOVERNING LAW

To the extent the Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the state of Oregon.

11.14 WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of the Plan must be filed in either state or federal court in the state of Oregon.

11.15 TIME LIMIT FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against the Plan by a member or any third party must be filed in court no more than 3 years after the time the claim was filed (see section 10.1). All internal levels of appeal under the Plan must be exhausted before filing a legal action in court.

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SECTION 12. CONTINUATION OF DENTAL COVERAGE

The following sections on continuation of coverage may apply. Members should check with their employer's Risk & Benefits Division to find out whether they qualify for this coverage. Both subscribers and their dependents should read the following sections carefully.

12.1 OREGON CONTINUATION FOR SPOUSES & DOMESTIC PARTNERS AGE 55 AND OVER

12.1.1 Introduction

The Plan offers enrolled spouses and domestic partners the opportunity to request a temporary extension of dental coverage for themselves and their dependents if coverage is lost due to a specific event identified in the following paragraphs.

55+ Oregon Continuation only applies to employers with 20 or more employees. The Plan will provide 55+ Oregon Continuation coverage to those members who elect it, subject to the following conditions:

a. The Plan will offer no greater rights than ORS 743B.343 to 743B.345 requires
b. The Plan will not provide 55+ Oregon Continuation coverage for members who do not comply with the requirements outlined below
c. The Group or its designated third party administrator is responsible for providing the required notices within the statutory time periods, including the notice of death and the election notice. If the Group or its designated third party administrator fails to notify the eligible spouse or domestic partner, premiums shall be waived from the date the notice was required until the date notice is received by the spouse or domestic partner. The Group shall be responsible for such premiums.

Note: In section 12.2 the term "domestic partner" refers only to a registered domestic partner, as defined in section 4.

12.1.2 Eligibility

The spouse or domestic partner of the subscriber may elect 55+ Oregon Continuation coverage for himself or herself and any enrolled dependents if the following requirements are met:

a. Coverage is lost because of the death of the subscriber, dissolution of marriage or domestic partnership with the subscriber, or legal separation from the subscriber
b. The spouse or domestic partner is 55 years of age or older at the time of such event
c. The spouse or domestic partner is not eligible for Medicare

12.1.3 Notice and Election Requirements

Notice of Divorce, Dissolution, or Legal Separation. Within 60 days of legal separation or the entry of a judgment of dissolution of marriage or domestic partnership, a member who is eligible for 55+ Oregon Continuation and seeks such coverage shall give the Group or its designated third party administrator written notice of the legal separation or dissolution. The notice shall include his or her mailing address.

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Notice of Death. Within 30 days of the death of the subscriber, the Group shall give the designated third party administrator, if any, written notice of the death and the mailing address of the eligible surviving spouse or domestic partner.

Election Notice. Within 14 days of receipt of the above notice (or within 44 days of the death of the subscriber if there is no third party administrator), the Group or its designated third party administrator shall provide notice to the surviving, legally separated or divorced spouse or domestic partner that coverage can be continued, along with an election form. If the Group or its designated third party administrator does not provide this election notice within the required timeframe, premiums shall be waived until the date notice is received.

Election. The surviving, legally separated or divorced spouse or domestic partner must return the election form within 60 days after the form is mailed. If the election is not made within 60 days of the notification, the member will lose the right to continued benefits under this section.

12.1.4 Premiums

Monthly premiums for 55+ Oregon Continuation are limited to 102% of the premiums paid by a current subscriber. The first premiums shall be paid by the surviving, legally separated or divorced spouse or domestic partner to the Group or its designated third party administrator within 45 days of the date of election. All remaining monthly premiums must be paid within 30 days of the premium due date.

12.1.5 When Coverage Ends

55+ Oregon Continuation will end on the earliest of any of the following events:

a. Failure to pay premiums when due, including any grace period allowed by the Plan
b. The date the Plan ends, unless a different group plan is made available to members
c. The date the member becomes insured under any other group dental plan
d. The date the member remarries or registers another domestic partnership
e. The date the member becomes eligible for Medicare.

12.2 COBRA Continuation Coverage

12.2.1 Introduction

COBRA only applies to employers with 20 or more employees on 50% of the typical business days in the prior calendar year. Certain church plans are exempted from COBRA. The Plan will provide COBRA continuation coverage to members who have experienced a qualifying event and who elect coverage under COBRA, subject to the following conditions:

a. The Plan will offer no greater COBRA rights than the COBRA statute requires
b. The Plan will not provide COBRA coverage for members who do not comply with the notice, election or other requirements outlined below

For purposes of section 12.22, COBRA Administrator means either the Group or a third party administrator delegated by the Group to handle COBRA administration.

12.2.2 Qualifying Events

Subscriber. A subscriber may elect continuation coverage if coverage is lost because of termination of employment (other than termination for gross misconduct, which may include misrepresenting immigration status to obtain employment), or a reduction in hours.

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Spouse. The spouse of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Divorce or legal separation from the subscriber
d. The subscriber becomes entitled to Medicare

If it can be established that a subscriber has eliminated coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the COBRA Administrator within 60 days of the divorce or legal separation, COBRA coverage may be available for the period after the divorce or legal separation.

Children. A child of a subscriber has the right to continuation coverage if coverage is lost for any of the following qualifying events:

a. Death of the subscriber
b. Termination of the subscriber's employment (for reasons other than gross misconduct) or reduction in the subscriber's hours of employment with the Group
c. Parents' divorce or legal separation
d. Subscriber becomes entitled to Medicare
e. Child ceases to be a child under the Plan

Domestic Partners. A subscriber, who at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the subscriber is not an eligible member under COBRA and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ends immediately when the subscriber's COBRA coverage terminates (for example, due to the subscriber's death or because the subscriber becomes covered under another plan).

Retirees. If the Plan provides retiree coverage and the subscriber's former employer files a Chapter 11 bankruptcy proceeding, this may be a qualifying event for the retiree who loses coverage as a result, and for his or her covered dependents.

12.2.3 Other Coverage

The right to elect continuation coverage shall be available to persons who are covered under another group dental plan at the time of the election.

12.2.4 Notice and Election Requirements

Qualifying Event Notice. A dependent member's coverage ends as of the last day of the month in which a divorce or legal separation occurs (spouse's coverage is lost) or a child loses dependent status under the Plan (child loses coverage). Under COBRA, the subscriber or a family member has the responsibility to notify the County's Risk and Benefits Division if one of these events occurs by mailing or hand-delivering a written notice to the COBRA Administrator. The notice must include the following: 1) the name of the Group; 2) the name and social security number of the affected members; 3) the event (e.g. divorce); and 4) the date the event occurred. Notice

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must be given no later than 60 days after the loss of coverage under the Plan. If notice of the event is not given on time, continuation coverage will not be available.

Election Notice. Members will be notified of their right to continuation coverage within 14 days after the COBRA Administrator receives a timely qualifying event notice.

Otherwise, members will be notified by the COBRA Administrator of the right to elect COBRA continuation coverage within 44 days of any of the following events that result in a loss of coverage: the subscriber's termination of employment (other than for gross misconduct) or reduction in hours, death of the subscriber, the subscriber's becoming entitled to Medicare, or the Group files for Chapter 11 reorganization.

Election. A member must elect continuation coverage within 60 days after plan coverage ends, or, if later, 60 days after the COBRA Administrator sends notice of the right to elect continuation coverage to the member. If continuation coverage is not elected, group dental coverage will end.

A subscriber or the spouse may elect continuation coverage for eligible family members. Each family member also has an independent right to elect COBRA coverage. This means that a spouse or child may elect continuation coverage even if the subscriber does not.

If COBRA is elected, the Group will provide the same coverage as is available to similarly situated members under the Plan.

12.2.5 COBRA Premiums
Members are responsible for all premiums for continuation coverage. Due to the 60-day election period, it is likely that retroactive premiums will be owed for the months between when regular coverage ended and the first payment date. These premiums must be paid in a lump sum at the first payment. The first payment for continuation coverage is due within 45 days after a member provides notice of electing coverage (this is the date the election notice is postmarked, if mailed, or the date the election notice is received by the COBRA Administrator if hand delivered). Subsequent payments are due on the first day of the month. There will be a grace period of 30 days to pay the premiums. The Plan will not send a bill for any payments due. The member is responsible for paying the applicable premiums when due; otherwise continuation coverage will end and may not be reinstated. The premium rate may include a 2% add-on to cover administrative expenses.

12.2.6 Length of Continuation Coverage
18-Month Continuation Period. When coverage is lost due to end of employment or a reduction of hours of employment, coverage generally may be continued for up to a total of 18 months.

36-Month Continuation Period. When coverage is lost due to a subscriber's death, divorce or legal separation, or a child ceasing to be a dependent under the terms of the Plan, coverage under the Plan may be continued for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the subscriber's hours of employment, and the subscriber became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage for members (other than the subscriber) who lose coverage as a result of the qualifying event can last up to 36 months after the date of Medicare entitlement. This COBRA coverage period is available only if the subscriber becomes entitled to Medicare within 18 months before the termination or reduction of hours.

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Extended Period. In the case of loss of coverage due to the bankruptcy of the Group, coverage for the retired subscriber may be continued up to his or her death. Coverage for each dependent may be continued up to the dependent's death or 36 months after the retired subscriber's death, whichever is earlier.

12.2.7 Extending the Length of COBRA Coverage

An extension of the maximum period of coverage may be available if a member is disabled or a second qualifying event occurs. The COBRA Administrator must be notified of a disability or a second qualifying event in order to extend the period of COBRA coverage. If the member does not provide notice of a disability or second qualifying event, he or she will lose the right to extend the period of COBRA coverage.

Disability. If any of the members is determined by the Social Security Administration to be disabled, the maximum COBRA coverage period that results from a subscriber's termination of employment or reduction of hours may be extended to a total of up to 29 months. The disability must have started before the 61st day after the subscriber's termination of employment or reduction of hours and must last at least until the end of the period of COBRA coverage that would be available without the disability extension (generally 18 months). Each member who has elected COBRA coverage will be entitled to the disability extension if one of them qualifies.

The disability extension is available only if the Social Security Administration determination is within the 18-month period following the subscriber's termination of employment or reduction of hours. The member must provide a copy of the Social Security Administration's determination of disability to the COBRA Administrator within 60 days after the latest of:

a. The date of the Social Security Administration's disability determination
b. The date of the subscriber's termination of employment or reduction of hours
c. The date on which the member loses (or would lose) coverage under the terms of the Plan as a result of the subscriber's termination or reduction of hours

If the notice is not provided within this timeframe, then there will be no disability extension of COBRA coverage. The premiums for COBRA coverage may increase after the 18th month of coverage to 150% of the premium.

If determined by the Social Security Administration to no longer be disabled, the member must notify the COBRA Administrator of that fact within 30 days after the Social Security Administration's determination.

Second Qualifying Event. An extension of coverage will be available to spouses and children who are receiving COBRA coverage if a second qualifying event occurs during the 18 months (or, in the case of a disability extension, the 29 months) following the subscriber's termination of employment or reduction of hours. The maximum amount of COBRA coverage available when a second qualifying event occurs is 36 months from the date of the first qualifying event. Second qualifying events may include the death of a subscriber, divorce or legal separation from the subscriber, or a child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the member to lose coverage under the Plan if the first qualifying event had not occurred. (This extension is not available under the Plan when a subscriber becomes entitled to Medicare after his or her termination of employment or reduction of hours.)

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This extension is only available if the COBRA Administrator is notified in writing of the second qualifying event within 60 days after the date of the event. If this notice is not provided to the COBRA Administrator during the 60-day notice period, then there will be no extension of COBRA coverage due to a second qualifying event.

Note: Longer continuation coverage may be available under Oregon law for a subscriber's spouse or domestic partner age 55 and older who loses coverage due to the subscriber's death, or due to legal separation or dissolution of marriage or domestic partnership (see section 12.11).

12.2.8 Newborn or Adopted Child

If, a child is born to or placed for adoption or as a foster child with the subscriber, the child is considered an eligible member. The subscriber may elect continuation coverage for the child provided the child satisfies the otherwise applicable plan eligibility requirements (e.g., age). The subscriber or a family member must notify the COBRA Administrator within 31 days of the birth or placement to obtain coverage. If the COBRA Administrator is not notified in the required timeframe, the child will not be eligible for coverage.

12.2.9 Special Enrollment and Open Enrollment

Members under continuation coverage have the same rights as similarly situated members who are not enrolled in COBRA. A member may add children, spouses, or domestic partners as covered dependents in accordance with the Plan's eligibility and enrollment rules (see sections 8.4 and 9.2), including HIPAA special enrollment. If non-COBRA members can change plans at open enrollment, COBRA members may also change plans at open enrollment.

12.2.10 When Continuation Coverage Ends

COBRA coverage will end earlier than the maximum period if:

a. Any required premiums are not paid in full on time
b. A member becomes covered under another group dental plan
c. A member becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing COBRA. (However, if the qualifying event is the Group's bankruptcy, the member will not lose COBRA because of entitlement to Medicare benefits)
d. The Group ceases to provide any group dental plan for its employees
e. During a disability extension period (section 12.2.7), the disabled member is determined by the Social Security Administration to be no longer disabled (COBRA coverage for all members, not just the disabled member, will end)

COBRA coverage may also be cancelled for any reason the Plan would terminate coverage of a member not receiving COBRA coverage (such as fraud).

Questions about COBRA should be directed to the COBRA Administrator. The COBRA Administrator should be informed of any address changes.

12.3 UNIFORMED SERVICES EMPLOYMENT & REEMPLOYMENT RIGHTS ACT (USERRA)

Coverage will end if a subscriber is called to active duty by any of the armed forces of the United States of America. However, if a subscriber asks to continue coverage under USERRA, coverage can be continued for up to 24 months or the period of uniformed service leave, whichever is shortest, if the subscriber pays any required contributions toward the cost of the coverage during the leave. If the leave is 30 days or less, the contribution rate will be the same as for active

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members. If the leave is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

If a subscriber does not elect continuation coverage under USERRA or if continuation coverage is terminated or exhausted, coverage will be reinstated on the first day he or she returns to active employment with the Group if released under honorable conditions, but only if he or she returns to active employment:

a. On the first full business day following completion of military service for a leave of 30 days or less
b. Within 14 days of completing military service for a leave of 31 to 180 days
c. Within 90 days of completing military service for a leave of more than 180 days

Regardless of the length of the leave, a reasonable amount of travel time or recovery time for an illness or injury determined by the Veteran's Administration (VA) to be service connected will be allowed.

When coverage under the Plan is reinstated, all plan provisions and limitations will apply to the extent that they would have applied if the subscriber had not taken military leave and coverage had been continuous under the Plan. There will be no additional eligibility waiting period. (This waiver of limitations does not provide coverage for any illness or injury caused or aggravated by military service, as determined by the VA. Complete information regarding rights under USERRA is available from the Group).

12.4 FAMILY AND MEDICAL LEAVE

Subscribers should check with the Group to find out if they qualify for this coverage. If the Group grants a leave of absence under state or federal family and medical leave laws, the following rules will apply:

a. Affected members will remain eligible for coverage during a family and medical leave.
b. If members elect not to remain enrolled during a family and medical leave, they will be eligible to re-enroll in the Plan on the date the subscriber returns from leave. To re-enroll, a complete and signed application must be submitted within 60 days of the return to work. All of the terms and conditions of the Plan will resume at the time of re-enrollment as if there had been no lapse in coverage. Any group eligibility waiting period under the Plan will not have to be re-served.
c. A subscriber's rights under family and medical leave will be governed by applicable state or federal statute and regulations.

12.5 LEAVE OF ABSENCE

A leave of absence is a period off work granted by the Group at a subscriber's request during which he or she is still considered to be employed and is carried on the employment records of the Group A leave can be granted for any reason acceptable to the Group. If a subscriber is on leave for a family and medical leave-qualifying reason (see section 12.44), he or she remains eligible on the plan only for the period of the family and medical leave. The subscriber may not also continue or extend coverage under this leave of absence provision.

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If granted a leave of absence by the Group, a subscriber may continue coverage for up to the amount of times specified by the Group. Premiums must be paid through the Group in order to maintain coverage during a leave of absence.

12.6 STRIKE OR LOCKOUT

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the Group, directly to the union or trust, and the union or trust must continue to pay the Group the premiums when due.

Continuation of coverage during a strike or lockout will not occur if:

a. Fewer than 75% of those normally enrolled choose to continue their coverage
b. A subscriber accepts full-time employment with another employer
c. A subscriber otherwise loses eligibility under the Plan

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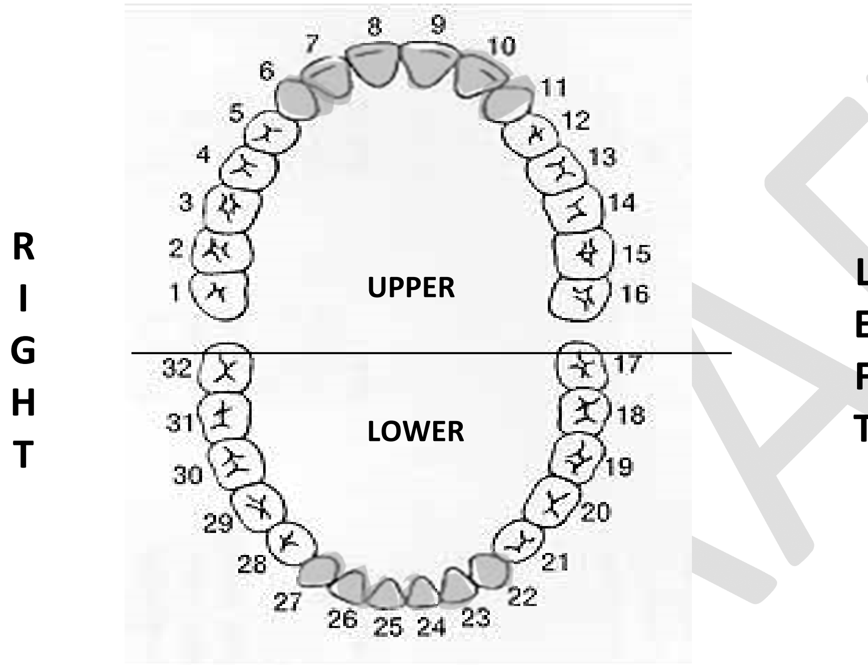
SECTION 13. TOOTH CHART

The Permanent Arch



Anterior teeth are shaded gray.

