Your Benefit Summary

Open Option

Clackamas County POA

Providence Health Plan

POWERED BY Collective Health

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

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Summary Plan Description, register at providencehealthplan.collectivehealth.com

Not sure what a word or phrase means? See the back for the definitions used in this summary.

This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).

Your deductibles, some services and penalities do not apply to out-of-pocket maximums.

Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).

Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

Benefit Highlights

[3] No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then you pay the following for covered services: **In-Plan Copay or Coinsurance** (after deductible, when you use a participating provider)	**Out-of-Plan Copay or Coinsurance** (after deductible, when you use a non-participating provider)
Physician / Provider Services		
Providence ExpressCare Retail Health Clinics	$10 / visit[3]	Not applicable
Providence ExpressCare Virtual	$5 / visit[3]	Not applicable
Office visits to Primary Care Provider or Naturopath (In-person) (First 3 in-network, in-person visits: $5, then plan copay)	$10 / visit[3]	20%[3]
Office visits to Primary Care Provider or Naturopath (Virtually)	$5 / visit[3]	20%[3]
Office visits to Specialist (In-person)	$10 / visit[3]	20%[3]
Office visits to Specialist (Virtually)	$5 / visit[3]	20%[3]
Office visits to an Alternative Care Provider (In-person and Virtually)	$10 / visit[3]	$10 / visit[3]
Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full[3]	20%[3]
Vision and hearing screenings for children under 18	Covered in full[3]	20%[3]
Routine immunizations; shots	Covered in full[3]	20%[3]
Maternity services: prenatal	Covered in full[3]	20%
Maternity services: delivery and postnatal	$50 / delivery[3]	20%
Allergy shots; serums; injectable medications	Covered in full	20%
Inpatient hospital visits	Covered in full	20%
Surgery; anesthesia	Covered in full	20%
Women's Health Services		
Gynecological exams (calendar year); Pap tests	Covered in full[3]	20%[3]
Mammograms	Covered in full[3]	20%
Hospital Services		
Inpatient care	Covered in full	20%
Observation care	Covered in full	20%
Maternity care	Covered in full	20%
Routine newborn nursery care	Covered in full[3]	20%
Rehabilitative care (30 days per calendar year)	Covered in full	20%
Skilled nursing facility (60 days per calendar year)	Covered in full	20%
Outpatient Diagnostic Services		
X-ray; lab services	Covered in full[3]	20%
Imaging services (such as PET, CT, MRI)	Covered in full[3]	20%

Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Member out-of-pocket costs for DME are capped at $500)	20%[v]	20%
Hearing Aids (one per ear every three calendar years)	20%[3]	20%
Emergency / Urgent Care / Emergency Medical Transportation		
Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits)	$100[3]	$100[3]
Urgent care services (for non-life threatening illness/minor injury)	$10 / visit[3]	20%[3]
Emergency medical transportation (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	$50	$50
Other Covered Services		
Outpatient rehabilitative services (Up to 30 visits per calendar year)	$10 / visit	20%
Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	$10 / visit	20%
Chiropractic manipulation (Limited to 30 visits per calendar year)	$10 / visit✓	$10 / visit✓
Acupuncture (Limited to 30 visits per calendar year)	$10 / visit✓	$10 / visit✓
Massage therapy (Limited to 30 visits per calendar year)	$10 / visit✓	$10 / visit✓
Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
Home health care	Covered in full	20%
Hospice care	Covered in full[3]	Covered in full[3]
Tobacco use cessation; counseling/classes and deterrent medications	Covered in full[3]	Not covered
Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	$10[3]	Not covered
-Formulary brand-name drugs	$10[3]	Not covered
-Non-formulary brand-name drugs	$10[3]	Not covered
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	Covered in full	20%
Day treatment, intensive outpatient and partial hospitalization services	Covered in full	20%
Applied behavior analysis	$10 / visit[3]	20%
Outpatient provider office visits (In-person) (First 3 in-network, in-person visits: $5, then plan copay)	$10 / visit[3]	20%[3]
Outpatient provider office visits (Virtually)	$5 / visit	20%[3]

[v] Your deductible does not apply to purchase of diabetes supplies

[w] No deductible needs to be met prior to receiving this benefit. Copayment does not apply to out-of-pocket maximums.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Your Benefit Summary

Prescription Drug Plan
Clackamas County POA

Providence Health Plan
POWERED BY Collective Health

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, including your Member Handbook, http://my.collectivehealth.com

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at http://providencehealthplan.collectivehealth.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/planpharmacies or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copays, coinsurance and any difference in costs for prescription drugs do not apply to your calendar year medical plan out-of-pocket maximums or deductibles.

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

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you 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 drugs are medications that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

Using your prescription drug benefit

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

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- 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
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 drugs.

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

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

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

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

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 drugs.

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

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

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

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

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

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