Administered by Providence Health Plan

Your Benefit Summary

Personal Option Plan (Base Plan)

Clackamas County - General County Employees

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
$15	20% coinsurance (after deductible)	$2,500 per person $5,000 per family (2 or more)	$850 per person $1,700 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 myprovidence.com.

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

Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services:
✓ No deductible needs to be met prior to receiving this service	**Copay or Coinsurance** (from in-network providers only)
Preventive Care	
• Periodic health exams and well-baby care	Covered in full ✓
• Vision and hearing screenings for children under 18	Covered in full ✓
• Routine immunizations; shots	Covered in full ✓
• Gynecological exams (calendar year) and Pap tests	Covered in full ✓
• Mammograms	Covered in full ✓
• Colonoscopy; sigmoidoscopy	Covered in full ✓
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓
Physician / Provider Services	
• Office visits (covered in full after 30 visits, in-network only) (First 3 in-network, in-person visits: $5, then plan copay)	$15 / visit ✓
• Office visits to Alternative Care Provider	$15 / visit ✓
• Phone and video visits	$5 / visit ✓
• Providence ExpressCare Retail Health Clinics	$15 / visit ✓
• Allergy shots, serums, infusions and injectable medications	$15 / visit ✓
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Diagnostic Services	
• X-ray and lab services	Covered in full ✓
• High-tech imaging services (such as PET, CT or MRI)	Covered in full ✓
• Sleep studies	10% ✓
Emergency and Urgent Services	
• Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)	$100 ✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit ✓
• Emergency medical transportation (air and/or ground)	20%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (limited to 30 days per calendar year)	20%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%

Benefit Highlights (continued)	Copay or Coinsurance
Outpatient Services	
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (Limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Outpatient rehabilitative services: physical, occupational or speech therapy (Up to 30 visits per calendar year)	$15 / visit✓
• Chiropractic manipulation, acupuncture, and massage therapy (Limited to 30 visits per service per calendar year)	$15 / visit*
Maternity Services	
• Prenatal care	Covered in full✓
• Delivery and postnatal services	$150 / delivery✓
• Inpatient hospital/facility services	20%
• Routine newborn nursery care	20%✓
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%✓
• Diabetes supplies (lancets, test strips and needles)	20%✓
• Prosthetic and orthotic devices	20%✓
• Hearing aids (One per ear per every three calendar years)	20%✓
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	20%
• Day treatment, intensive outpatient and partial hospitalization services	20%
• Applied behavior analysis	20%
• Outpatient provider visits (covered in full after 30 visits) (First 3 in-network, in-person visits: $5, then plan copay)	$15 / visit✓
• Outpatient provider office visits (Virtually)	$5 / visit✓
Home Health and Hospice	
• Home health care	20%
• Hospice care	Covered in full✓

* 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.

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

Deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:
- Services not covered by your plan.
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan.
- Penalties incurred if you do not follow your plan's prior authorization requirements.
- Copays and coinsurance for services that do not apply to the deductible.

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

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

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

Out-of-Network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

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

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

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

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

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

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

Administered by Providence Health Plan

Your Benefit Summary

Personal Option Plan (Base Plan)
Prescription Drug Plan
Clackamas County - General County Employees

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at myprovidence.com.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to 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)	$10	$20	N/A
Brand-name drugs (preferred and non-preferred)	50% up to $150	50% up to $300	
Specialty drug	N/A	N/A	50% up to $200

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 up to $200. 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.

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY:711) for assistance.

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

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ຊືນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).