

Your Benefit Summary

Open Option Plan

Clackamas County Early Retirees and COBRA Participants



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
\$15	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	\$2,000 per person \$6,000 per family (3 or more)	\$1,000 per person \$3,000 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for myProvidence at www.providence.org/php/getstarted.

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Open Option Plan Benefit Highlights

✓ 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 (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services		
• Office visits	\$15 / visit ✓	50% ✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full ✓	50% ✓
• Vision and hearing screenings for children under 18	Covered in full ✓	50% ✓
• Routine immunizations; shots	Covered in full ✓	50% ✓
• Maternity services; pre- and postnatal visits	\$100 / delivery ✓	50%
• Allergy shots; serums; injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full ✓	50% ✓
• Mammograms	Covered in full ✓	50%
Hospital Services		
• Inpatient care	30%	50%
• Observation care	30%	50%
• Maternity care	30%	50%
• Routine newborn nursery care	30% ✓	50%
• Rehabilitative care (30 days per calendar year)	30%	50%
• Skilled nursing facility (60 days per calendar year)	30%	50%
Outpatient Diagnostic Services		
• X-ray; lab services	30% ✓	50%
• Imaging services (such as PET, CT, MRI)	30% ✓	50%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices		
(Removable custom shoe orthotics are limited to \$200 per calendar year; deductible waived)	30%*	50%
Emergency / Urgent Care / Emergency Medical Transportation		
(your emergency/urgent copay is waived if admitted to the hospital within 24 hours)		
• Emergency services (for emergency medical conditions only)	\$100 ✓	\$100 ✓
• Urgent care services (for non-life threatening illness/minor injury)	\$15 / visit ✓	50% ✓
• Emergency medical transportation	30%	30%

*Your deductible(s) do not apply to purchases of diabetes supplies.

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services		
<ul style="list-style-type: none"> • Outpatient rehabilitative services (30 visits per calendar year) • Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy • Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime) • Home health care • Hospice care • Tobacco use cessation; counseling/classes and deterrent medications • Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> -Generic drugs -Formulary brand-name drugs -Non-formulary brand-name drugs 	30% 30% 50% 30% Covered in full✓ Covered in full✓ \$10✓ \$50✓ \$100✓	50% 50% Not covered 50% Covered in full✓ Not covered Not covered Not covered
Mental Health / Chemical Dependency		
(To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
<ul style="list-style-type: none"> • Inpatient and day treatment services • Residential services • Outpatient provider visits 	30% 30% \$15 / visit✓	50% 50% 50%✓

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.providence.org/php/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.providence.org/php/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.providence.org/php/providerdirectory.

Prior authorization

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

Self-administered chemotherapy

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

Usual, Customary & Reasonable (UCR)

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

Contact us

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Your Benefit Summary

Prescription Drug Plan



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, register for [myProvidence](http://www.providence.org/php/getstarted) at www.providence.org/php/getstarted.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.providence.org/healthplans or call us.
- You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.providence.org/healthplans 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, coinsurance maximums, or deductibles.

Drug Coverage Category	Copay or Coinsurance			Calendar Year Out-of-Pocket Maximum
	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)	
Generic drug	\$10	\$30	\$10	\$1,000 per person \$3,000 per family (3 or more)
Brand name drug	50%	50%	50%	
Compounded drug	50%	Does not apply	Does not apply	

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- Some medications are less costly. If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain 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 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.providence.org/healthplans.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.providence.org/healthplans for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail

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

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.

What you need to know about limitations and exclusions

The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to: www.providence.org/healthplans.

Limitations

- All drugs must be Food and Drug Administration (FDA) approved, medically necessary, and require by law, a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months following FDA approval.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
- Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, they are not considered “maintenance” drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty medications are listed in the formulary.
- Self-injectible drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and referenced in the formulary.