The Permanent Arch		
Tooth #		Description of Tooth
Upper	Lower	
1	17	3rd Molar (wisdom tooth)
2	18	2nd Molar (12-yr molar)
3	19	1st Molar (6-yr molar)
4	20	2nd Bicuspid (2nd premolar)
5	21	1st Bicuspid (1st premolar)
6	22	Cuspid (canine/eye tooth)
7	23	Lateral Incisor
8	24	Central Incisor
9	25	Central Incisor
10	26	Lateral Incisor
11	27	Cuspid (canine/eye tooth)
12	28	1st Bicuspid (1st premolar)
13	29	2nd Bicuspid (2nd premolar)
14	30	1st Molar (6-yr molar)
15	31	2nd Molar (12-yr molar)
16	32	3rd Molar (wisdom tooth)

Nondiscrimination notice

We follow federal civil rights laws. We do not discriminate based on race, color, national origin, age, disability, gender identity, sex or sexual orientation.

We provide free services to people with disabilities so that they can communicate with us. These include sign language interpreters and other forms of communication.

If your first language is not English, we will give you free interpretation services and/or materials in other languages.

If you need any of the above, call Customer Service at:

888-374-8906 (TDD/TTY 711)

If you think we did not offer these services or discriminated, you can file a written complaint. Please mail or fax it to:

Delta Dental of Oregon and Alaska
Attention: Appeal Unit
601 SW Second Ave.
Portland, OR 97204
Fax: 503-412-4003

Dave Nesseler-Cass coordinates our nondiscrimination work:

Dave Nesseler-Cass,
Chief Compliance Officer
601 SW Second Ave.
Portland, OR 97204
855-232-9111
compliance@modahealth.com

If you need help filing a complaint, please call Customer Service.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services Office for Civil Rights at ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone:

U.S. Department of Health
and Human Services
200 Independence Ave. SW, Room 509F
HHH Building, Washington, DC 20201

800-368-1019, 800-537-7697 (TDD)

You can get Office for Civil Rights complaint forms at hhs.gov/ocr/office/file/index.html.

Dental plans in Oregon provided by Oregon Dental Service, dba Delta Dental Plan of Oregon. Dental plans in Alaska provided by Delta Dental of Alaska. 60667319 (10/19)

DELTA DENTAL
Delta Dental of Oregon & Alaska

ATENCIÓN: Si habla español, hay disponibles servicios de ayuda con el idioma sin costo alguno para usted. Llame al 1-877-605-3229 (TTY: 711).

CHÚ Ý: Nếu bạn nói tiếng Việt, có dịch vụ hổ trợ ngôn ngữ miễn phí cho bạn. Gọi 1-877-605-3229 (TTY:711)

注意：如果您說中文，可得到免費語言幫助服務。請致電1-877-605-3229（聾啞人專用：711）

주의: 한국어로 무료 언어 지원 서비스를 이용하시려면 다음 연락처로 연락해주시기 바랍니다. 전화 1-877-605-3229 (TTY: 711)

PAUNAWA: Kung nagsasalita ka ng Tagalog, ang mga serbisyong tulong sa wika, ay walang bayad, at magagamit mo. Tumawag sa numerong 1-877-605-3229 (TTY: 711)

تنبيه: إذا كنت تتحدث العربية، فهناك خدمات مساعدة لغوية متاحة لك مجانًا. اتصل برقم 1-877-605-3229 (الهاتف النصي: 711)

توجہ دیں: اگر آپ اردو (URDU) بولتے ہیں تو لسانی اعانت آپ کے لیے بلا معاوضہ دستیاب ہے۔ 1-877-605-3229 (TTY: 711) پر کال کریں

ВНИМАНИЕ! Если Вы говорите по-русски, воспользуйтесь бесплатной языковой поддержкой. Позвоните по тел. 1-877-605-3229 (текстовый телефон: 711).

ATTENTION : si vous êtes locuteurs francophones, le service d’assistance linguistique gratuit est disponible. Appelez au 1-877-605-3229 (TTY : 711)

توجه: در صورتی که به فارسی صحبت می کنید، خدمات ترجمه به صورت رایگان برای شما موجود است. با 1-877-605-3229 (TTY: 711) تماس بگیرید.

ध्यान दें: यदि आप हिंदी बोलते हैं, तो आपको भाषाई सहायता बिना कोई पैसा दिए उपलब्ध है। 1-877-605-3229 पर कॉल करें (TTY: 711)

Achtung: Falls Sie Deutsch sprechen, stehen Ihnen kostenlos Sprachassistenzdienste zur Verfügung. Rufen sie 1-877-605-3229 (TTY: 711)

注意：日本語をご希望の方には、日本語サービスを無料で提供しております。1-877-605-3229（TYY、テレタイプライターをご利用の方は711）までお電話ください。

અગત્યનું: જો તમે (ભાષાંતર કરેલ ભાષા અહીં દર્શાવો) બોલો છો તો તે ભાષામાં તમારે માટે વિના મૂલ્યે સહાય ઉપલબ્ધ છે. 1-877-605-3229 (TTY: 711) પર કૉલ કરો

ໂປດຊາບ: ຖ້າທ່ານເວົ້າພາສາລາວ, ການຊ່ວຍເຫຼືອດ້ານພາສາແມ່ນມີໃຫ້ທ່ານໂດຍບໍ່ເສັຍຄ່າ. ໂທ 1-877-605-3229 (TTY: 711)

УВАГА! Якщо ви говорите українською, для вас доступні безкоштовні консультації рідною мовою. Зателефонуйте 1-877-605-3229 (TTY: 711)

ATENȚIE: Dacă vorbiți limba română, vă punem la dispoziție serviciul de asistență lingvistică în mod gratuit. Sunați la 1-877-605-3229 (TTY 711)

THOV CEEB TOOM: Yog hais tias koj hais lus Hmoob, muaj cov kev pab cuam txhais lus, pub dawb rau koj. Hu rau 1-877-605-3229 (TTY: 711)

ត្រូវចងចាំ៖ បើអ្នកនិយាយភាសាខ្មែរ ហើយត្រូវការសេវាកម្មជំនួយផ្នែកភាសាដោយឥតគិតថ្លៃ គឺមានផ្តល់ជូនលោកអ្នក។ សូមទូរស័ព្ទទៅកាន់លេខ 1-877-605-3229 (TTY: 711)

HUBACHIISA: Yoo afaan Kshtik kan dubbattan ta’e tajaajiloonni gargaarsaa isiniif jira 1-877-605-3229 (TTY:711) tiin bilbilaa.

โปรดทราบ: หากคุณพูดภาษาไทย คุณสามารถใช้บริการช่วยเหลือด้านภาษาได้ฟรี โทร 1-877-605-3229 (TTY: 711)

FA’AUTAGIA: Afai e te tautala i le gagana Samoa, o loo avanoa fesoasoani tau gagana mo oe e le totogia. Vala’au i le 1-877-605-3229 (TTY: 711)

IPANGAG: Nu agsasaoka iti Ilocano, sidadaan ti tulong iti lengguahe para kenka nga awan bayadna. Umawag iti 1-877-605-3229 (TTY: 711)

UWAGA: Dla osób mówiących po polsku dostępna jest bezpłatna pomoc językowa. Zadzwoń: 1-877-605-3229 (obsługa TTY: 711)

Delta Dental of Oregon & Alaska

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For help, call us directly at 888-217-2365
(En Español: 877-299-9063)

P.O. Box 40384
Portland, OR 97240

COPY

CLACKAMAS COUNTY BOARD OF COUNTY COMMISSIONERS
Policy Session Worksheet

Presentation Date: October 6, 2020 **Approx. Start Time:** 2:00 PM **Approx. Length:** 30 Min

Presentation Title: Benefit Renewals for 2021

Department: Human Resources

Presenters: Kristi Durham, Benefits Manager

Other Invitees: Evelyn Minor-Lawrence, HR Director & Eric Sarha, Asst. HR Director

WHAT ACTION ARE YOU REQUESTING FROM THE BOARD?

HR is seeking formal approval to renew benefit plans with providers for the 2021 calendar year, as well as approval of the 2021 non-represented cost sharing arrangement. Final plan documents 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 formal adoption at a future business meeting.

EXECUTIVE SUMMARY:

This policy session will update the Board on 2021 benefit plan renewals, including final plan design, language changes, rates, and benefit cost shares.

Medical/Vision:

There are approximately 1600 employees and early retirees enrolled in the General County medical plans. Due to a combination of plan changes the Benefits Review Committee (BRC) made in the 2017 plan year, and have continued to evaluate for the 2018-2020 renewal period, the 2021 Providence renewal rates increased 4.2%, and the 2021 Kaiser renewal rates decreased 2.5%.

The BRC chose not to make any plan design changes to the General County plans for the 2021 plan year, since the renewals were good overall, and the BRC felt it was important to take the county's financial picture and uncertainty around future COVID-19 claims into consideration. The BRC also felt it was important to provide stability in the county's benefits at this time, since the county and employees are already in a state of flux.

There are approximately 430 employees and early retirees enrolled in the Peace Officers Association (POA) medical plans. The 2021 Providence POA renewal rates increased 4.4%, and the 2021 Kaiser POA renewal rates increased 1.1%.

The POA union did not make any plan design changes to the POA medical plans for 2021.

The rate changes for the General County and POA medical and dental plans are associated with a variety of factors, including paid claims, stop loss credits and charges, historical cost trends and other fixed expenses.

The medical opt-out cash back amount is remaining the same for all groups in 2021.

Retiree/COBRA/Temporary Employee Medical:

The Clackamas County benefits division is proposing changes to the Providence and Kaiser $1000 deductible plans, which are more affordable medical plan options available to retired employees, COBRA participants and temporary employees who meet certain eligibility requirements. These plans are not available to regular employees.

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The proposed changes will reduce confusion, create consistency and maintain affordability and choice. The proposal includes:

- Rebranding the plans as “high deductible” instead of “$1,000 deductible.”
- Using the same rate for the general county and POA Kaiser high deductible plans.
- Increasing Kaiser deductible from $1,000 per individual to $1,400 per individual, and indexing the deductible going forward to the definition of a high deductible medical plan as defined by the federal government.
- Increasing Kaiser pharmacy co-pay from $15/$30 to $20/$40.
- Increasing Providence deductible from $1,000 per individual to $1,400 per individual, and indexing the deductible going forward to the definition of a high deductible medical plan as defined by the federal government.
- Increasing Providence out-of-pocket maximum from $2,000 per individual to $3,000 per individual.
- Increasing Providence office visit co-pay from $15 to $25.

The proposed changes have been reviewed by all county unions and HR leadership.

Dental:
The General County self-insured dental plans experienced an average rate increase of 5.8%, and the POA self-insured dental plan experienced a rate increase of 1.9%. The Kaiser dental plan for General County and POA had no change in total premium. The BRC and POA union did not make any plan design changes to the dental plans for the 2021 plan year.

The dental opt-out cash back amount is remaining the same for all groups in 2021.

Flexible Spending Account:
The Navia flexible spending account (FSA) admin fee is increasing by 3.0% from $5.00 per participant per month (PPPM) to $5.15 PPPM.

Other Benefits:

All life insurance products (group term life, group universal life, accidental death & dismemberment, and dependent term life insurance), short-term and long-term disability plans, and long-term care will retain the same rates as 2020.

Represented Employee Cost-Sharing:
Represented employee cost sharing is defined in the collective bargaining agreements (CBA) of each union. Under the AFSCME, EA and FOPPO CBAs, the County pays 95% of the monthly composite premium for each medical plan up to a maximum of 105% of the previous year’s County contribution. Under the POA CBA, the County pays 95% of the composite premium rate for Providence medical plans and the employee agrees to pay 5% of the premium costs. However, if the premium increases more than 10% in any one year, the County and the POA employees shall evenly split the increased costs above 10%. The County pays 100% of the premium for POA employees enrolled in the Kaiser medical plan. The County pays 100% of the dental, life and disability premiums and the administrative costs for the Navia FSA.

Non-Represented Employee Cost-Sharing:
The current practice for non-represented 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 Navia FSA.

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FINANCIAL IMPLICATIONS (current year and ongoing):

Is this item in your current budget? ☒ YES ☐ NO

What is the cost?
The estimated fiscal impact for the 2021 plan year based on current enrollment is:

Medical/Vision:	$40,509,735.60 (increase of approximately $700,000 from 2020)
Dental:	$ 4,414,282.45 (increase of approximately $120,000 from 2020)
Opt-out cash back:	$ 486,960.00
Group Term Life:	$ 193,708.80
Disability (STD):	$ 265,708.00
Navia FSA Admin:	$ 37,327.20

What is the funding source? The funding is through contributions and fees paid by county departments, employees, retirees, COBRA beneficiaries, and other agencies contracting with Clackamas County for employee benefits administration.

STRATEGIC PLAN ALIGNMENT:

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

  The purpose of the Benefits program is to provide cost-effective, responsive and comprehensive benefit services to County departments, current, retired employees and their family members so they can better serve the residents of Clackamas County.

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

  Build trust through good government.

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

PUBLIC/GOVERNMENTAL PARTICIPATION:
The County Benefits Review Committee met regularly throughout the 2021 renewal period in a series of meetings throughout spring and summer 2020. The Benefits Program, with the assistance of Public & Government Affairs (PGA), continues to revise the successful communication plan used in prior years. With the current pandemic environment, PGA and the Benefits team have been working together to create more virtual resources for employees as part of the upcoming open enrollment campaign. Benefits has continued to partner with PGA to maintain a strong communications presence regarding benefits.

OPTIONS:
1. Approve 2021 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve retiree/COBRA/temporary employee medical plan changes. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

2. Approve non-represented employee cost sharing arrangement with changes. Approve 2021 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia and move it forward for formal adoption at a future business meeting. Approve retiree/COBRA/temporary employee medical plan changes.

3. Do not approve 2021 renewals, retiree/COBRA/temporary employee medical plan changes and/or non-represented employee cost sharing arrangement.

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RECOMMENDATION:
Staff recommends option 1: Approve 2021 renewals with Providence, Kaiser, Delta Dental, VSP, Metropolitan Life, Standard Insurance and Navia, and move it forward for formal adoption at a future business meeting. Approve retiree/COBRA/temporary employee medical plan changes. Approve 95%/5% cost share of medical premiums and 100% of the premiums for dental, life, and disability plans for non-represented employees.

ATTACHMENTS:
1. 2021 Rate Chart (Exhibit A)
2. Clackamas County General County 2021 Draft Renewal Report (Exhibit B)
3. General County Providence 2021 Plan Language Changes (Exhibit C)
4. General County Kaiser 2021 Plan Language Changes (Exhibit D)
5. General County Delta Dental 2021 Plan Language Changes (Exhibit E)
6. Clackamas County POA 2021 Draft Renewal Report (Exhibit F)
7. POA Providence 2021 Plan Language Changes (Exhibit G)
8. POA Kaiser 2021 Plan Language Changes (Exhibit H)
9. POA Delta Dental 2021 Plan Language Changes (Exhibit I)
10. Retiree/COBRA/Temporary Employee Medical Proposal (Exhibit J)

SUBMITTED BY:
Division Director/Head Approval _______KD__________
Department Director/Head Approval ____EM-L__________
County Administrator Approval _________________

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

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2021	NONREPRESENTED				REPRESENTED				PEACE OFFICERS			
MEDICAL												
	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family	Single	Married	Single w/ Child/ren	Family
Kaiser												
Employer	641.82	1,283.62	1,155.26	1,925.44	603.82	1,279.40	1,144.28	1,955.00	689.88	1,379.76	1,241.78	2,069.64
Employee	33.78	67.56	60.80	101.34	71.78	71.78	71.78	71.78	-	-	-	-
	675.60	1,351.18	1,216.06	2,026.78	675.60	1,351.18	1,216.06	2,026.78	689.88	1,379.76	1,241.78	2,069.64
Composite Equivalent				1,435.54				1,435.54				1,571.44
Employer							95%	1,363.76				
Employee								71.78				
Providence Personal Option/VSP Vision												
Employer	738.14	1,476.30	1,330.94	2,217.30	694.44	1,471.44	1,318.44	2,251.44	707.00	1,511.00	1,352.00	2,319.00
Employee	38.86	77.70	70.06	116.70	82.56	82.56	82.56	82.56	98.00	98.00	98.00	98.00
	777.00	1,554.00	1,401.00	2,334.00	777.00	1,554.00	1,401.00	2,334.00	805.00	1,609.00	1,450.00	2,417.00
Composite Equivalent				1,651.00				1,651.00				1,960.00
Employer							95%	1,568.44				1,862.00
Employee								82.56				98.00
Providence Open Option/VSP Vision												
Employer	814.14	1,627.34	1,467.74	2,442.44	650.00	1,506.00	1,338.00	2,364.00	756.70	1,615.70	1,446.70	2,477.70
Employee	42.86	85.66	77.26	128.56	207.00	207.00	207.00	207.00	104.30	104.30	104.30	104.30
	857.00	1,713.00	1,545.00	2,571.00	857.00	1,713.00	1,545.00	2,571.00	861.00	1,720.00	1,551.00	2,582.00
Composite Equivalent				2,011.00				2,011.00				2,086.00
Employer							90%	1,804.00				1,981.70
Employee								207.00				104.30
Medical Opt Out - Cash Back	83.00	164.00	148.00	247.00	185.00	185.00	185.00	185.00				
Medical Opt Out - HRA Contribution									176.00	176.00	176.00	176.00

