Your Benefit Summary

Open Option (Buy-Up Plan)

Clackamas County - General County Employees

Providence Health Plan

POWERED BY Collective Health

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
$15	10% coinsurance (after deductible)	30% coinsurance (after deductible; UCR applies)	$2,500 per person $5,000 per family (2 or more)	$750 per person $1,500 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at http://www.providencehealthplan.collectivehealth.com

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

Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	**In-Network Copay or Coinsurance** (after deductible, when you see an in-network provider)	**Out-of-Network Copay or Coinsurance** (after deductible, when you see a non-network provider)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full ✓	30% ✓
• Vision and hearing screenings for children under 18	Covered in full ✓	30% ✓
• Routine immunizations; shots	Covered in full ✓	30% ✓
• Gynecological exams (calendar year) and Pap tests	Covered in full ✓	30% ✓
• Mammograms	Covered in full ✓	30%
• Colonoscopy; sigmoidoscopy	Covered in full ✓	30%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not covered
Physician / Provider Services		
• Office visits (covered in full after 24 visits, in-network only) (First 3 in-network, in-person visits: $5, then plan copay)	$15 / visit ✓	30% ✓
• Office visits to Alternative Care Provider	$15 / visit ✓	$15 / visit ✓
• Phone and video visits	$5 / visit ✓	30% ✓
• Providence ExpressCare Retail Health Clinics	$15 / visit ✓	Not applicable
• Allergy shots, serums, infusions and injectable medications	10%	30%
• Inpatient hospital visits	10%	30%
• Surgery; anesthesia	10%	30%
Diagnostic Services		
• X-ray and lab services	Covered in full ✓	30%
• High-tech imaging services (such as PET, CT or MRI)	Covered in full ✓	30%
• Sleep studies	Covered in full ✓	30%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$125 ✓	$125 ✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit ✓	30% ✓
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an In-Network Provider)	10%	10%

Your Benefit Summary

Open Option Plan (Buy-Up Plan)
Prescription Drug Plan
Clackamas County - General County Employees

Providence Health Plan
POWERED BY Collective Health

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at http://www.providencehealthplan.collectivehealth.com

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

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drugs (preferred and non-preferred)	$15	$30	N/A
Brand-name drugs (preferred and non-preferred)	$30	$60	
Specialty drug	N/A	N/A	$30

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Covered in full for up to a 90-day supply of maintenance drugs at a preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you request a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They may be obtained at your participating pharmacy and must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist and are limited to 30 days. In rare circumstances, specialty medications may be filled for a great than 30-day supply; in these cases, additional specialty cost-share(s) may apply.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

Using your prescription drug benefit

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

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website. If a formulary exception is approved, your generic or brand-name cost share will apply.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.
- Insulin cost share capped at $35 for a 30-day supply, $105 for a 90-day supply. Deductible does not apply.

Ordering prescriptions by mail

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

If you use a non-participating pharmacy

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

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

Brand-name drug / Preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

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

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

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

Generic drug / Preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Generic or Preferred generic drugs. Generally your out-of-pocket costs will be less for Preferred generic drugs.

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

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

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

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Preventive drug
A generic or brand medication included on the formulary, and required to be covered at no cost per federal regulation.

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

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

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Hospital Services		
• Inpatient/Observation care	10%	30%
• Rehabilitative care (30 days per calendar year)	10%	30%
• Skilled nursing facility (60 days per calendar year)	10%	30%
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	10%	30%
• Temporomandibular joint (TMJ) service (Limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (Up to 30 visits per calendar year)	$15 / visit✓	30%
• Chiropractic manipulation, acupuncture, and massage therapy (Limited to 30 visits per service per calendar year)	$15 / visit**	$15 / visit**
Maternity Services		
• Prenatal care	Covered in full✓	30%
• Delivery and postnatal services	$150 / delivery✓	30%
• Inpatient hospital/facility services	10%	30%
• Routine newborn nursery care	10%✓	30%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	10%✓	30%
• Diabetes supplies (lancets, test strips and needles)	10%✓	30%
• Prosthetic and orthotic devices	10%✓	30%
• Hearing aids (One per ear per every three calendar years)	10%✓	30%
Mental Health / Substance Use Disorder (To initiate services, call 800-878-4445. All services, except outpatient provider visits, may require prior authorization.)		
• Inpatient and residential services	10%	30%
• Day treatment, intensive outpatient and partial hospitalization services	10%	30%
• Applied behavior analysis	10%	30%
• Outpatient provider visits (covered in full after 24 visits) (First 3 in-network, in-person visits: $5, then plan copay)	$15 / visit✓	30%✓
• Outpatient provider office visits (Virtually)	$5 / visit✓	30%✓
Home Health and Hospice		
• Home health care	10%	30%
• Hospice care	Covered in full✓	Covered in full✓

* Your deductible(s) do not apply to purchases of diabetes supplies.
** No deductible needs to be met prior to receiving this benefit. Copayment does not apply to out-of-pocket maximums.

Contact us

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

(855) 284-1368

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: http://my.collectivehealth.com

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

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

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

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

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

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

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

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

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

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

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

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

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

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