Exclusions

- Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of the common cold.
- Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment.
- Intrauterine devices (IUDs), diaphragms and implantable contraceptives. Some of these items may be covered under your medical benefits.
- Drugs or medications delivered, injected or administered for you by a physician, other provider or another trained person.
- Drugs prescribed by naturopathic physicians (N.D.).
- Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults.
- Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra® or drugs required for, or as a result of, sexual transformation.
- Drugs used for the treatment of fertility or infertility.
- Fluoride, for members over the age of 10 years old.
- Replacement of lost or stolen medication.
- Drugs used for weight loss or cosmetic purposes.
- Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Over-the-counter (OTC) drugs, medications or vitamins that may be purchased without a provider's written prescription and prescription drugs that are available in an OTC therapeutically similar form.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions.
- Drugs or prescribed medications that are not medically necessary or are not provided according to our medical policy.
- Drugs to stimulate hair growth, including, but not limited to, Rogaine® (i.e., topical minoxidil) or other similar drug preparations.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Drugs that are not FDA approved or designated as “less than effective” by the FDA, also known as a “DESI” drug.
- Drugs placed on prescription-only status as required by state or local law.
- Compounded drugs from bulk powders that are not a component of an FDA-approved drug.
- Vaccines, immunizations and preventative medications solely for the purpose of travel.

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

Brand-name drug

Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

Coinsurance

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

Compounded drug

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

Copay

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

Formulary

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

Generic drug

Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only available after the brand-name patent expires. Visit www.providence.org/healthplans for answers to frequently asked questions about generic drugs.

Maintenance drug

Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future.

Out-of-pocket maximum

The limit on the dollar amount you will have to spend for covered prescription drugs in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

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.

Prior authorization

The process used to request an exception to the Providence Health Plan drug formulary. This process is initiated by the prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit www.providence.org/healthplans for additional information.

Self-administered chemotherapy

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

Contact us

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www.providence.org/php/contactus

Your Benefit Summary

Non-Medicare Eligible Retired Employees

Clackamas County



Important information about your plan

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

Retired Employee definition

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

Retired Employee eligibility

A retiring subscriber is eligible for retiree medical coverage on the date of retirement upon satisfying the eligibility requirements as stated in the Member Handbook and/or the Employer Group Contract.

Retired Employee dependent eligibility

Eligible family dependents of Retired Employees are eligible for coverage when indicated as covered in the Employer/Group Agreement. Please check with your employer to see if your family dependents are eligible for coverage. Eligible family dependents are subject to the eligibility and enrollment requirements as stated in your Member Handbook.

Enrollment

Notification of the subscriber's retirement must be submitted to us by your employer within 60 days of the date of retirement, unless otherwise indicated on your employer's group contract.

Termination of coverage

In addition to the termination provisions stated in your Member Handbook, members who become eligible for Medicare will no longer qualify for coverage under this supplemental benefit. Termination will occur on the earlier of the effective date stated in the Employer/Group Agreement or the last day of the month in which the individual no longer qualifies for this coverage.

Continuation of coverage

Retired employees and their eligible family dependents who qualify for Continuation Coverage are entitled to elect Continuation Coverage under this group contract.

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Your Benefit Summary

Elective Sterilization



Covered Services

Covered Services under this supplemental benefit endorsement include a Member's elective sterilization (vasectomy or tubal ligation). Prior Authorization is not required and Members may receive Covered Services from the provider and/or facility of their choice.

Please review your medical Benefit Summary for your Copayment or Coinsurance amounts. For Members enrolled on a medical plan with In-Plan and Out-of-Plan benefits, elective sterilization Services are covered at the In-Plan Copayment/Coinsurance amount.

For Members enrolled in a HSA-Qualified Open Option Plan, the calendar year medical/pharmacy Deductible DOES apply to this benefit. Also, Copayments or Coinsurance payments for Services provided by this benefit apply to your calendar year medical/pharmacy Out-of-Pocket Maximum.

For Members on all other plans, the medical Deductible, if any, DOES NOT apply to this benefit, and Copayments or Coinsurance for Services provided by this benefit DO NOT apply to the calendar year Out-of-Pocket Maximums.

All Covered Services are subject to the specific conditions, duration limitations and all applicable maximums of the Group Contract on a Usual, Customary and Reasonable (UCR) cost basis.

Please Note:

Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience does not offer these services at Providence Health & Services facilities.

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