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	NONREPRESENTED				REPRESENTED				PEACE OFFICERS			
DENTAL												
Kaiser												
Employer	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68	104.10	206.10	143.66	246.68
Composite:				191.00				191.00				191.00
MODA Preventive												
Employer	84.00	169.00	121.00	207.00	84.00	169.00	121.00	207.00				
Employee	-	-	-	-	-	-	-	-				
	84.00	169.00	121.00	207.00	84.00	169.00	121.00	207.00				
Composite:				166.00				166.00				
MODA Incentive												-
Employer	96.00	194.00	136.00	233.00	96.00	194.00	136.00	233.00	74.00	146.00	105.00	177.00
Employee	-	-	-	-	-	-	-	-	-	-	-	-
	96.00	194.00	136.00	233.00	96.00	194.00	136.00	233.00	74.00	146.00	105.00	177.00
Composite:				184.00				184.00				150.00
MODA 50%												
Employer	109.95	216.46	150.17	259.69	172.12	204.12	184.12	217.12				
Employee Cash Back	(48.00)	(94.00)	(65.00)	(113.00)	(87.00)	(87.00)	(87.00)	(87.00)				
FICA/PERS	(28.95)	(57.46)	(40.17)	(68.69)	(52.12)	(52.12)	(52.12)	(52.12)				
	33.00	65.00	45.00	78.00	33.00	65.00	45.00	78.00				
Composite:				63.00				63.00				
Dental Opt Out												
Employer	77.95	152.46	106.17	182.69	140.12	140.12	140.12	140.12	140.12	140.12	140.12	140.12
Employee Cash Back	(49.00)	(95.00)	(66.00)	(114.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)	(88.00)
FICA/PERS	(28.95)	(57.46)	(40.17)	(68.69)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)	(52.12)
EAP												
Employer Paid	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66	$2.66
WELLNESS												
Employer Paid	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86	$2.86

Exhibit: A
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	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LIFE INSURANCE										
Face Value	$ 150,000	$ 150,000	$ 50,000	$ 50,000	$ 50,000	$ 50,000	$ 75,000	$ 50,000	$ 50,000	$ 75,000
Employer Paid Premium	$22.20	$22.20	$6.80	$6.80	$6.80	$6.80	$10.20	$6.80	$6.80	$10.20
Face Value (Opt Down Coverage)	$ 50,000	$ 50,000								
Employer Premium	$22.88	$22.88								
Employee Cash Back	$ (11.00)	$ (11.00)								
FICA/PERS	$ (4.48)	$ (4.48)								
Premium	$ 7.40	$ 7.40								
$5000 Dependent - Employee Paid	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	$2.38	
$2000 Dependent - Employer Paid										$0.38
AD&D - Employee - Employee Paid	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040	$0.040
AD&D - Family - Employee Paid	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060	$0.060
DISABILITY										
Short-Term Rate per $100 Salary	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24	$ 0.24
Long-Term Rate per $100 Salary	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34	$ 0.34
Maximum Covered Salary	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333	$ 3,333
Employee Paid Buy-Up Max Salary	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 8,333	$ 10,000
DEFERRED COMPENSATION										
Employer Paid	6.27%						1.00%	1-3% Match	1-3% Match	4.00%
PERS/OPSRP PENSION										
Employee Rate - County Paid	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%	6.00%
Employer Rate - PERS Tier 1 & 2	27.07%	25.27%	27.07%	25.27%	27.07%	27.07%	27.07%	27.07%	27.07%	27.07%
OPSRP General Service	19.22%	17.75%	19.22%	17.75%	19.22%	19.22%	19.22%	19.22%	19.22%	19.22%
OPSRP Police & Fire	23.85%						23.85%			23.85%
FICA										
Social Security	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%	6.20%
Medicare	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%	1.45%
RETIREE MEDICAL FUND										
Employer Paid - % of Base Salary	3.50%	(Sheriff's Office Employees Only - POA Union)								
	3.50%	(Sheriff's Office Employees Only - Command)								

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	Elected/ Nonrep	Nonrep Housing Authority	EA	HA/EA	DTD	WES	FOPPO	C-COM (Non-Dispatch)	C-COM (Dispatch)	POA
LONGEVITY										
5 - 9 Years	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	1.0%	$ 67.32
10-14 Years	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	1.5%	$ 134.64
15-19 Years	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	2.0%	$ 201.96
20-24 Years	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	2.5%	$ 269.28
25-30 Years	3.5%	3.5%	3.5%	3.5%	3.5%	3.5%	3.0%	3.0%	3.0%	$ 336.60
30+ Years	4.0%	4.0%	4.0%	4.0%	4.0%	4.0%	3.5%	3.5%	3.5%	$ 403.92
VACATION ACCRUALS (MONTHLY)**										
< 5 Years	12.7	12.7	8.7	8.7	8.7	8.7	8.7	10.7	19.1	11.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
5 - 9 Years	14.0	14.0	10.7	10.7	10.7	10.7	10.7	12.7	21.1	13.7
Annual Maximum Carryover	280	280	250	250	250	218	280	240	240	240
10-14 Years	16.0	16.0	12.7	12.7	12.7	12.7	12.7	14.7	23.1	15.7
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
15-19 Years	18.0	18.0	14.7	14.7	14.7	14.7	14.7	16.0	24.4	17.0
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	320
20+ Years	19.3	19.3	16.7	16.7	16.7	16.7	16.7	16.7	25.1	18.3
Annual Maximum Carryover	280	280	250	250	250	258	280	280	280	360
VACATION SELLBACK ACCRUALS (MONTHLY)**										
Accrual (all years of service)	16	16	12	12	12	12	12			
Annual Maximum Carryover	280	280	250	250	250	250	250			
SICK LEAVE										
Monthly accrual	8	8	8	8	8	8	8	8	8	8
No Maximum Carryover										
HOLIDAYS										
Regular	10	10	10	10	10	10	10	10	0	10
Personal (Floating Holiday)	1	1	1	1	1	1	2	1	0	2

Note: Elected Officials do not receive longevity pay, nor do they accrue vacation, sick leave or Personal Holidays.
**Employees hired prior to 01/01/01 have a choice between the regular Vacation plan and the Vacation Sell Back plan.
Employees hired on or after 01/01/01 are enrolled in the Vacation Sell Back plan (except CCOM & POA).
Employees may sell one week of vacation each calendar year as long as they have taken at least one week of vacation during that year.
CCOM Dispatch employees earn additional vacation time in lieu of most holidays.

Exhibit: A
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2021 Health and Welfare Benefit Plan Preliminary Renewal Report

Clackamas County
September 2020

General County

welcome to brighter

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Summary

The Clackamas County General County 2021 health and welfare benefit plans renewal decisions are outlined in this report.

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

PLAN	2020 BUDGET RATE	2021 RENEWAL	% INCREASE
Active / Retiree Medical*			
General County			
VALUE: Kaiser HMO Option 10/10/1000 $250 Deductible; Vision $250/12 months			
EE	$693.18	$675.60	-2.5%
EE, SP	1,386.38	1,351.18	-2.5%
EE, CH	1,247.74	1,216.06	-2.5%
EE, FAM	2,079.56	2,026.78	-2.5%
COMPOSITE	$1,466.68	1,435.54	-2.1%
BASE: PHP Personal Option 20/20/3000 $1000 Common Deductible (includes VSP vision)			
EE	$746.00	$777.00	4.2%
EE, SP	1,492.00	1,554.00	4.2%
EE, CH	1,345.00	1,401.00	4.2%
EE, FAM	2,241.00	2,334.00	4.1%
COMPOSITE	$1,594.00	1,651.00	3.6%
BUY-UP: PHP Open Option 20/10/30/2500 $750 Common Deductible (includes VSP vision)			
EE	$823.00	$857.00	4.1%
EE, SP	1,645.00	1,713.00	4.1%
EE, CH	1,483.00	1,545.00	4.2%
EE, FAM	2,469.00	2,571.00	4.1%
COMPOSITE	$1,933.00	2,011.00	4.0%
Retiree / Temporary Medical			
PHP $1000 Deductible			
EE	$730.63	$761.32	4.2%
EE, SP	1,461.36	$1,522.74	4.2%
EE, CH	1,315.14	$1,370.38	4.2%
EE, FAM	2,191.92	$2,283.98	4.2%
Kaiser $1000 Deductible - General County			
EE	$533.84	$520.32	-2.5%
EE, SP	1,067.68	$1,040.64	-2.5%
EE, CH	960.90	$936.58	-2.5%
EE, FAM	1,601.56	$1,561.06	-2.5%
PHP Medicare Align			
General County	$351.90	$351.90	0.0%
Kaiser Medicare			
General County	$398.54	$405.42	1.7%

Vision (VSP) – Rates and Contributions combined with Medical

General County: VSP 12/12/12; $10/$30 copay; $130/$70 allowance			
EE	$7.00	$6.72	-4.0%
EE, SP	13.96	13.38	-4.2%
EE, CH	14.96	14.34	-4.1%
EE, FAM	23.88	22.90	-4.1%
COMPOSITE	$17.00	$16.00	-5.9%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County

General County: Delta Dental Incentive			
EE	$91.00	$96.00	5.5%
EE, SP	183.00	194.00	6.0%
EE, CH	128.00	136.00	6.3%
EE, FAM	220.00	233.00	5.9%
COMPOSITE	$176.00	$184.00	4.5%
General County: Delta Dental Constant (50%)			
EE	$30.00	$33.00	10.0%
EE, SP	59.00	65.00	10.2%
EE, CH	41.00	45.00	9.8%
EE, FAM	70.00	78.00	11.4%
COMPOSITE	$57.00	$63.00	10.5%
General County: Delta Dental Preventive			
EE	$80.00	$84.00	5.0%
EE, SP	160.00	169.00	5.6%
EE, CH	115.00	121.00	5.2%
EE, FAM	196.00	207.00	5.6%
COMPOSITE	$158.00	$166.00	5.1%
General County/POA: Kaiser			
EE	$104.10	$104.10	0.0%
EE, SP	206.10	206.10	0.0%
EE, CH	143.66	143.66	0.0%
EE, FAM	246.68	246.68	0.0%
COMPOSITE	$190.00	$191.00	0.5%

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Life and AD&D (MetLife)			
Basic Life (Rate per $1,000 benefit)			
Nonrepresented – GC	$0.148	$0.148	0.0%
Represented – GC & POA	$0.136	$0.136	0.0%
Group Universal Life			
General County and POA	Age Rated	Age Rated	0.0%
Dependent Life per Employee (Rate per Family)			
$5,000 per Dependent – GC	$2.38	$2.38	0.0%
Voluntary AD&D – General County Only (Rate per $1,000 benefit)			
Employee Only	$0.04	$0.04	0.0%
Employee and Family	$0.06	$0.06	0.0%
LTD (Standard)			
Self Insured – General County			
Funding Rate (Per $100 of Covered Salary)	$0.24	$0.24	0.0%
General Fee (PEPM)	$0.36	$0.36	0.0%
New Claim Fee (Per Claim)	$390.00	$390.00	0.0%
Open Claim Fee (Per Claim)	$19.00	$19.00	0.0%
Fully Insured – General County			
Base Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Buy-Up Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Employee Assistance Program – EAP			
Cascade (Previously with Standard)			
General Fee PEPM	$2.60	$2.66	2.3%
Flexible Spending Account			
Navia			
Monthly Fee PPPM	$5.00	$5.15	3.0%
Long Term Care – LTC			
Unum – General County			
General Fee PEPM	Age Rated	Age Rated	0.0%

**Rates include the standard 2021 contract changes.*

PEPM = Per Employee Per Month
PMPM = Per Member Per Month
PPPM = Per Participant Per Month

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Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2021 projection for the Open and Personal Options called for an overall 4.2% increase for the General County.

The 2021 Providence ASO fees are shown below as per employee per month (PEPM).

Providence Health Plan Administrative Fees

	2021 PEPM
Medical Administration	$32.45
Pharmacy Administration	5.41
Alternative Care Administration	2.30
Case and Disease Management	9.37
Network Access Fee	8.11
Health Coaching – 12 Sessions	2.12
	$59.76

Stop Loss Administrative Fees – Optum Health

The 2021 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is $200,000.

Mercer's underwriting projection for the 2021 renewal is included in **Exhibit A** for reference.

General County

The BRC did not elect any plan changes for the 2021 plan year:

Exhibit B contains the preliminary required 2021 contract changes summary for non-grandfathered plans, which was provided by Providence. These will be effective January 1, 2021.

See **Exhibit C** for the Providence 2021 General County benefit summaries.

Retirees – General County

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 2021 plan year. The 2021 benefit summary is included in **Exhibit C**.

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)
There is no change to the 2021 premium rate for the Providence Medicare Align plan.

Medicare Align Plan	
Medicare Align With Prescription Drug	$351.90

Exhibit B contains the standard 2021 contract changes for non-grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2021 early retiree benefit summaries.

Kaiser Permanente

General County

Kaiser proposed an overall 2.5% decrease to the 2021 premium rates.

General County

The General County did not elect to make benefit changes to this plan.

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

Exhibit E contains the 2021 contract changes provided by Kaiser. The BRC accepted the proposed 2021 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

Retirees – General County

Early (pre-age 65) retirees are eligible for the active employee HMO plan. The County also offers a $1000 deductible plan for early retirees and COBRA participants. The proposed rate decrease of 2.5% for the General County was accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. Premium rates increased by 1.7% for the General County plans.

Exhibit E contains the 2021 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The County elected to renew their vision plans with VSP. The rates for the 2021 plan year are provided in Section 1.

The VSP plan is receiving a 2-year rate guarantee. The plan will next renew January 1, 2023.

See **Exhibit G** for the 2021 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

The Incentive Plan is available to all employees. 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).

Clackamas County is entering the second year of a three-year fee agreement with Delta. The fee for each year of the three-year agreement are as follows:

Fee per Employee per Month	2020	2021	2022
Administration fee	$6.55	$6.62	$6.69

The BRC elected the following dental plan change for the 2021 plan year:

1. A separate charge for pulp capping is not covered

Exhibit I contains the Delta administrative contract changes for 2021 for General County.

See **Exhibit J** for the 2021 Delta benefit summaries.

Underwriting

Mercer projected a 2021 combined funding increase of 5.8% for the 2021 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 2021 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 April 1, 2019, through March 31, 2020. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2021 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed no increase to the 2020 premium rates.

Exhibit E contains the 2021 standard contract changes provided by Kaiser, which will be effective January 1, 2021. See **Exhibit F** for the Kaiser 2021 benefit summaries.

The 2021 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. The rates are entering the second year of a two-year year agreement.

A summary of the rates for the 2021 plan year are as follows:

General County

Basic Life	
Non-Represented Employees	$0.148/$1,000
Represented Employees	$0.136/$1,000
Dependent Life	
$5,000 per spouse/domestic partner or child	$2.38 PEPM
Voluntary Accidental Death and Dismemberment	
Employee	$0.040/$1,000
Employee and Family (spouse/domestic partner or child)	$0.060/$1,000

General County

Group Universal Life (Rates Per $1,000)		
Age	Non-Smoker Rates	Smoker Rates
< 30	$0.044	$0.066
30-34	0.048	0.074
35-39	0.062	0.102
40-44	0.096	0.150
45-49	0.164	0.224
50-54	0.270	0.330
55-59	0.424	0.518
60-64	0.640	0.798
65-69	1.186	1.270
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	$0.12	$0.24	$0.36	$0.48	$0.60

Long Term Disability Insurance

The Standard

The County offers two LTD plans through The Standard as follows:

- **Base LTD Plan**
  - This coverage is provided by the County without contribution from employees. The disability benefit is 60% of the first $3,333 of monthly pre-disability income. The plan is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.

- **Buy-up LTD Plan**
  - **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.

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

The benefits will remain unchanged for the 2021 plan year.

Fees and Premium Rates

The Standard will hold the current rates for two more years. The current rates will be in effect through December 31, 2022.

The 2021 funding, premium, and fees are as follows:

Self-Insured Plan	
Funding	$0.24 per $100 of 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	$0.34/$100
Buy-Up – General County	$0.34/$100

Employee Assistance Plan

Cascade Centers

The 2021 fee for EAP services is as follows:

Fee per Participant per Month	
Employee Assistance Program	$2.66

Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia) to provide administration for the FSA plans. The fee will increase from $5.00 per participant per month to $5.15 effective January 1, 2021. The renewal fee will be guaranteed for three years.

The 2021 fees are as follows:

Fees per Participant per Month	
Health Care FSA	$5.15
Annual Maximum	$2,500
Dependent Care FSA	$5.15
Annual Maximum	$5,000

Long Term Care Insurance

Unum

Unum insures the voluntary long term care (LTC) coverage for General County employees. There is a rate hold for the 2021 plan year.

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Employee Contributions

General County

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

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

	Employee Only	Employee w/ Spouse/Partner	Employee w/ Child(ren)	Employee w/ Family
NONREPRESENTED				
Providence Personal Option – Base				
Employer	$738.14	$1,476.30	$1,330.94	$2,217.30
Employee	38.86	77.70	70.06	116.70
Providence Open Option – Buy-Up				
Employer	$814.14	1,627.34	1,467.74	2,442.44
Employee	42.86	85.66	77.26	128.56
Kaiser – Value				
Employer	$641.82	1,283.62	1,155.26	1,925.44
Employee	33.78	67.56	60.80	101.34
Medical Opt Out				
Cash Back	83.00	164.00	148.00	247.00
REPRESENTED				
Providence Personal Option – Base				
Employer	694.44	1,471.44	1,318.44	2,251.44
Employee	82.56	82.56	82.56	82.56
Providence Open Option – Buy-Up				
Employer	650.00	1,506.00	1,338.00	2,364.00
Employee	207.00	207.00	207.00	207.00
Kaiser – Value				
Employer	603.82	1,279.40	1,144.28	1,955.00
Employee	71.78	71.78	71.78	71.78
Medical Opt Out				
Cash Back	185.00	185.00	185.00	185.00

General County - Dental

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	$48.00	$94.00	$65.00	$113.00
Represented				
Cash Back	87.00	87.00	87.00	87.00
Dental Opt Out				
Nonrepresented				
Cash Back	49.00	95.00	66.00	114.00
Represented				
Cash Back	88.00	88.00	88.00	88.00

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MARSH & McLENNAN
COMPANIES

0120 to 0121 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice (Medical Home)

– UPDATED 09.10.2020 –

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Benefit Changes – For all plan types, except as otherwise denoted								
Section 4.7.1 language added for osteopathic manipulation	All handbooks	Adding language for osteopathic manipulation coverage to be covered under outpatient services	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Osteopathic Manipulation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, osteopathic manipulation and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	Yes	No	Currently, osteopathic office visits and **osteopathic manipulations** are both considered under the PCP office visit benefit and assessed one copay. We are changing **osteopathic manipulation** so that it is not counted as part of the PCP visit but mapped to another benefit. This means a higher cost share for the member than the current setup, where it is considered part of a PCP visit. Recommendation is to map osteopathic manipulation to the Outpatient Services benefit, subject to its own cost share, to align with PHP's intended administration of the osteopathic manipulation benefit. It is not common practice to bundle osteopathic manipulation with office visits. Note: Acceptance is *optional*.	☐ Yes ☒ No
Section 4.9.1 glucometer benefit change and additional clarifying language for limits	All handbooks	Updating language to provide greater transparency to members of how diabetes supplies/glucose monitors are covered and where they can find more information Changing benefit coverage of glucometers from Durable Medical Equipment to Diabetes Supplies	**4.9.1 Medical Supplies (including Diabetes Supplies)** ***** 2. Diabetes supplies, such as needles, syringes, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices. *****	**4.9.1 Medical Supplies (including Diabetes Supplies)** ***** 2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. ~~Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members.~~ Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as ~~glucometers and~~ insulin pump devices. *****	Yes – Glucometer changes only	No	Glucometers are currently stated as being covered under the Durable Medical Equipment Benefit. However, since they are used for testing blood levels related to Diabetes, we suggest moving glucometers to the diabetic supplies benefit so that they are covered in full. This will provide a better benefit for diabetic members. Leaving glucometers as a Durable Medical Equipment benefit applies a cost share to members. Note: Acceptance is *optional*, however, PHP recommends adoption to provide a better benefit for diabetic members. Language on test strip limits should be removed to reduce confusion, as what we actually allow is more than what is listed in the handbook. We recommend referring members to their formulary for details.	☒ Yes ☐ No

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4. *****	4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include ~~glucometers and~~ insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4. *****				
Section 4.10.2 removal of neurofeedback	All handbooks	Should have been removed previously to align with mental health parity	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, neurofeedback, chelation or hyperbaric chambers; *****	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy~~, neurofeedback~~, chelation or hyperbaric chambers; *****	Yes	No	The decision to remove neurofeedback as an ABA exclusion is based on PHP's interpretation of federal and state mental health parity laws. This change is also based on federal case law, which prohibits plans from including categorical exclusions for the treatment of mental health conditions (including autism). Note: Acceptance is *optional* for ASO. However, PHP recommends adoption to adhere to what we have interpreted as following mental health parity laws.	☒ Yes ☐ No
Section 4.12.17 inclusion of coverage for drug-induced Alopecia	All handbooks	Adding coverage for drug-induced Alopecia	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	Yes	Yes – OR state regulation only (OAR 836-053-0012(3)(c)(B); no federal mandate	Wigs are currently written as covered for chemotherapy, but we are suggesting to include coverage for people who have hair-loss from the same drugs as chemo, but not related to cancer. Note: Acceptance is *optional* for ASO groups that are not required to or do not electively follow state mandates. However, PHP recommends adoption to reduce barriers to health. AM Note: negligible. However Clackamas County has elected to follow all mandates. Coverage is considered accepted to comply	☒ Yes ☐ No
New section and update for biofeedback	All handbooks	New section explaining coverage for biofeedback	N/A – adding section on Biofeedback	4.12.19 Biofeedback Coverage is provided, as shown in the Benefit Summary for biofeedback to treat migraine headaches or urinary incontinence. Services must be Medically Necessary and within the Qualified Practitioner's scope of license.	Yes	No	This is already a covered benefit for some groups. This change is to call it out for member visibility, and to align to current medical policy. Currently, it is covered by waiving the deductible and having unlimited visits.	☒ Yes ☐ No

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administ ration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			5. EXCLUSIONS ***** **The Plan does not cover:** ***** • Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs; • • Thermography;	***** 5. EXCLUSIONS ***** **The Plan does not cover:** ***** • Charges for health clubs or health spas, aerobic and strength conditioning, work-hardening programs, and all related material and products for these programs; • Biofeedback, except as provided in section 4.12.19; • Thermography;			The proposal is to add biofeedback language to the handbook, and change biofeedback coverage to apply a deductible & coinsurance and have a limit of 10 visits per lifetime. Limits do not apply to Mental Health Services. Coverage would be for the following medical conditions only: migraines and urinary incontinence. Note: Acceptance is *optional*, however, PHP recommends adoption to align with medical policy. 2 questions: 1. Add to handbook per the changes noted to the left and 2. Update cost shares to apply deductible and limit to 10 visits per lifetime	
Early refill of eye drops exclusion	All handbooks	Updating language to better reflect an exclusion and when the exclusion does not apply	**4.14.8 Prescription Drug Exclusions** ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.	**4.14.8 Prescription Drug Exclusions** ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); ~~and~~ 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC~~.~~; and ~~20.~~21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. [This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.]	Yes	Yes - second sentence only applies to state abiding ASO groups (ORS 743A.065)	First sentence added to provide transparency of coverage for members that have or may require eye drops. The second bracketed sentence is required for groups that are required to or electively choose to follow state mandates. State abiding ASO groups cannot exclude early refills of eye drops for glaucoma members, per ORS 743A.065. Note: Acceptance of the second sentence is *optional* for ASO groups that are not required to or do not electively follow state mandates. However, PHP recommends adoption to provide a better benefit for members with glaucoma.	☒ Yes ☐ No
Section 5. Exclusions	All handbooks	Removing civil riot/military activities exclusion per Oregon state's direction	**5. EXCLUSIONS** ***** **General Exclusions:** **The Plan does not cover Services and supplies which:** ***** • Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.	**5. EXCLUSIONS** ***** **General Exclusions:** **The Plan does not cover Services and supplies which:** ***** • ~~Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.~~	Yes	Yes (OR state mandate only; no federal mandate)	Removing plan exclusion of coverage for any injuries or illnesses related to a member's voluntary participation in a civil riot, military services, or war-related activities. This is being done at the express direction of Oregon DFR out of their concerns of potential discrimination against: 1) military personnel who may have a pre-existing condition or may not have full access to care under their military plan, and 2) individuals who may be injured in the ongoing civil protests.	☒ Yes ☐ No

0120 to 0121 ASO Contract Comparison – ACA non-grandfathered plans (non-GR)

Option Advantage, Personal Option, HSA-Qualified, Choice (Medical Home)

– UPDATED 09.10.2020 –

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
							Note: This change only applies to ASO groups which are required to or electively choose to follow state law. It is otherwise completely *optional* for ASO.	
Benefit Administration Changes – For all plan types, except as otherwise denoted								
Additional language added to prior authorization list	All handbooks	Adding language to callout some additional services that require prior authorization	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; *****	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; • Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	
Removal of authorizing agent language	All handbooks	Removing language around authorizing agent due to bringing services in-house	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan or their authorizing agent. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us or our authorizing agent; *****	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan ~~or our authorizing agent~~ must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan ~~or their authorizing agent~~. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us ~~or our authorizing agent~~; *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	

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Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
			An approved ABA treatment plan is subject to review by us or our authorizing agent, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.	An approved ABA treatment plan is subject to review by us or ~~our authorizing agent~~, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services ***** Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan ~~or their authorizing agent~~.				
Section 4.7.1 language added for pain management	All Handbooks	Adding language to reflect pain management benefit	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy<u>, and Multidisciplinary Pain Management Programs</u>** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, ~~and~~ therapeutic procedures<u>, and approved multidisciplinary pain management programs</u> as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	Yes	No	We need to map the Pain Management Program to the Outpatient Services benefit. Right now, the Pain Management codes are hitting the Physical Therapy benefit, but should be separated to align with the intent of the Pain Management Program. The Pain Management Program is separate from Physical Therapy. The Physical Therapy benefit has its own yearly accumulations. Changing this will be a better benefit for the member, in regards to the Pain Management Program.	
Appeals and Grievances	All Handbooks	Changing response time for non-urgent post-service claim	7.2.1 Your Grievance and Appeal Rights ***** To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. We	7.2.1 Your Grievance and Appeal Rights *****	Yes	Yes	For 2021, PHP has elected to change our ASO appeals process to follow the full 60-day notification time frame for responding to <u>non-urgent</u> <u>post-service</u> claim appeals, as expressly	

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		appeals to follow ERISA	will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and resolve within 30 days or sooner depending on the clinical urgency. Urgent medical conditions and concurrent care have different resolution timelines, as noted below. *****	• To the extent possible, Customer Service will resolve complaints filed by telephone at the point of service. We will acknowledge all non-urgent pre-service and post-service Grievances and Appeals within seven days of receipt and notify you of our decision~~resolve~~ within 30 days (for non-urgent pre-service matters) or 60 days (for non-urgent post-service matters). ~~or sooner depending on the clinical urgency.~~ Urgent medical conditions and concurrent care have different resolution timelines, as noted below. *****			permitted by ERISA. [29 CFR § 2560.503-1(i)(2)(iii)(A)]. Previously, PHP followed the State standard (30-day notification time frame) for responding to this type of appeals across both fully-insured and ASO lines for simplicity and uniformity in administration. In current day, with greater resources and process flows in place, we seek to administer appeals for ASO line in accordance with the federal laws which are intended for ERISA-subject self-funded plans. Note: This change does not apply to non-ERISA ASO groups which are required to or electively choose to follow state law. State-abiding ASO groups will remain on the 30-day State standard.	
Language Changes – For all plan types, except as otherwise denoted								
Update provider directory web address	Some handbooks where existing language exists	Updating the provider directory web address to increase the ease of access	http://phppd.providence.org/	~~http://phppd.providence.org/~~ProvidenceHealthPlan.com/findaprovider	No	No	Only applies to groups that currently use the provider directory link http://phppd.providence.org/	
Updating Quick Reference Guide	All Handbooks	Updating the Customer Service Quick Reference Guide to provide correct contact information for members	**Customer Service Quick Reference Guide:** ***** Medical Prior Authorization Requests 800-638-0449 (toll-free) Mental Health and Chemical Dependency Prior Authorization 800-711-4577 (toll-free)	**Customer Service Quick Reference Guide:** ***** Medical[, Mental Health, and Chemical Dependency] Prior Authorization Requests 800-638-0449 (toll-free) 503-574-6464 (fax) ~~[Mental Health and Chemical Dependency Prior Authorization 800-711-4577 (toll-free)]~~ Provider Directory ProvidenceHealthPlan.com/findaprovider	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Adding Prior Authorization fax number and provider directory link are updates independent of brining behavioral health in-house and are effective today.	
Privacy Policy Revision	All handbooks	Removing unnecessary language	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and Your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the	No	No	Removing extraneous language. Last sentence of the paragraph under "Confidentiality and your Employer" is too detailed as the language immediately following it explains the HIPAA guidelines.	

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			Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed. Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****	Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. ~~In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.~~ Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****				
Section 3.1.1 Medical Home Selection form web address	Choice (Medical Home) handbooks only	Update the link for online access to the Medical Home Selection form	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Mail your completed form to: Providence Health Plan Attn: Customer Service PO Box 3125 Portland, OR 97208 • **Email:** Download the Medical Home Selection Form from our website at	**3.1.1 Choosing or Changing a Medical Home** ***** Once you have chosen a Medical Home, you must communicate your Medical Home selection to Providence Health Plan before receiving services: • **Phone:** Call Customer Service at 503-574-7500 or 800-878-4445, Monday through Friday, 8 a.m. to 5 p.m. • **Mail:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Mail your completed form to: Providence Health Plan Attn: Customer Service PO Box ~~3125~~4327 Portland, OR 97208 • **Email:** Download the Medical Home Selection Form from our website at	No	No	Updating medical home form link.	

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			ProvidenceHealthPlan.com. E-mail your completed form to medicalhomeselectionforms@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com. Fax your completed form to 503-574-8208.	ProvidenceHealthPlan.com/medhomeform. E-mail your completed form to medicalhomeselectionforms@providence.org. • **Fax:** Download the Medical Home Selection Form from our website at ProvidenceHealthPlan.com/medhomeform. Fax your completed form to 503-574-8208.				
Language update to clarify current billing process for Out-of-Network emergency services	All handbooks except Personal Option	Updating language to call out potential balance billing by Out-of-Network providers and Out-of-Network Hospitals	**4.5.1 Emergency Care** ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. *****	**4.5.1 Emergency Care** ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 4.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR. *****	No	No	Language update necessary to advise members of potential balance billing by Out-Of-Network providers and Out-Of-Network hospitals (unless otherwise prohibited by state or federal law), even when emergency services are covered at an In-Network benefit until the member is stable and able to be transferred to an In-Network facility.	
Section 4.12.14 additional clarifying language	All handbooks	Providing clarifying language about the type of treatment of Gender Dysphoria that is subject to Medical Necessity	**4.12.14 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see	**4.12.14 Gender Dysphoria** Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. ~~Treatment~~ Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may	No	No	Language update necessary to accurately reflect that *surgical* treatment of gender dysphoria is subject to medical necessity review.	

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			section 3.5 for a list of services requiring Prior Authorization. *****	apply. Please see section 4.4 for a list of services requiring Prior Authorization. *****				
Language update to reflect override allowances	All handbooks	Updating language to better reflect available benefits	**4.14.7 Prescription Drug Limitations** ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.	**4.14.7 Prescription Drug Limitations** ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan. ~~7.~~8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis. ~~8.~~9. A 30 day supply medication refill override will be granted if you are out of medication and have not yet received your drugs from a participating mail order pharmacy.	No	No	Language update necessary to provide greater transparency of medication override benefits for members and limits to the coverage.	
Prescription combination drugs exclusion	All handbooks	Updating language to better reflect scope of existing exclusion	**4.14.8 Prescription Drug Exclusions** ***** 11. Drugs placed on a prescription-only status as required by state or local law;	**4.14.8 Prescription Drug Exclusions** ***** 11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;	No	No	This language change clarifies the scope of the existing prescription drug exclusion.	
Removing address due to in-house services	All handbooks	Removing the address due to bringing services in-house Correcting P.O. Box number	**6.1.1 Timely Submission of Claims** ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box 4327 Portland, OR 97208-4327 Mental Health and Chemical Dependency claims should be submitted to:	**6.1.1 Timely Submission of Claims** ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box 3125 ~~4327~~ Portland, OR 97208-3125~~4327~~ ~~Mental Health and Chemical Dependency claims should be submitted to:~~	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Reverting claims PO Box number back to 3125 as it was changed in error.	

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			PBH PO Box 30602 Salt Lake City, UT 84130 *****	~~PBH~~ ~~PO Box 30602~~ ~~Salt Lake City, UT 84130~~ *****				
Section 8 language modification	All handbooks	Modified language to improve readability	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide us with evidence of eligibility as requested. *****	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide ~~us~~ Providence Health Plan with evidence of eligibility as requested. *****	No	No	Updating reference to Providence Health Plan to avoid confusion	

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2021 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups (General County Plans)

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2021. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus® medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- For Deductible and High Deductible Health Plans, we have added selected preventive care services to be covered without a deductible for individuals diagnosed with specific chronic conditions, as allowed under the IRS and US Treasury Department Notice 2019-45.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified to indicate that the cost share for insulin is not subject to Deductible and will not exceed $100 per 30-day supply.
- The "Maternity and Newborn Care" section of the *EOC* and Benefit Summary has been modified to indicate that newborn nurse home visiting Services are covered as required per Oregon Senate Bill 526.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions has been added to the list of covered DME under the "Outpatient Durable Medical Equipment (DME)" section of the *EOC*.

Benefit clarifications

- The "Post-Stabilization Care" section of *EOC* has been modified to clarify that these benefit provisions apply to covered Services from vendors, such as providers of Durable Medical Equipment (DME).
- The "Preventive Care Services" section of the *EOC* has been modified. A bullet has been added to the confirm coverage for any state-required reproductive health preventive Services for all Members.
- The "Chemical Dependency Services" section of the *EOC* has been modified. A statement has been added to confirm that the benefits in this section comply with the federal Mental Health Parity and Addiction Equity Act.

- The term "DME formulary" is being removed from the "Outpatient Durable Medical Equipment (DME)" and "External Prosthetic Devices and Orthotic Devices" sections for clarity and to reduce confusion with "formulary" in reference to prescription drug benefits.
- The "External Prosthetic Devices and Orthotic Devices" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy and consistency within the contract. Language has been added to specify that Services are covered subject to Utilization Review.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been revised for better alignment with the requirements of ORS 743A.141.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified for alignment across products. A parenthetical was added, excepting insulin from the "Injectable drugs that are self-administered" exclusion.
- The "Mental Health Services" section of the *EOC* and the Benefit Summary have been modified to clarify that partial hospitalization is a covered Service.
- The "Outpatient Durable Medical Equipment" section of the *EOC* has been modified to clarify that both blood glucose monitors and continuous glucose monitors are covered.
- The Low-Vision Aids and Vision Hardware and Optical Services exclusions in the Exclusions and Limitations section of the *EOC* have been modified for clarity to include a cross reference to the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."
- The "Exclusions and Limitations" section of the *EOC* has been modified. The surrogacy limitation clarifies that it applies to both traditional and gestational surrogacy arrangements.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The term Cost Share has been defined and added to the "Definitions" section of the *EOC*. Throughout all documents, the defined term Cost Share replaces some, but not all, instances of Deductible, Copayments, or Coinsurance used for improved readability, accuracy, and administrative purposes.
- The terms Non-Participating Vendor and Participating Vendor have been added to the "Definitions" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* for alignment across products.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services" section of the *EOC*, has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.
- The definition of Spouse has been modified to clarify that the term includes a person who is validly registered as a domestic partner under the laws of another state.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- The "Prior and Concurrent Authorization and Utilization Review" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is

required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, and Appeals" section.

- The "Out-of-Pocket Maximum" section of the *EOC* has been modified to remove an incorrect reference to payments for Services under the "Alternative Care Services" section of the *EOC* as the *EOC* does not contain this section.
- The "Out-of-Pocket Maximum" section of the *EOC* has been modified for accuracy. The bullets indicating that payments for Services under the "Infertility Services" section and the "Infertility Treatment Services Rider" have been removed. Payments for these Services do apply to the "Out-of-Pocket Maximum."
- Throughout the *EOC*, references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Surrogacy Arrangements" section of the *EOC* has been modified to clarify that the section applies to both traditional and gestational surrogacy arrangements.
- The "Grievances, Claims, Appeals, and External Review" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.
- The "Moving to Another Kaiser Foundation Health Plan Service Area" section of the *EOC* has been modified to clarify that a Member may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan Service Area, rather than transferring to another plan, as they would still need to meet the eligibility requirements of the new plan.
- The "Unusual Circumstances" section of the *EOC* has been modified to clarify that, in the event of unusual circumstances that could result in delay or inability to provide covered Services, Kaiser Permanente will make a good faith effort to provide or arrange for Services within the limitations of available personnel and facilities.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in all tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements," "Tier 3 Out-of-Pocket Maximum," and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a

Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor, or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "How to Obtain Services - General Information" section of the *EOC* has been modified for accuracy. The language noting Urgent Care as an exception to the Tier 1 requirements has been removed. Only Emergency Services received at a PPO Facility or Non-Participating Facility are covered under Tier 1. Urgent Care Services received at a PPO Facility or Non-Participating Facility are covered under Tier 2 or Tier 3, whichever applies.
- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3" section of the *EOC* has been modified. The list of Services that do not require prior authorization in Tier 2 and Tier 3 has been revised for clarity and accuracy.
- The "Tier 2 and Tier 3 Urgent Care" section of the *EOC* has been modified to clarify that we cover Urgent Care under Tier 2 or Tier 3. The language indicating that if a Member receives Urgent Care that is not covered under Tier 1 has been removed as Urgent Care is covered under Tier 1. We do not cover Services in Tier 2 or Tier 3 that are not covered under Tier 1.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Tier 1 Prior Authorization Review Requirements" and the "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections of the *EOC* have been updated to The "Prior and Concurrent Authorization and Utilization Review" section of the *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Additional changes and clarifications that apply to PPO Plus® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in both tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements" and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor,

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or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "General Information" subsection under "How to Obtain Services" has been modified for accuracy. The language regarding an exception to the Tier 1 requirements has been revised to clarify that Emergency Services received at a Non-Participating Facility are not subject to these requirements.
- The "Services Subject to Prior Authorization Review" section of the *EOC* has been modified. The list of Services that do not require prior authorization has been revised for clarity and accuracy.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Prior Authorization Review Requirements" section of the *EOC* has been modified to reflect that prior authorization determinations will be provided within two business days per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Changes and clarifications that apply to medical benefit riders

Benefit changes

- The "Cost Share for Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" used for Added Choice and PPO Plus plans has been modified to reflect a change in how the Member cost share is applied for drugs obtained from MedImpact Pharmacies when a generic equivalent is available, but the Member chooses a brand-name drug. Language stating that the Member would pay the difference between the pharmacy's retail price for the brand-name drug and the generic drug, in addition to the applicable drug tier cost share, has been removed. Members will now only pay the Copayment or Coinsurance for the brand-name drug.

Benefit clarifications

- The "Medication Management Program" section of the "Outpatient Prescription Drug Rider" has been modified for clarity.

Administrative changes or clarifications

- Throughout the riders, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services Rider," has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.

- Language has been added to the "Hearing Aid Rider" to clarify that the hearing aid allowance is combined across all tiers under which hearing aids are covered.
- The first paragraph of the "Infertility Treatment Services" section in the "Infertility Treatment Services Rider" has been modified for alignment with other products. Language indicating that Services are covered "only under Tier 1" has been removed as this concept is discussed later in the rider.
- The "Infertility Treatment Services Rider" has been modified. The language indicating that the Lifetime Benefit Maximum is combined across all tiers has been moved from the rider benefit summary table to the text of the rider.
- The Member Services phone number has been removed throughout the "Outpatient Prescription Drug Rider" templates to align with the *EOC*.
- Throughout the "Outpatient Prescription Drug Rider," references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Outpatient Prescription Drug Rider" for plans that cover sexual dysfunction drugs has been modified. The bullet limiting sexual dysfunction drugs to eight pills per a 30-day supply has been removed as this limit is captured in the "You Pay" cell of the Sexual Dysfunction drugs row on the Rider Benefit Summary Table for plans that have the limit.

Changes and clarifications that apply to dental plans

Benefit clarifications

- Minor edits were made for clarity to the exclusion for government agency responsibility in the "Exclusions" section of the *EOC*.
- The exclusion for use of alternative materials in the "Exclusions" section of the *EOC* was modified to improve readability and understanding.
- A new limitation has been added to clarify that routine fillings are limited to amalgam or glass ionomer fillings on posterior teeth and composite fillings on anterior teeth. This limitation does not change how fillings are currently restored.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The column for In and Out-of-Network Benefit Maximum in the PPO *EOCs* was split from one to two columns for administrative ease and clarity.
- Language in various sections throughout the *EOC* has been modified to align with similar sections across products and lines of business. This synchronization did not result in any benefit or administrative changes.
- References to online directories have been updated where applicable to ensure accuracy.
- The definitions of Dentally Necessary and Medically Necessary have been revised to eliminate redundancy when defining Services.
- The definition of Spouse has been modified to clarify that a person who is validly registered as your domestic partner under the laws of another state is defined as a Spouse.

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- The reference to "effective date" in the "When Coverage Begins" section has been updated to "membership effective date" and other references throughout the *EOC* to "effective date of coverage" for clarity.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- References to dental claim forms in the "Post-Service Claims - Services Already Received" section have been updated for accuracy.
- The PPO *EOCs* have been revised to clarify that all care and Service must be directed by a Participating or Non-Participating Provider within the United States.
- United States Food and Drug Administration was updated to U.S. Food and Drug Administration (FDA) for consistency and accuracy.
- The term "Calendar" was removed from all limitations referring to "Calendar Year." The defined term is Year.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Grievances, Claims, and Appeals" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- A note has been added to the "Dental Implant Benefit" section clarifying that pontics are not covered under the Dental Implant Services Rider but under the "Major Restorative Services" section of the *EOC*.
- The first bullet under the "Exclusions" section of the Dental Implant Services Rider has been modified for clarity. An implant or any part of an implant surgically placed prior to a Member's effective date of Company coverage is not covered. This clarification supports current administration.
- A new limitation has been added to the Implant rider to clarify that removing and reinserting a prosthesis and abutments for cleaning is limited to implants placed by a Permanente Dental Associates Participating Dentist. This will enable Participating Dentists to maintain consistent and high quality of care. This clarification supports current administration.

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Administrative changes or clarifications

- The first bullet under the "General Benefit Requirements" section of the Dental Implant Services Rider has been modified to clarify that all care and Service must be directed by a Participating or Non-Participating Provider.
- References to "effective date" have been updated to "effective date of coverage" for clarity.
- References to "charges" in the Dental Implant Services Rider and Orthodontic Services Rider have been removed to accurately reflect the Member's cost share as "coinsurance."

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart located at the front of the *EOC*:
  - Acupuncture for chronic low back pain has been added. This is a CMS benefit change effective January 21, 2020 and was not previously included in the Chart.
  - More detail about covered services has been added to the "Colorectal cancer screening" section of the Chart to describe cost-sharing for colonoscopies.
  - The "Durable medical equipment (DME) and related supplies" section has been revised to add phototherapy equipment for home use to treat psoriasis to the items covered at $0 cost sharing, and also to list DME items not covered by Medicare but covered by us when medically necessary.
  - The Silver&Fit® Healthy Aging and Exercise Program benefit description has been revised. Members who enroll in Silver&Fit may choose all or some of the available options: basic gym membership, two "Home Fitness" kits, and one "Stay Fit" kit.
  - More detail has been added to the "Home infusion therapy" section to describe covered services necessary to perform home infusion, including drugs, equipment, supplies, professional services, patient training and education, and monitoring.
  - Three specific lab tests for persons with certain chronic conditions have been added to the "Outpatient diagnostic tests and therapeutic services and supplies" section and are covered at $0 cost-sharing (not subject to deductible, if applicable), for all members.
  - Sleep studies have been added as a covered item in the "Outpatient diagnostic tests and therapeutic services and supplies" section.
  - The "Physician/practitioner services, including doctor's office visits" section has been revised. We have added information to explain when the outpatient surgery cost-sharing is applied. The description of covered telehealth services has also been modified for clarity.
- A new Section 8 has been added to Chapter 3 of the *EOC* to describe what oxygen benefits (equipment, supplies and maintenance) a Senior Advantage member is entitled to; what is the cost-sharing; and how coverage is affected if a member leaves our plan and returns to Original Medicare.
- A paragraph has been added to Chapter 4, Section 1 of the *EOC* – "Understanding your out-of-pocket costs for covered services" – to inform members there is no cost-sharing related to COVID-19 testing or treatment for the duration of the public health emergency.
- We have removed genetic testing from the exclusions or limitations chart in Chapter 4 of the *EOC* because genetic testing is covered by Medicare in certain situations.

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- Several *EOC* definitions have been revised for clarity and accuracy, including the terms Emergency Medical Condition, Exception, Network Physician, and Plan.

Administrative changes and clarifications

- The Senior Advantage eligibility requirements in Chapter 1, Section 2.1 of the *EOC* have changed to remove enrollment restrictions on beneficiaries with ESRD, in accordance with the 21st Century Cares Act.
- In Chapter 1, Section 2.3 of the *EOC*, we have added Lane County in Oregon to our plan service area for Senior Advantage.
- For Medicare Part D plans, Chapter 1, Section 3.5 of the *EOC* has been revised to explain the additional information provided on the Part D Explanation of Benefits (EOB).
- For Medicare Part D plans, Chapter 2, Section 1 of the *EOC* has been revised to provide new contact information for Part D prescription drugs coverage decisions.
- For Medicare plans that do not include Part D prescription drug coverage, Chapter 2, Section 7 of the *EOC* – "Programs that help pay for prescription drugs" – has been modified to provide additional information about prescription cost-sharing assistance programs for persons with HIV/AIDS.
- For Medicare Part D plans, Chapter 5, Section 10.2 of the *EOC* has been revised to provide additional information about the Drug Management Program and member appeals related to limits or restrictions on opioid medications.
- A new Section 18, "Surrogacy," has been added to the "Legal Notices" chapter of the *EOC* to explain our right to seek reimbursement of plan charges for covered services that a member receives associated with a surrogacy arrangement.

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Clackamas County
Oregon ASO Dental Plan Changes
Renewing January 1, 2021
(Preliminary draft as of 8/20/2020)

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2021. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
	Additional changes may be required as a result of new federal rules or regulations.	Delta Dental will provide written notice of any additional changes.	TBD

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☒	☐	**Benefits and Limitations** Pulp Capping	Pulp capping was covered only when there was exposure of the pulp.	A separate charge for pulp capping is not covered.	Pulp capping is performed at the same time as a restorative service and should be included in the charge of the restoration.	-0.02%
☐	☒	**Benefits and Limitations** Re-cement and Re-bond	Re-cement or re-bond of a crown, inlay, onlay or veneer are covered.	Re-cement or re-bond of a crown, inlay, onlay or veneer, by the same dentist, is limited to once per lifetime.	In an otherwise healthy tooth, a properly placed restoration should not need continuous efforts to maintain its attachment.	Negligible

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ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Minor wording changes for readability.	This includes separating 1 sentence into 2, and replacing some words with simpler synonyms (e.g., consult changed to talk with)
General Exclusions Illegal Acts, Riot, Rebellion	Narrow the exclusion to require member be convicted of a crime for the exclusion to be applied.	Oregon Department of Consumer and Business Services request. Will ensure that protesters who have not committed a crime will have coverage if injured.
Claims Administration & Payment Order of Benefit Determination	The plan will now coordinate benefits with Medicare.	The new Medicare COB process will comply with the Oregon and Federal rules.

ASO AGREEMENT CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
None		

*Based on Delta Dental book of business.

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

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

Signature Evelyn Minor-Lawrence, IPMA-CP Digitally signed by Evelyn Minor-Lawrence, IPMA-CP Date: 2020.09.17 17:20:33 -07'00' **Date** 09/17/2020

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2021 Health and Welfare Benefit Plan Preliminary Renewal Report

Clackamas County
September 2020

Peace Officers Association

1

Summary

The Clackamas County Peace Officers Association (POA) 2021 health and welfare benefit plans renewal decisions are outlined in this report.

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

PLAN	2020 BUDGET RATE	STATUS QUO 2021 RENEWAL	% INCREASE
Active / Retiree Medical*			
POA			
Kaiser HMO Option			
EE	$707.84	$689.88	-2.5%
EE, SP	1,415.70	1,379.76	-2.5%
EE, CH	1,274.12	1,241.78	-2.5%
EE, FAM	2,123.54	2,069.64	-2.5%
COMPOSITE	$1,553.58	$1,571.44	1.1%
PHP Personal Option 15/0/1000 (Includes VSP Vision)			
EE	$771.00	$805.00	4.4%
EE, SP	1,542.00	1,609.00	4.3%
EE, CH	1,390.00	1,450.00	4.3%
EE, FAM	2,316.00	2,417.00	4.4%
COMPOSITE	$1,870.00	$1,960.00	4.8%
PHP Open Option 10/0/20/2000 $50 Common Deductible (Includes VSP Vision)			
EE	$825.00	$861.00	4.4%
EE, SP	1,648.00	1,720.00	4.4%
EE, CH	1,486.00	1,551.00	4.4%
EE, FAM	2,474.00	2,582.00	4.4%
COMPOSITE	$1,998.00	$2,086.00	4.4%
Retiree / Temporary Medical			
PHP $1000 Deductible			
EE	$730.63	$761.32	4.2%
EE, SP	1,461.36	1,522.74	4.2%
EE, CH	1,315.14	1,370.38	4.2%
EE, FAM	2,191.92	2,283.98	4.2%
Kaiser $1000 Deductible - POA			
EE	$533.90	$520.32	-2.5%
EE, SP	1,067.80	1,040.64	-2.5%
EE, CH	961.02	936.58	-2.5%
EE, FAM	1,601.82	1,561.06	-2.5%
PHP Medicare Align			
POA	$351.90	$351.90	0.0%
Kaiser Medicare			
POA	$391.10	$396.44	1.4%

Vision (VSP) – Rates and Contributions combined with Medical

POA: VSP 12/24/24; $10 copay; $130 allowance			
EE	$3.90	$3.74	-4.1%
EE, SP	7.82	7.50	-4.1%
EE, CH	8.36	8.02	-4.1%
EE, FAM	13.38	12.84	-4.0%
COMPOSITE	$10.54	$10.10	-4.2%

Dental (Delta Dental of Oregon) – Rates paid 100% by Clackamas County

POA: Delta Dental Incentive			
EE	$73.00	$74.00	1.4%
EE, SP	143.00	146.00	2.1%
EE, CH	103.00	105.00	1.9%
EE, FAM	174.00	177.00	1.7%
COMPOSITE	$147.00	$150.00	2.0%
General County/POA: Kaiser			
EE	$104.10	$104.10	0.0%
EE, SP	206.10	206.10	0.0%
EE, CH	143.66	143.66	0.0%
EE, FAM	246.68	246.68	0.0%
COMPOSITE	$190.00	$191.00	0.5%

Life and AD&D (MetLife)			
Basic Life (Rate per $1,000 benefit)			
Represented – GC & POA	$0.136	$0.136	0.0%
Group Universal Life			
General County and POA	Age Rated	Age Rated	0.0%
Dependent Life per Employee (Rate per Family)			
$2,000 per Dependent – POA	$0.38	$0.38	0.0%
LTD (Standard)			
Fully Insured – Peace Officers			
Base Plan (Per $100 of Covered Salary)	$0.30	$0.30	0.0%
Buy-Up Plan (Per $100 of Covered Salary)	$0.34	$0.34	0.0%
Employee Assistance Program – EAP			
Cascade (Previously with Standard)			
General Fee PEPM	$2.60	$2.66	2.3%
Flexible Spending Account			
Navia			
Monthly Fee PPPM	$5.00	$5.15	3.0%

**Rates include the standard 2021 contract changes.*

PEPM = Per Employee Per Month
PMPM = Per Member Per Month
PPPM = Per Participant Per Month

2

Medical/Prescription Drug/Vision/Alternative Care Plans

Self-Funded Plans

The 2021 projection for the Open and Personal Options called for an overall 4.4% increase for the POA.

The 2021 Providence ASO fees are shown below as per employee per month (PEPM).

Providence Health Plan Administrative Fees

	2021 PEPM
Medical Administration	$32.45
Pharmacy Administration	5.41
Alternative Care Administration	2.30
Case and Disease Management	9.37
Network Access Fee	8.11
Health Coaching – 12 Sessions	2.12
	$59.76

Stop Loss Administrative Fees – Optum Health

The 2021 stop loss fee has not been finalized at this time. It will be finalized by no later than the end of November. The current specific attachment point is $200,000.

Mercer's underwriting projection for the 2021 renewal is included in **Exhibit A** for reference.

Peace Officers

There were no plan changes for the 2021 plan year for the POA plans.

The standard 2021 contract changes summary for grandfathered plans in **Exhibit B** apply to the POA plans.

See **Exhibit C** for the Providence 2021 POA benefit summaries.

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Retirees – 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 2021 plan year. The 2021 benefit summary is included in **Exhibit C**.

Providence Fully-Insured Medicare Align Plan (Medicare Eligible)
There is no change to the premium rate for the Providence Medicare Align plan.

Medicare Align Plan

Medicare Align With Prescription Drug	$351.90

Exhibit B contains the standard 2021 contract changes for grandfathered plans proposed by Providence.

See **Exhibit C** for the Providence 2021 early retiree benefit summaries.

Kaiser Permanente

Peace Officers

Kaiser proposed an overall 2.5% decrease to the 2020 premium rates.

POA

The POA did not elect to make benefit changes to this plan.

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

Exhibit E contains the 2021 contract changes provided by Kaiser. The POA accepted the proposed 2021 benefit and administrative clarifications.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

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Retirees – 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 2.5% for the POA plan was accepted by the County.

Medicare-Eligible retirees (age 65 and over) are eligible for the Medicare Supplement plan. Premium rates increased by 1.4%.

Exhibit E contains the 2021 contract changes provided by Kaiser.

See **Exhibit F** for the Kaiser 2021 benefit summaries.

Vision Plans

Vision Service Plan (VSP)

The County elected to renew their vision plans with VSP for POA. The rates for the 2020 plan year are provided in Section 1.

The VSP plan is receiving a 2-year rate guarantee. The plan will next renew January 1, 2023.

See **Exhibit G** for the 2021 VSP benefit summaries.

Dental Plans

Delta Dental of Oregon

The Incentive Plan is available to all employees.

Clackamas County is entering the second year of a three-year fee agreement with Delta. The fee for each year of the three-year agreement are as follows:

Rates per Employee per Month	2020	2021	2022
Administration fee	$6.55	$6.62	$6.69

The POA elected the following dental plan change for the 2021 plan year:

1. A separate charge for pulp capping is not covered
2. Re-cement or re-bond of a crown, inlay, onlay or veneer by the same dentist is limited to once per lifetime

Exhibit I contains the Delta administrative contract changes for 2021 for POA.

See **Exhibit J** for the 2021 Delta benefit summaries.

Underwriting

Mercer projected a 2021 funding increase of 1.9% for the 2021 self-insured dental plan. See **Exhibit H**.

Projections for the County's self-funded dental plans were based on 12 months of claims experience from April 1, 2019, through March 31, 2020. An annual trend factor of 5.0% and 3% margin were used.

Mercer recommended and the County accepted the 2021 funding rates provided in Section 1.

Kaiser Permanente

The County has a fully insured dental plan through Kaiser that is available to all employees. Kaiser proposed no increase to the 2020 premium rates.

Exhibit E contains the 2021 standard contract changes provided by Kaiser, which will be effective January 1, 2021. See **Exhibit F** for the Kaiser 2021 benefit summaries.

The 2021 premium rates for Kaiser dental plan are shown in Section 1.

Life and Voluntary AD&D Insurance

MetLife

The County has basic life, AD&D, dependent life, and group universal life plans with MetLife. The rates are entering the second year of a two-year year agreement.

A summary of the rates for the 2021 plan year are as follows:

Peace Officer Association

Basic Life	
Represented Employees	$0.136/$1,000
Dependent Life	
$2,000 per spouse/domestic partner or child	$0.38 PEPM

Long Term Disability Insurance

The Standard

The County offers two LTD plans through The Standard as follows:

- **Base LTD Plans**
  - **POA.** This coverage is provided by the County without contributions from employees. The disability benefit is 60% of the first $3,333 of monthly pre-disability income. The plan

is self-funded for the first 180 days of a disability and is fully insured starting on the 181st day of a disability.

- **Buy-up LTD Plans**
  - **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.

The buy-up LTD benefit plans for 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 2021 plan year.

Fees and Premium Rates

The Standard will hold the current rates for two more years. The current rates will be in effect through December 31, 2022.

The 2021 funding, premium, and fees are as follows:

Self-Insured Plan	
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 – Peace Officers	$0.30/$100
Buy-Up – Peace Officers	$0.34/$100

Employee Assistance Plan

Cascade Centers

The 2021 fee for EAP services is as follows:

Fee per Participant per Month	
Employee Assistance Program	$2.66

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Flexible Spending Account Administrator

Navia Benefits Solutions

The County uses Navia Benefits Solutions (Navia) to provide administration for the FSA plans. The fee will increase from $5.00 per participant per month to $5.15 effective January 1, 2021. The renewal fee will be guaranteed for three years.

The 2021 fees are as follows:

Fees per Participant per Month	
Health Care FSA	$5.15
Annual Maximum	$2,500
Dependent Care FSA	$5.15
Annual Maximum	$5,000

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Employee Contributions

Peace Officers

The County pays 95% of the premium for the Providence medical plans. However, if the premium increases more than 10% in any one year, the County and the employees shall evenly split the increased costs above 10%. 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	$707.00	$1,511.00	$1,352.00	$2,319.00
Employee	$98.00	$98.00	$98.00	$98.00
Providence Open Option				
Employer	$756.70	$1,615.70	$1,446.70	$2,477.70
Employee	$104.30	$104.30	$104.30	$104.30
Kaiser				
Employer	$689.88	$1,379.76	$1,241.78	$2,069.64
Employee	$0.00	$0.00	$0.00	$0.00
HRA VEBA				
Cash Back	$176.00	$176.00	$176.00	$176.00

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	$88.00	$88.00	$88.00	$88.00

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MARSH & McLENNAN
COMPANIES

0120 to 0121 ASO Contract Comparison – ACA grandfathered plans (GR)

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Open Option, Personal Option

- UPDATED 09.10.2020 -

NOTE: The language below represents contract changes proposed by PHP for our commercial (fully insured) Large Group Grandfathered plans, as filed with the State of Oregon DFR for plan year 2021. As such, all changes reflected herein are subject to change, pending final approval by the State. When language changes are carried over from fully insured to ASO handbooks, any ASO-specific changes will be accommodated. Also, section numbers may vary between fully insured and ASO handbooks, as well as between different ASO plan types.

Topic	Affected Material	Description	Current Language & Provisions (from existing 0120 documents)	New Language & Provisions (in new 0121 documents)	Benefit or Benefit Administration change?	Required by regulation or rule?	Comments	Client Accepts Change? (Y/N)
Benefit Changes – For all plan types, except as otherwise denoted								
Section 4.9.1 glucometer benefit change and additional clarifying language for limits	All handbooks	Updating language to provide greater transparency to members of how diabetes supplies/glucose monitors are covered and where they can find more information Changing benefit coverage of glucometers from Durable Medical Equipment to Diabetes Supplies	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 2. Diabetes supplies, such as needles, syringes, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members. See section 4.9.4 for coverage of diabetic equipment such as glucometers and insulin pump devices. ***** 4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include glucometers and insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.	4.9.1 Medical Supplies (including Diabetes Supplies) ***** 2. Diabetes supplies, such as needles, syringes, continuous glucose monitors and blood glucose monitors, lancets and test strips, may be purchased through Providence Health Plan In-Network medical supply providers or under this benefit at Participating Pharmacies. ~~Unless there is a medical exception on file, diabetes test strips are limited to products listed in our pharmacy formulary and are restricted to 100 test strips per month for insulin dependent Members and 100 test strips every three months for non-insulin dependent Members.~~ Formulary, Prior Authorization, and quantity limits may apply – please see your Formulary for details. See section 4.9.4 for coverage of diabetic equipment such as ~~glucometers and~~ insulin pump devices. ***** 4.14.1 Using Your Prescription Drug Benefit ***** • Diabetes supplies and inhalation extender devices may be obtained at your Participating Pharmacy. However, these items are considered medical supplies and devices and are subject to your Medical Supplies benefits, limitations and Copayments and/or Coinsurances. See section 4.9.1 and your Benefit Summary. Diabetes supplies do not include ~~glucometers and~~ insulin pump devices, which are covered under your Durable Medical Equipment benefit, section 4.9.4.	Yes – Glucometer changes only	No	Glucometers are currently stated as being covered under the Durable Medical Equipment Benefit. However, since they are used for testing blood levels related to Diabetes, it makes sense to move glucometers to the diabetic supplies benefit so that they are covered in full. This will provide a better benefit for diabetic members. Leaving glucometers as a Durable Medical Equipment benefit applies a cost share to members. Note: Acceptance is *optional*. This change is made to provide a better benefit for diabetic members. Language on test strip limits should be removed to reduce confusion, as what we actually allow is more than what is listed in the handbook. Members are referred to their formulary for details. **IMPORTANT NOTE:** For grandfathered plans, once a new or richer benefit is added to the plan, the ASO employer **cannot** thereafter eliminate or significantly reduce that benefit, unless permitted by subsequent new law.	[X] Yes [ ] No
Section 4.10.2 removal of neurofeedback	All handbooks	Should have been removed previously to align with mental health parity	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy, neurofeedback, chelation or hyperbaric chambers; *****	4.10.2 Applied Behavior Analysis ***** Exclusions to ABA Services: ***** • Custodial or respite care, creative arts therapy, wilderness or adventure camps, social counseling, music therapy~~, neurofeedback~~, chelation or hyperbaric chambers; *****	Yes	No	The decision to remove neurofeedback as an ABA exclusion is based on PHP's interpretation of federal and state mental health parity laws. Ths change is also based on federal case law, which prohibits plans from including categorical exclusions for the treatment of mental health conditions (including autism). Note: Acceptance is *optional* for ASO. PHP is making this change to adhere to what we have interpreted as following mental health parity laws.	[X] Yes [ ] No

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							IMPORTANT NOTE: For grandfathered plans, once a new or richer benefit is added to the plan, the ASO employer **cannot** thereafter eliminate or significantly reduce that benefit, unless permitted by subsequent new law.	
Section 4.12.17 inclusion of coverage for drug-induced Alopecia	All handbooks	Adding coverage for drug-induced Alopecia	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	4.12.17 Wigs The Plan will provide coverage for one synthetic wig every calendar year for Members who have undergone chemotherapy or radiation therapy or are experiencing pharmaceutical drug-induced Alopecia at the Medical Equipment, Supplies and Devices benefit level listed in your Benefit Summary. Wigs may be purchased from any wig supplier. Wig suppliers may require Members to pay for items and submit the paid receipt to Providence Health Plan for reimbursement. For information about submitting claims, see section 6.1.1.	Yes	Yes – OR state regulation only (OAR 836-053-0012(3)(c)(B); no federal mandate	Wigs are currently written as covered for chemotherapy, but we are adding coverage for people who have hair-loss from the same drugs as chemo, but not related to cancer. Note: Acceptance is *required* for ASO groups that electively follow state mandates.	
Early refill of eye drops exclusion	All handbooks	Updating language to better reflect an exclusion and when the exclusion does not apply	4.14.8 Prescription Drug Exclusions ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); and 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC.	4.14.8 Prescription Drug Exclusions ***** 19. Drugs that are not FDA-approved or are designated as "less than effective" by the FDA (also known as "DESI" drugs); ~~and~~ 20. Vaccines and medications solely for the purpose of preventing travel related diseases as defined by the CDC~~.~~; and ~~20.~~21. Early refill of eye drops, except when there is a change in directions by your provider, or if synchronizing your prescription refills. [This exclusion does not apply to eye drops prescribed for the treatment of glaucoma.]	Yes	Yes - second sentence only applies to state abiding ASO groups (ORS 743A.065)	First sentence added to provide transparency of coverage for members that have or may require eye drops. The second bracketed sentence is required for groups that are required to or electively choose to follow state mandates. State abiding ASO groups cannot exclude early refills of eye drops for glaucoma members, per ORS 743A.065. Note: Acceptance of the second sentence is *required* for ASO groups that electively follow state mandates.	
Section 5. Exclusions	All handbooks	Removing civil riot/military activities exclusion per Oregon state's direction	5. EXCLUSIONS ***** General Exclusions: The Plan does not cover Services and supplies which: ***** Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.	5. EXCLUSIONS ***** General Exclusions: The Plan does not cover Services and supplies which: ***** ~~Relate to participation in a civil revolution or riot, duty as a member of the armed forces of any state or country, or a war or act of war which is declared or undeclared.~~	Yes	Yes (OR state mandate only; no federal mandate)	Removing plan exclusion of coverage for any injuries or illnesses related to a member's voluntary participation in a civil riot, military services, or war-related activities. This is being done at the express direction of Oregon DFR out of their concerns of potential discrimination against: 1) military personnel who may have a pre-existing condition or may not have full access to care under their military plan, and 2) individuals who may be injured in the ongoing civil protests. Note: Acceptance is *required* for ASO groups that electively follow state mandates.	

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0120 to 0121 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

- UPDATED 09.10.2020 -

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Benefit Administration Changes – For all plan types, except as otherwise denoted								
Additional language added to prior authorization list	All handbooks	Adding language to callout some additional services that require prior authorization	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; *****	3.5 PRIOR AUTHORIZATION ***** Services requiring Prior Authorization: ***** • Certain Medical Supplies, Medical Appliances, Prosthetic and Orthotic Devices, and Durable Medical Equipment, as provided in section 4.9; • Certain outpatient services including, but not limited to, neurodevelopmental therapy, neurological testing, and botulinum therapies. *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	
Removal of authorizing agent language	All handbooks	Removing language around authorizing agent due to bringing services in-house	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan or our authorizing agent must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan or their authorizing agent. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us or our authorizing agent; ***** An approved ABA treatment plan is subject to review by us or our authorizing agent, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services *****	4.5.4 Emergency Detoxification Services Medically Necessary detoxification will be treated as an Emergency Medical Condition when the Member is not enrolled in a Chemical Dependency treatment program, as stated in section 4.10.3, at the time Services are received. Prior Authorization is not required for emergency treatment; however, Providence Health Plan ~~or our authorizing agent~~ must be notified within 48 hours following the onset of treatment, or as soon as reasonably possible, in order for coverage to continue. If a Member is to be transferred to an In-Network Provider for continued inpatient care, the cost of Medically Necessary transportation will be covered. Continuing or follow-up care is not a Covered Service unless Prior Authorized by Providence Health Plan ~~or their authorizing agent~~. 4.10.2 Applied Behavior Analysis Benefits are provided for Applied Behavior Analysis (ABA) for the treatment of autism spectrum disorders, subject to the following limitations: ***** • Prior Authorization is received by us ~~or our authorizing agent~~; ***** An approved ABA treatment plan is subject to review by us or ~~our authorizing agent~~, and may be modified or discontinued if review shows that the Member receiving treatment is not making measurable clinical progress toward the goals identified in the treatment plan. 4.10.3 Chemical Dependency Services *****	Yes	No	This change is being made in anticipation of bringing Behavioral Health services in-house.	

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			Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan or their authorizing agent.	Covered Services include diagnostic evaluation, detoxification, individual and group therapy, inpatient hospitalization as stated in section 4.6.1, residential, day, intensive outpatient, or partial hospitalization Services when they are Medically Necessary as determined by Providence Health Plan ~~or their authorizing agent~~.				
Section 4.7.1 language added for pain management	All Handbooks	Adding language to reflect pain management benefit	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy** Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, and therapeutic procedures as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	**4.7.1 Outpatient Services: Surgery, Cardiac Rehabilitation, Dialysis, Infusion, Chemotherapy and Radiation Therapy**, and Multidisciplinary Pain Management Programs Benefits are provided as shown in the Benefit Summary and include Services at a Hospital-based Outpatient Surgical Facility or an Ambulatory Surgery Center. See section 4.3.5 regarding injectable or infused medications received in a Provider's office. Covered Services include, but are not limited to, Services for a surgical procedure, outpatient cardiac rehabilitation, and regularly scheduled therapy such as dialysis, infusion (including infused medications), chemotherapy, inhalation therapy, radiation therapy, ~~and~~ therapeutic procedures, and approved multidisciplinary pain management programs as ordered by your Qualified Practitioner. Some injectable and infused medications may be required to be supplied by a contracted Specialty Pharmacy. The Plan may require that you obtain a second opinion for some procedures. If you do not obtain a second opinion when requested, Providence Health Plan will not Prior Authorize the Services. For additional information about Prior Authorization, see section 3.5. *****	Yes	No	We need to map the Pain Management Program to the Outpatient Services benefit. Right now, the Pain Management codes are hitting the Physical Therapy benefit, but should be separated to align with the intent of the Pain Management Program. The Pain Management Program is separate from Physical Therapy. The Physical Therapy benefit has its own yearly accumulations. Changing this will be a better benefit for the member, in regards to the Pain Management Program.	
Language Changes – For all plan types, except as otherwise denoted								
Update provider directory web address	Some handbooks where existing language exists	Updating the provider directory web address to increase the ease of access	http://phppd.providence.org/	~~http://phppd.providence.org/~~ProvidenceHealthPlan.com/findaprovider	No	No	Only applies to groups that **currently** use the provider directory link http://phppd.providence.org/	
Updating Quick Reference Guide	All Handbooks	Updating the Customer Service Quick Reference Guide to provide correct contact information for members	**Customer Service Quick Reference Guide:** ***** Medical Prior Authorization Requests 800-638-0449 (toll-free) Mental Health and Chemical Dependency Prior Authorization 800-711-4577 (toll-free)	**Customer Service Quick Reference Guide:** ***** Medical[, Mental Health, and Chemical Dependency] Prior Authorization Requests 800-638-0449 (toll-free) 503-574-6464 (fax) ~~[Mental Health and Chemical Dependency~~ ~~Prior Authorization~~	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Adding Prior Authorization fax number and provider directory link are updates independent of brining behavioral health in-house and are effective today.	

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				~~800-711-4577 (toll-free)~~] Provider Directory ProvidenceHealthPlan.com/findaprovider				
Privacy Policy Revision	All handbooks	Removing unnecessary language	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and Your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed. Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****	2.8 PRIVACY OF MEMBER INFORMATION ***** Confidentiality and your Employer In accordance with the federal privacy requirements of the Health Insurance Portability and Accountability Act (HIPAA), Providence Health Plan will not disclose a Member's protected health information (PHI) to the Employer or any agent of the Employer unless requested for the HIPAA allowed purpose of the Employer's obtaining bids from other health plans for further health coverage or for the Employer's modifying, amending, or terminating any benefit under the health plan. ~~In these circumstances, Providence Health Plan may release summary health information, which is PHI from which your name, ID number, dates smaller than a year, and certain other identifiers have been removed.~~ Providence Health Plan may disclose a Member's PHI to an Employer or any agent of the Employer if the disclosure is: 1. In compliance with the applicable provisions of HIPAA; and 2. -Due to a HIPAA-compliant authorization the Member has completed to allow the Employer access to the Member's PHI; or 3. Consistent with the HIPAA privacy protections that are contained in the Employer's group health plan documents, as certified in writing to Providence Health Plan by the Employer. The details of this required certification can be reviewed at https://healthplans.providence.org/about-us/privacy-notices-policies/protected-health-information-and-your-employer/. *****	No	No	Removing extraneous language. Last sentence of the paragraph under "Confidentiality and your Employer" is too detailed as the language immediately following it explains the HIPAA guidelines.	
Language update to clarify current billing process for Out-of-Network emergency services	All handbooks except Personal Option	Updating language to call out potential balance billing by Out-of-Network providers and Out-of-Network Hospitals	4.5.1 Emergency Care ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. *****	4.5.1 Emergency Care ***** If you decline transfer to an In-Network facility once we have determined that repatriation is medically appropriate, the additional days spent at the Out-of-Network Hospital will be subject to your Out-of-Network benefits. Note: While Emergency Services received from Out-of-Network Providers at Out-of-Network Facilities are	No	No	Language update necessary to advise members of potential balance billing by Out-Of-Network providers and Out-Of-Network hospitals (unless otherwise prohibited by state or federal law), even when emergency services are covered at an In-Network benefit until the member is stable and able to be transferred to an In-Network facility.	

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				covered under your In-Patient benefit until the time that your condition becomes stable, the Out-of-Network Providers and Out-of-Network Facilities are not contracted with Providence Health Plan. Therefore, the claims are priced using Usual, Reasonable and Customary (UCR) pricing, as described in section 4.3. Unless otherwise prohibited by state or federal law, you may be billed by the Out-of-Network Providers and Out-of-Network Facilities for amounts above the Allowed Amount of the claim, as determined by UCR. *****				
Section 4.12.14 additional clarifying language	All handbooks	Providing clarifying language about the type of treatment of Gender Dysphoria that is subject to Medical Necessity	4.12.14 Gender Dysphoria Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. Treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 3.5 for a list of services requiring Prior Authorization. *****	4.12.14 Gender Dysphoria Benefits are provided for the treatment of Gender Dysphoria. Covered Services include, but are not limited to, Mental Health, Prescription Drug, and surgical procedures. Coverage is provided at the applicable benefit level for the type of Covered Services received, as shown in your Benefit Summary. For example, surgical procedures are subject to your provider surgical benefit and applicable inpatient or outpatient facility benefit. ~~Treatment~~ Surgical treatment of Gender Dysphoria is subject to Medical Necessity, as set forth in our medical policy, and must be received from licensed providers and facilities. Prior Authorization may apply. Please see section 4.4 for a list of services requiring Prior Authorization. *****	No	No	Language update necessary to accurately reflect that *surgical* treatment of gender dysphoria is subject to medical necessity review.	
Language update to reflect override allowances	All handbooks	Updating language to better reflect available benefits	4.14.7 Prescription Drug Limitations ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan.	4.14.7 Prescription Drug Limitations ***** 7. In accordance with the ACA, your Plan provides coverage in full of certain medications, including contraceptives, when these medications are purchased from Participating Pharmacies. Not all preventive medications are required to be covered in full by the ACA. Medications in this category may be subject to medical management techniques to determine frequency, method, treatment, or setting. Brand medications for which a generic is available will not be covered in full unless the Member has received Prior Authorization from Providence Health Plan. ~~7.~~8. Vacation supply medication refill overrides are limited to a 30-day supply once per Calendar Year, unless otherwise provided under your Plan. Additional exceptions may be granted on a case-by-case basis. ~~8.~~9. A 30 day supply medication refill override will be granted if you are out of medication and	No	No	Language update necessary to provide greater transparency of medication override benefits for members and limits to the coverage.	

0120 to 0121 ASO Contract Comparison – ACA grandfathered plans (GR)

Open Option, Personal Option

- UPDATED 09.10.2020 -

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				have not yet received your drugs from a participating mail order pharmacy.				
Prescription combination drugs exclusion	All handbooks	Updating language to better reflect scope of existing exclusion	4.14.8 Prescription Drug Exclusions ***** 11. Drugs placed on a prescription-only status as required by state or local law;	4.14.8 Prescription Drug Exclusions ***** 11. Drugs, which may include prescription combination drugs, placed on a prescription-only status as required by state or local law;	No	No	This language change clarifies the scope of the existing prescription drug exclusion.	
Removing address due to in-house services	All handbooks	Removing the address due to bringing services in-house Correcting P.O. Box number	6.1.1 Timely Submission of Claims ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box 4327 Portland, OR 97208-4327 Mental Health and Chemical Dependency claims should be submitted to: PBH PO Box 30602 Salt Lake City, UT 84130 *****	6.1.1 Timely Submission of Claims ***** Please send all claims to: Providence Health Plan Attn: Claims Dept P.O. Box ~~4327~~3125 Portland, OR 97208-~~4327~~3125 ~~Mental Health and Chemical Dependency claims should be submitted to:~~ ~~PBH~~ ~~PO Box 30602~~ ~~Salt Lake City, UT 84130~~ *****	No	No	This change is being made in anticipation of bringing Behavioral Health services in-house. Reverting claims PO Box number back to 3125 as it was changed in error.	
Section 8 language modification	All handbooks	Modified language to improve readability	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide us with evidence of eligibility as requested. *****	8. ELIGIBILITY AND ENROLLMENT This section outlines who is eligible for coverage, and how and when to enroll yourself and your Eligible Family Dependents. No benefits shall be available to anyone not enrolled under this Plan. You and your Employer must provide ~~us~~ Providence Health Plan with evidence of eligibility as requested. *****	No	No	Updating reference to Providence Health Plan to avoid confusion	

KAISER PERMANENTE

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2021 *Group Agreement* and *Evidence of Coverage* Summary of Changes and Clarifications for Oregon Large Employer Groups (POA Plans)

This is a summary of changes and clarifications that we have made to your *Group Agreement*. The *Group Agreement* includes the *Evidence of Coverage* (*EOC*), "Benefit Summary," and any applicable rider and endorsement documents. This summary does not include minor changes and clarifications we are making to improve the readability and accuracy of the *Group Agreement*. These changes and clarifications do not include changes that may occur throughout the remainder of the year as a result of federal or state mandates.

Other Group-specific or product-specific plan design changes (including changes to Copayment or Coinsurance amounts) may apply, such as moving to standard benefits. Refer to the Rate Proposal and/or the Summary of Plan Changes document for information about these types of changes.

To the extent that this summary of changes and clarifications conflicts with, modifies, or supplements the information contained in your *Group Agreement*, the information contained in the *Group Agreement* shall supersede what is set forth below. Unless another date is listed, the changes in this document are effective when your Group renews in 2021. The products named below are offered and underwritten by Kaiser Foundation Health Plan of the Northwest.

Changes and clarifications that apply to Traditional, Deductible, High Deductible, Added Choice®, and PPO Plus® medical plans

Changes to Senior Advantage plans are explained at the end of this summary.

Benefit changes

- For Deductible and High Deductible Health Plans, we have added selected preventive care services to be covered without a deductible for individuals diagnosed with specific chronic conditions, as allowed under the IRS and US Treasury Department Notice 2019-45.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the "Benefit Summary" has been modified to indicate that the cost share for insulin is not subject to Deductible and will not exceed $100 per 30-day supply.
- The "Maternity and Newborn Care" section of the *EOC* and Benefit Summary has been modified to indicate that newborn nurse home visiting Services are covered as required per Oregon Senate Bill 526.
- Home ultraviolet light therapy equipment for treatment of certain skin conditions has been added to the list of covered DME under the "Outpatient Durable Medical Equipment (DME)" section of the *EOC*.

Benefit clarifications

- The "Post-Stabilization Care" section of *EOC* has been modified to clarify that these benefit provisions apply to covered Services from vendors, such as providers of Durable Medical Equipment (DME).
- The "Preventive Care Services" section of the *EOC* has been modified. A bullet has been added to the confirm coverage for any state-required reproductive health preventive Services for all Members.
- The "Chemical Dependency Services" section of the *EOC* has been modified. A statement has been added to confirm that the benefits in this section comply with the federal Mental Health Parity and Addiction Equity Act.

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- The term "DME formulary" is being removed from the "Outpatient Durable Medical Equipment (DME)" and "External Prosthetic Devices and Orthotic Devices" sections for clarity and to reduce confusion with "formulary" in reference to prescription drug benefits.
- The "External Prosthetic Devices and Orthotic Devices" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified for accuracy and consistency within the contract. Language has been added to specify that Services are covered subject to Utilization Review.
- The "Hearing Aid Services for Dependents" section of the *EOC* has been revised for better alignment with the requirements of ORS 743A.141.
- The "Limited Outpatient Prescription Drugs and Supplies" section of the Traditional, Deductible and High Deductible Health Plan *EOCs* has been modified for alignment across products. A parenthetical was added, excepting insulin from the "Injectable drugs that are self-administered" exclusion.
- The "Mental Health Services" section of the *EOC* and the Benefit Summary have been modified to clarify that partial hospitalization is a covered Service.
- The "Outpatient Durable Medical Equipment" section of the *EOC* has been modified to clarify that both blood glucose monitors and continuous glucose monitors are covered.
- The Low-Vision Aids and Vision Hardware and Optical Services exclusions in the Exclusions and Limitations section of the *EOC* have been modified for clarity to include a cross reference to the "Pediatric Vision Hardware and Optical Services Enhanced Benefit Rider."
- The "Exclusions and Limitations" section of the *EOC* has been modified. The surrogacy limitation clarifies that it applies to both traditional and gestational surrogacy arrangements.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The term Cost Share has been defined and added to the "Definitions" section of the *EOC*. Throughout all documents, the defined term Cost Share replaces some, but not all, instances of Deductible, Copayments, or Coinsurance used for improved readability, accuracy, and administrative purposes.
- The terms Non-Participating Vendor and Participating Vendor have been added to the "Definitions" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* for alignment across products.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services" section of the *EOC*, has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.
- The definition of Spouse has been modified to clarify that the term includes a person who is validly registered as a domestic partner under the laws of another state.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- The "Prior and Concurrent Authorization and Utilization Review" section of the Traditional, Deductible, and High Deductible Health Plan *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is

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required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, and Appeals" section.

- The "Out-of-Pocket Maximum" section of the *EOC* has been modified to remove an incorrect reference to payments for Services under the "Alternative Care Services" section of the *EOC* as the *EOC* does not contain this section.
- The "Out-of-Pocket Maximum" section of the *EOC* has been modified for accuracy. The bullets indicating that payments for Services under the "Infertility Services" section and the "Infertility Treatment Services Rider" have been removed. Payments for these Services do apply to the "Out-of-Pocket Maximum."
- Throughout the *EOC*, references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Surrogacy Arrangements" section of the *EOC* has been modified to clarify that the section applies to both traditional and gestational surrogacy arrangements.
- The "Grievances, Claims, Appeals, and External Review" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.
- The "Moving to Another Kaiser Foundation Health Plan Service Area" section of the *EOC* has been modified to clarify that a Member may be eligible to enroll in a plan in the other Kaiser Foundation Health Plan Service Area, rather than transferring to another plan, as they would still need to meet the eligibility requirements of the new plan.
- The "Unusual Circumstances" section of the *EOC* has been modified to clarify that, in the event of unusual circumstances that could result in delay or inability to provide covered Services, Kaiser Permanente will make a good faith effort to provide or arrange for Services within the limitations of available personnel and facilities.

Additional changes and clarifications that apply to Added Choice® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in all tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements," "Tier 3 Out-of-Pocket Maximum," and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a

Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor, or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "How to Obtain Services - General Information" section of the *EOC* has been modified for accuracy. The language noting Urgent Care as an exception to the Tier 1 requirements has been removed. Only Emergency Services received at a PPO Facility or Non-Participating Facility are covered under Tier 1. Urgent Care Services received at a PPO Facility or Non-Participating Facility are covered under Tier 2 or Tier 3, whichever applies.
- The "Services Subject to Prior Authorization Review under Tier 2 and Tier 3" section of the *EOC* has been modified. The list of Services that do not require prior authorization in Tier 2 and Tier 3 has been revised for clarity and accuracy.
- The "Tier 2 and Tier 3 Urgent Care" section of the *EOC* has been modified to clarify that we cover Urgent Care under Tier 2 or Tier 3. The language indicating that if a Member receives Urgent Care that is not covered under Tier 1 has been removed as Urgent Care is covered under Tier 1. We do not cover Services in Tier 2 or Tier 3 that are not covered under Tier 1.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Tier 1 Prior Authorization Review Requirements" and the "Tier 2 and Tier 3 Prior Authorization Review Requirements" sections of the *EOC* have been updated to The "Prior and Concurrent Authorization and Utilization Review" section of the *EOC* has been modified to reflect that prior authorization determination notices will be provided to both the Member and the requesting provider within two business days of the request and to outline the timelines when additional information is required to make a decision, per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Additional changes and clarifications that apply to PPO Plus® medical plans only

Benefit changes

- The "Services Subject to Prior Authorization Review," "External Prosthetic Devices and Orthotic Devices," and "Outpatient Durable Medical Equipment (DME)" sections of the *EOC* have been modified to reflect that DME items will now require prior authorization in both tiers.
- The "Failure to Satisfy Prior Authorization Review Requirements" and "Tier 2 Out-of-Pocket Maximum" sections of the *EOC* have been modified to specify that if a Member does not obtain the required prior authorization for Services from a Non-Participating Provider, Non-Participating Vendor,

or Non-Participating Facility, the claim will be denied and the Member will be responsible for the Charges.

Benefit clarifications

- The "General Information" subsection under "How to Obtain Services" has been modified for accuracy. The language regarding an exception to the Tier 1 requirements has been revised to clarify that Emergency Services received at a Non-Participating Facility are not subject to these requirements.
- The "Services Subject to Prior Authorization Review" section of the *EOC* has been modified. The list of Services that do not require prior authorization has been revised for clarity and accuracy.

Administrative changes or clarifications

- Throughout the *EOC*, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed. Language indicating that benefits are subject to the additional provisions in the applicable tier sections has also been removed. The "How to Obtain Services" section indicates that the type of provider from which Services are received determines under which tier the benefit is covered. Removed language to reduce redundancy and for better clarity and readability.
- The "Prior Authorization Review Requirements" section of the *EOC* has been modified to reflect that prior authorization determinations will be provided within two business days per Oregon Senate Bill 249. Updates have also been made to clarify that requests for Services submitted by a Member are outlined in the "Grievances, Claims, Appeals, and External Review" section.

Changes and clarifications that apply to medical benefit riders

Benefit changes

- The "Cost Share for Covered Drugs and Supplies" section of the "Outpatient Prescription Drug Rider" used for Added Choice and PPO Plus plans has been modified to reflect a change in how the Member cost share is applied for drugs obtained from MedImpact Pharmacies when a generic equivalent is available, but the Member chooses a brand-name drug. Language stating that the Member would pay the difference between the pharmacy's retail price for the brand-name drug and the generic drug, in addition to the applicable drug tier cost share, has been removed. Members will now only pay the Copayment or Coinsurance for the brand-name drug.

Benefit clarifications

- The "Medication Management Program" section of the "Outpatient Prescription Drug Rider" has been modified for clarity.

Administrative changes or clarifications

- Throughout the riders, parenthetical references indicating the Tier under which Services are covered, based on the provider type, have been removed.
- The definition of Non-Participating Provider, specific to the "Alternative Care Services Rider," has been modified for accuracy to reflect that a Non-Participating Provider is an Alternative Care provider who is not a Participating Provider.

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- Language has been added to the "Hearing Aid Rider" to clarify that the hearing aid allowance is combined across all tiers under which hearing aids are covered.
- The first paragraph of the "Infertility Treatment Services" section in the "Infertility Treatment Services Rider" has been modified for alignment with other products. Language indicating that Services are covered "only under Tier 1" has been removed as this concept is discussed later in the rider.
- The "Infertility Treatment Services Rider" has been modified. The language indicating that the Lifetime Benefit Maximum is combined across all tiers has been moved from the rider benefit summary table to the text of the rider.
- The Member Services phone number has been removed throughout the "Outpatient Prescription Drug Rider" templates to align with the *EOC*.
- Throughout the "Outpatient Prescription Drug Rider," references to the U.S. Food and Drug Administration (FDA) have been edited for consistency.
- The "Outpatient Prescription Drug Rider" for plans that cover sexual dysfunction drugs has been modified. The bullet limiting sexual dysfunction drugs to eight pills per a 30-day supply has been removed as this limit is captured in the "You Pay" cell of the Sexual Dysfunction drugs row on the Rider Benefit Summary Table for plans that have the limit.

Changes and clarifications that apply to dental plans

Benefit clarifications

- Minor edits were made for clarity to the exclusion for government agency responsibility in the "Exclusions" section of the *EOC*.
- The exclusion for use of alternative materials in the "Exclusions" section of the *EOC* was modified to improve readability and understanding.
- A new limitation has been added to clarify that routine fillings are limited to amalgam or glass ionomer fillings on posterior teeth and composite fillings on anterior teeth. This limitation does not change how fillings are currently restored.

Administrative changes or clarifications

- The *Group Agreement* has been modified to clarify that Company may terminate the *Group Agreement* if there are no Members covered, regardless of whether Members reside or work in the Service Area, as that is not a requirement of eligibility for all products.
- The column for In and Out-of-Network Benefit Maximum in the PPO *EOCs* was split from one to two columns for administrative ease and clarity.
- Language in various sections throughout the *EOC* has been modified to align with similar sections across products and lines of business. This synchronization did not result in any benefit or administrative changes.
- References to online directories have been updated where applicable to ensure accuracy.
- The definitions of Dentally Necessary and Medically Necessary have been revised to eliminate redundancy when defining Services.
- The definition of Spouse has been modified to clarify that a person who is validly registered as your domestic partner under the laws of another state is defined as a Spouse.

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- The reference to "effective date" in the "When Coverage Begins" section has been updated to "membership effective date" and other references throughout the *EOC* to "effective date of coverage" for clarity.
- The "Adding New Dependents to an Existing Account" section of the *EOC* has been modified. The time allowed to submit an enrollment application for a newborn or adopted child has been changed from 30 days to 31 days.
- References to dental claim forms in the "Post-Service Claims - Services Already Received" section have been updated for accuracy.
- The PPO *EOCs* have been revised to clarify that all care and Service must be directed by a Participating or Non-Participating Provider within the United States.
- United States Food and Drug Administration was updated to U.S. Food and Drug Administration (FDA) for consistency and accuracy.
- The term "Calendar" was removed from all limitations referring to "Calendar Year." The defined term is Year.
- The "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been modified for accuracy and clarity. The section has been retitled "Injuries or Illnesses Alleged to be Caused by Other Parties" and references throughout the section to "third parties" have been changed. Language has also been added to clarify that reimbursements due to the Plan are not subject to the Out-of-Pocket Maximum. The address to send notice of claims or legal action has been updated.
- Language in the "Injuries or Illnesses Alleged to be Caused by Third Parties" section of the *EOC* has been revised in accordance with Oregon Senate Bill 421 to address the order in which Company can receive reimbursement or subrogate recovery for the cost of services we cover in the case of a motor vehicle accident.
- The "Grievances, Claims, and Appeals" section of the *EOC* has been revised to align across all product lines to ensure consistency. It has also been updated to comply with Oregon Senate Bill 249.

Changes and clarifications that apply to dental benefit riders

Benefit clarifications

- A note has been added to the "Dental Implant Benefit" section clarifying that pontics are not covered under the Dental Implant Services Rider but under the "Major Restorative Services" section of the *EOC*.
- The first bullet under the "Exclusions" section of the Dental Implant Services Rider has been modified for clarity. An implant or any part of an implant surgically placed prior to a Member's effective date of Company coverage is not covered. This clarification supports current administration.
- A new limitation has been added to the Implant rider to clarify that removing and reinserting a prosthesis and abutments for cleaning is limited to implants placed by a Permanente Dental Associates Participating Dentist. This will enable Participating Dentists to maintain consistent and high quality of care. This clarification supports current administration.

Administrative changes or clarifications

- The first bullet under the "General Benefit Requirements" section of the Dental Implant Services Rider has been modified to clarify that all care and Service must be directed by a Participating or Non-Participating Provider.
- References to "effective date" have been updated to "effective date of coverage" for clarity.
- References to "charges" in the Dental Implant Services Rider and Orthodontic Services Rider have been removed to accurately reflect the Member's cost share as "coinsurance."

Changes and clarifications that apply to all Senior Advantage plans

Benefit changes and clarifications

- The following changes have been made to the Medical Benefits Chart located at the front of the *EOC*:
  - Acupuncture for chronic low back pain has been added. This is a CMS benefit change effective January 21, 2020 and was not previously included in the Chart.
  - More detail about covered services has been added to the "Colorectal cancer screening" section of the Chart to describe cost-sharing for colonoscopies.
  - The "Durable medical equipment (DME) and related supplies" section has been revised to add phototherapy equipment for home use to treat psoriasis to the items covered at $0 cost sharing, and also to list DME items not covered by Medicare but covered by us when medically necessary.
  - The Silver&Fit® Healthy Aging and Exercise Program benefit description has been revised. Members who enroll in Silver&Fit may choose all or some of the available options: basic gym membership, two "Home Fitness" kits, and one "Stay Fit" kit.
  - More detail has been added to the "Home infusion therapy" section to describe covered services necessary to perform home infusion, including drugs, equipment, supplies, professional services, patient training and education, and monitoring.
  - Three specific lab tests for persons with certain chronic conditions have been added to the "Outpatient diagnostic tests and therapeutic services and supplies" section and are covered at $0 cost-sharing (not subject to deductible, if applicable), for all members.
  - Sleep studies have been added as a covered item in the "Outpatient diagnostic tests and therapeutic services and supplies" section.
  - The "Physician/practitioner services, including doctor's office visits" section has been revised. We have added information to explain when the outpatient surgery cost-sharing is applied. The description of covered telehealth services has also been modified for clarity.
- A new Section 8 has been added to Chapter 3 of the *EOC* to describe what oxygen benefits (equipment, supplies and maintenance) a Senior Advantage member is entitled to; what is the cost-sharing; and how coverage is affected if a member leaves our plan and returns to Original Medicare.
- A paragraph has been added to Chapter 4, Section 1 of the *EOC* – "Understanding your out-of-pocket costs for covered services" – to inform members there is no cost-sharing related to COVID-19 testing or treatment for the duration of the public health emergency.
- We have removed genetic testing from the exclusions or limitations chart in Chapter 4 of the *EOC* because genetic testing is covered by Medicare in certain situations.

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- Several *EOC* definitions have been revised for clarity and accuracy, including the terms Emergency Medical Condition, Exception, Network Physician, and Plan.

Administrative changes and clarifications

- The Senior Advantage eligibility requirements in Chapter 1, Section 2.1 of the *EOC* have changed to remove enrollment restrictions on beneficiaries with ESRD, in accordance with the 21st Century Cares Act.
- In Chapter 1, Section 2.3 of the *EOC*, we have added Lane County in Oregon to our plan service area for Senior Advantage.
- For Medicare Part D plans, Chapter 1, Section 3.5 of the *EOC* has been revised to explain the additional information provided on the Part D Explanation of Benefits (EOB).
- For Medicare Part D plans, Chapter 2, Section 1 of the *EOC* has been revised to provide new contact information for Part D prescription drugs coverage decisions.
- For Medicare plans that do not include Part D prescription drug coverage, Chapter 2, Section 7 of the *EOC* – "Programs that help pay for prescription drugs" – has been modified to provide additional information about prescription cost-sharing assistance programs for persons with HIV/AIDS.
- For Medicare Part D plans, Chapter 5, Section 10.2 of the *EOC* has been revised to provide additional information about the Drug Management Program and member appeals related to limits or restrictions on opioid medications.
- A new Section 18, "Surrogacy," has been added to the "Legal Notices" chapter of the *EOC* to explain our right to seek reimbursement of plan charges for covered services that a member receives associated with a surrogacy arrangement.

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Clackamas County (POA)
Oregon ASO Dental Plan Changes
Renewing January 1, 2021
(Preliminary draft as of 8/20/2020)

The following is a summary of the significant changes that will be made to the Delta Dental ASO Agreement and member handbook when your group renews in 2021. The summary is provided for your convenience and shall not be binding upon the parties. The language in the ASO Agreement and member handbook is controlling in all cases. Minor changes, including grammatical, cosmetic or formatting changes or moving sections around for ease of use are not included in this summary.

FEDERAL REGULATORY CHANGES			
Reference	**Former Benefit**	**Change/Rationale/Exceptions**	**Claims Impact***
	Additional changes may be required as a result of new federal rules or regulations.	Delta Dental will provide written notice of any additional changes.	TBD

BENEFIT CHANGES						
Accepted		**Reference**	**Former Benefit**	**New Benefit**	**Explanation**	**Claims Impact***
Yes	**No**					
☑	☐	**Benefits and Limitations** Pulp Capping	Pulp capping was covered only when there was exposure of the pulp.	A separate charge for pulp capping is not covered.	Pulp capping is performed at the same time as a restorative service and should be included in the charge of the restoration.	-0.02%
☑	☐	**Benefits and Limitations** Re-cement and Re-bond	Re-cement or re-bond of a crown, inlay, onlay or veneer are covered.	Re-cement or re-bond of a crown, inlay, onlay or veneer, by the same dentist, is limited to once per lifetime.	In an otherwise healthy tooth, a properly placed restoration should not need continuous efforts to maintain its attachment.	Negligible

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ADMINISTRATIVE CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
Overall	Minor wording changes for readability.	This includes separating 1 sentence into 2, and replacing some words with simpler synonyms (e.g., consult changed to talk with)
General Exclusions Illegal Acts, Riot, Rebellion	Narrow the exclusion to require member be convicted of a crime for the exclusion to be applied.	Oregon Department of Consumer and Business Services request. Will ensure that protesters who have not committed a crime will have coverage if injured.
Claims Administration & Payment Order of Benefit Determination	The plan will now coordinate benefits with Medicare.	The new Medicare COB process will comply with the Oregon and Federal rules.

ASO AGREEMENT CHANGES		
Reference	**Change/Rationale/Exceptions**	**Details**
None		

*Based on Delta Dental book of business.

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

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

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Retiree, COBRA and Temporary Employee Low Cost Medical Plan Options

Executive Summary

Problem Statement:
The Clackamas County benefits division created the Providence and Kaiser $1000 deductible plans to provide more affordable medical plan options for retired employees and COBRA participants. The plan design for the Providence and Kaiser $1000 deductible plans, which are now also available to full-time temporary employees, have not been changed since the inception of these plans in 2005 and 2006. Consequently, the premiums associated with these plans are less affordable resulting in increasing costs to county departments, retired employees and COBRA participants.

Project Coordinator: Jason Morrill, HR Analyst

Review Team: Tamra Dickinson, Benefits and Wellness Coordinator; Billie Hurley, HR Analyst; Christi Hardy, HR Assistant

Internal Stakeholders: Benefits and Wellness Division, County Departments, Temporary Employees, County Unions, Employee & Labor Relations, Independent Retiree Medical Trust (IRMT), Workforce Data Management Division, Technical Services.

External Stakeholders: Retirees, COBRA Participants, William C Earhart Company, Mercer, Providence Health Plan, Kaiser Permanente.

Recommendation: Since the Kaiser $1000 deductible plan is the basis for determining the value of minimum essential coverage, and consequently the employer contribution amount, we recommend retaining this plan as the lowest cost option for temporary employees, retirees and COBRA participants. Since the Kaiser plan only provides coverage within the Oregon and Washington Kaiser service district, we also recommend retaining the Providence $1000 deductible plan as a lower cost option for retiree and COBRA participants living both inside and outside of the Kaiser service district.

We recommend combining rates for the two Kaiser $1000 deductible plans (general county and POA), since these plans are nearly identical and are already in the same rate pool. This consolidation will not have a meaningful impact on the plan rates, but will reduce administrative complexity and retiree/COBRA participant confusion.

Finally, we recommend making plan design changes to both the Kaiser and Providence $1000 deductible plans to reduce costs and maintain choice. This will involve renaming the plans as “high deductible” plans instead of $1000 deductible plans. These changes will reduce the cost to departments associated with maintaining temporary employees. It will also provide employees seeking to retire with lower cost options for medical insurance in retirement, thereby making it more practical for employees to afford retiring from Clackamas County.

We are proposing the following changes for the 2021 plan year:

Kaiser plans (GC & POA):
Increase deductible to $1400/$2800
Increase pharmacy benefit to $20/$40

Providence Plan:
Increase deductible to $1400/$2800
Increase out of pocket maximum to $3000/$6000
Increase office visit copay to $25

- See $1000 deductible plan options (Attachment A) for the premium impact associated with the changes.
- See $1000 deductible plan comparison (Attachment B) for current 2020 plan coverage options.

Going forward, we recommend increasing the deductible as needed to comply with the definition of a high deductible health plan (https://www.healthcare.gov/glossary/high-deductible-health-plan/). Other changes may also be necessary in the future to retain variation among the plan options and continue to meet the affordability guidelines of the Affordable Care Act (ACA) (https://acatimes.com/irs-safe-harbors-for-affordability-help-avoid-aca-penalties/) for active employees while continuing to comply with ACA minimum essential coverage requirements.

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Background: In 2005, Clackamas County implemented the $1000 deductible Providence Open Option medical plan for general county (GC) retiree and COBRA participants. In 2006, Clackamas County added two Kaiser $1000 deductible plans (GC and POA) and extended the $1000 deductible Providence Open Option medical plan to the POA retiree and COBRA population. Clackamas County has not made any plan changes to the $1000 deductible plans since their inception.

In response to the Affordable Care Act's (ACA) employer mandate, Clackamas County began offering the $1000 deductible plans to temporary employees meeting certain eligibility criteria to satisfy Clackamas County's requirement to provide minimum essential coverage as of January 1, 2016.

Through post-educational class employee surveys, the benefits and wellness team has learned that one barrier employees experience for retirement is the cost associated with medical insurance.

Other Organizations: Our analysis shows that other similar organizations in our region also provide low cost plans as an option for retired employees. Multnomah County has two "major medical" plans, Washington County offers two "high deductible" medical plans, and Lane County has one "high deductible" medical plan available for their retiree populations. These plans are lower in cost and coverage than their other employee and retiree plans.

Current State: Clackamas County has three $1000 deductible medical plan options that are available to retirees, COBRA participants and temporary employees meeting certain eligibility criteria. These plans include:

Coverage Tier:	**Kaiser General County (GC) $1000 deductible**	**Kaiser POA $1000 deductible**	**Providence GC & POA $1000 deductible**
Individual	$533.84 / Month	$533.90 / Month	$730.63 / Month
Individual & Spouse	$1,067.68 / Month	$1,067.80 / Month	$1,461.36 / Month
Individual & Child(ren)	$960.90 / Month	$961.02 / Month	$1,315.14 / Month
Family	$1,601.56 / Month	$1,601.82 / Month	$2,191.92 / Month

*Rates are for the 2020 calendar year.

Retirees and COBRA participants pay 100% of the premiums associated with the $1000 deductible plans. The employing department pays $533.84 per employee per month (PEPM) for temporary employees enrolled in a $1000 deductible plan, and the temporary employee pays the remaining premiums. The employer premium for qualifying temporary employees is based on the least expensive $1000 deductible plan, which is currently the general county Kaiser $1000 deductible plan.

As of September 2020, here is the distribution of use:

	Kaiser General County (GC) $1000 deductible	**Kaiser POA $1000 deductible**	**Providence GC & POA $1000 deductible**	**Eligible, not enrolled**
Retiree /COBRA	8	7	14	N/A
Temporary	9	0	2	28

Estimated financial impact: If all plan changes are implemented, the combined departmental savings for 2021 based on current enrollment levels will be $2,349.60. If additional eligible temporary employees elect medical benefits for 2021, the potential savings would be up to $8,330.40.

Premium reductions associated with these changes will be passed on to retiree and COBRA participants in full. The 2021 annual premium savings for each retiree are:

Coverage Tier:	**Kaiser (GC & POA) $1000 deductible**	**Providence (GC & POA) $1000 deductible**
Individual	$213.60	$347.28
Individual & Spouse	$427.20	$694.32
Individual & Child(ren)	$384.48	$624.96
Family	$640.80	$1,041.60

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Review Begin Date: 6/29/2020

Review End Date: 9/3/2020

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Clackamas County January 2021 Renewal
Temps/Retirees/COBRA - $1,000 Deductible Plan Options
General County & POA

August 24, 2020

PLAN	GC & POA Blended Renewal No Plan Changes	$1,400/$2,800 Deductible	$20/$40 Rx Copays	Both Plan Options
Kaiser $1,000 Deductible				
EE	$520.32	$506.14	$516.58	$502.52
EE, SP	1,040.64	1,012.28	1,033.18	1,005.04
EE, CH	936.58	911.04	929.86	904.54
EE, FAM	1,561.06	1,518.50	1,549.86	1,507.66

PLAN	GC & POA Blended Renewal No Plan Changes	$1,400/$2,800 Deductible	$3,000/$6,000 OOP Maximum	$25 Office Visit Copay	All Plan Options
Providence $1,000 Deductible					
EE	$761.32	$759.80	$738.48	$758.28	$732.38
EE, SP	1,522.74	1,519.70	1,477.06	1,516.64	1,464.88
EE, CH	1,370.38	1,367.64	1,329.26	1,364.90	1,318.30
EE, FAM	2,283.98	2,279.42	2,215.46	2,274.84	2,197.18

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Attachment B:

Clackamas County - 2020 $1000 Deductible Plan Comparison (Temporary Employees, Non-Medicare Retirees and COBRA)	GC Kaiser High Deductible Plan	POA Kaiser High Deductible Plan	Providence High Deductible Open Option	
	IN-PLAN COVERAGE ONLY	IN-PLAN COVERAGE ONLY	IN-PLAN	OUT-OF-PLAN
Annual Deductible: Individual/Family	$1000/$3000	$1000/$3000	$1000/$2000 Common Deductible	
Annual Out-of-Pocket Maximum: Individual/Family	$3000/$9000	$3000/$9000	$2000/$4000 Common Maximum	
PREVENTIVE SERVICES				
Periodic health exams	Covered in full	Covered in full	Covered in full	50%*
Well baby care, routine immunizations	Covered in full	Covered in full	Covered in full	50%*
Gynecology exams & tests	Covered in full	Covered in full	Covered in full	50%*
Mammograms	Covered in full	Covered in full	Covered in full	50%
Colonscopy & sigmoidoscopy	Covered in full	Covered in full	Covered in full	50%
PHYSICIAN/PROVIDER SERVICES				
Office visits	$25* primary care; 20% specialty care	$25* primary care; 20% specialty care	$15*	50%*
Allergy shots	Covered in full	Covered in full	30%	50%
Pre-natal & post-natal visits; delivery	Covered in full	Covered in full	$100*/pregnancy	50%
HOSPITAL SERVICES				
Inpatient care & provider visits	20%	20%	30%	50%
Maternity services	20%	20%	30%	50%
Routine newborn nursery care	20%	20%	30%*	50%
Surgery & anesthesia	20%	20%	30%	50%
Rehabilitative care (subject to limitations)	20%	20%	30%	50%
Skilled nursing facility (subject to limitations)	20%	20%	30%	50%
DURABLE MEDICAL EQUIPMENT				
Medical supplies, appliances and prosthetics	20%	20%	30%	50%
Diabetic equipment (glucose monitors, insulin pumps, etc)	20%	20%	30%	50%
EMERGENCY/URGENT & AMBULANCE SERVICES				
Emergency services	20%	20%	$100*	$100*
Urgent care services	$25*	$25*	$15*	50%*
Emergency medical transportation	20%	20%	30%	30%
OTHER COVERED SERVICES				
X-ray & lab services	20%	20%	30%*	50%
Outpatient rehabilitative services	20%* (limited to 20 visits per therapy per year)	20%* (limited to 20 visits per therapy per year)	30%	50%
Outpatient surgery	20%	20%	30%	50%
Chemotherapy & radiation	20%	20%	30%	50%
Home health care (subject to limitations)	20%	20%	30%	50%
Hospice	Covered in full	Covered in full	Covered in full	Covered in full
HEARING AID ALLOWANCE				
Children	20% - One hearing aid per ear every 4 years	20% - One hearing aid per ear every 4 years	30% (One per ear every 4 years)	50% (One per ear every 4 years)
Adults	$1500 allowance every 3 years for each ear	$1500 allowance every 3 years for each ear	30% (One per ear every 4 years)	50% (One per ear every 4 years)
VISION				
Children Vision - every year	Exam and standard lenses/frames or 12 months supply of contact lenses: Covered in full	Exam and standard lenses/frames or 12 months supply of contact lenses: Covered in full	Discount available	Discount available
Vision Examinations - every 12 months	$25 co pay*	$25 co pay*	Discount available	
Benefit every 12/24 months	$200 for lenses and frames or contact lenses every 2 years	$200 for lenses and frames or contact lenses every 2 years	Discount available	
ALTERNATIVE CARE				
Office visits	$10 for chiropractic, acupuncture, naturopath², $25 massage, $1500 combined annual max	$10 for chiropractic, acupuncture, naturopath², $25 massage, $1500 combined annual max	$25 co pay* for chiropractic and acupuncture***	N/A
PRESCRIPTION DRUGS				
Generic/Brand at pharmacy	$15/$30	$15/$30	$10*/50%*	N/A
Generic/Brand for 90-day mail (maint. drugs)	$30/$60	$30/$60	$30*/50%*	N/A

*Deductible does not apply

**Physician-referred acupuncture visits is limited to 12 visits per calendar year

***Participants may be responsible for more than 1 co-pay depending on how their provider bills Providence for their services. Eligible naturopathic services are billed as physician/provider services.

²Physician-referred acupuncture visits is limited to 12 visits per calendar year

Effective January 1, 2020 to December 31, 2020