Your Benefit Summary

Total Enhanced 500 Platinum

Providence Signature Network	In-Network	Out-of-Network
Individual Calendar Year Common Deductible (family amount is 2 times individual)	$500	
Individual Common Out-of-Pocket Maximum (family amount is 2 times individual) This amount includes the deductible.	$2,500	

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- In-network and out-of-network services accumulate toward your common deductible and common out-of-pocket maximum.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- To get the most out of your benefits, use the providers within the Providence Signature network.
- 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. See your handbook for details.

	Below is the amount you pay after you have met your calendar year deductible	
	In-Network	Out-of-Network
Preventive Care		
Periodic health exams and well-baby care	Covered in full✓	30%✓
Routine immunizations and shots	Covered in full✓	30%✓
Colonoscopy (preventive, age 50+)	Covered in full✓	30%
Gynecological exams (1 per calendar year) and Pap tests	Covered in full✓	30%
Mammograms	Covered in full✓	30%
Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not Covered
Physician/Professional Services		
Office visits to a Personal Physician/Provider	$10✓	30%✓
Visits to a Personal Physician/Provider by phone or video	Covered in full✓	Not Covered
Office visits to an Alternative Care Provider (Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.)	$10✓	30%✓
Office visits to specialists	$25✓	30%✓
Visits to a specialist by phone or video	$10✓	Not Covered
Inpatient hospital visits	10%	30%
Allergy shots, allergy serums, injectable and infused medications	10%	30%
Surgery and anesthesia	10%	30%
Diagnostic Services		
X-ray and lab services	10%✓	30%
High-tech imaging services (such as PET, CT or MRI)	10%	30%
Sleep studies	10%✓	30%
Emergency and Urgent Services		
Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits.)	$250 then 10%✓	$250 then 10%✓
Emergency medical transportation (air and/or ground) Emergency transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider.	10%	
Urgent care visits (for non-life threatening illness/minor injury)	$25✓	30%✓

Your Benefit Summary (continued)

	Below is the amount you pay after you have met your calendar year deductible	
	In-Network	Out-of-Network
Hospital Services		
Inpatient/Observation care	10%	30%
Skilled nursing facility (limited to 60 days per calendar year)	10%	30%
Inpatient rehabilitative care (limited to 30 days per calendar year; 60 days for head/spinal injuries; limits do not apply to Mental Health Services)	10%	30%
Inpatient habilitative care (limited to 30 days per calendar year; 60 days for head/spinal injuries; limits do not apply to Mental Health Services)	10%	30%
Outpatient Services		
Outpatient surgery at an ambulatory surgery center or a hospital-based facility	10%	30%
Colonoscopy (non-preventive) at an ambulatory surgery center or a hospital-based facility	10%	30%
Outpatient dialysis, infusion, chemotherapy and radiation therapy	10%	30%
Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year; up to 30 additional visits per specified condition; limits do not apply to Mental Health Services)	10%	30%
Outpatient habilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year; up to 30 additional visits per specified condition; limits do not apply to Mental Health Services)	10%	30%
Maternity Services		
Prenatal visits	Covered in full✓	30%
Delivery and postnatal physician/provider visits	10%	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 (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	10%	30%
Mental Health and Chemical Dependency (To initiate services, call 800-711-4577. All services, except outpatient provider office visits, must be prior authorized.)		
Inpatient and residential services	10%	30%
Day treatment, intensive outpatient, and partial hospitalization services	10%	30%
Outpatient provider visits	$10✓	30%✓
Applied Behavior Analysis	10%	30%
Home Health and Hospice		
Home health care	10%	30%
Hospice care	Covered in full✓	Covered in full✓
Respite care (limited to members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime)	10%	30%
Biofeedback		
Biofeedback for specified diagnosis (limited to 10 visits per lifetime)	10%	30%
Chiropractic Manipulation and Acupuncture (Copayments and coinsurance do not apply to your out-of-pocket maximums)		
Chiropractic manipulations and acupuncture (limited to 15 visits combined per calendar year)	$25✓	50%✓

✓ Deductible does not apply

Prescription Drugs

	Below is the amount you pay after you have met your calendar year deductible
Up to a 30-Day Supply (From a participating retail, preferred or specialty pharmacy)	
Preferred generic	$10✓
Non-preferred generic	$15✓
Preferred brand name	$25✓
Non-preferred brand name	30%✓
Specialty	50%✓
90-Day Supply (From a participating mail order or preferred retail pharmacy)	
Preferred generic	$30✓
Non-preferred generic	$45✓
Preferred brand name	$75✓
Non-preferred brand name	30%✓

Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply as outlined in your handbook 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. 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.
- View a list of our participating pharmacies www.ProvidenceHealthPlan.com/planpharmacies.

Using your prescription drug benefit

- To find if a drug is covered under your plan check online at www.ProvidenceHealthPlan.com/pharmacy. Note that your plan's formulary includes ACA Preventive drugs which are medications that are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy at 3 times the copay. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They 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 after the deductible.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefit limitations, and coinsurance. See your Member Handbook for details.
- 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.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Handbook for more information.
- Be sure you present your current Providence Health Plan member identification card.

Routine Vision Services

Provided by VSP

VSP Choice Network (For customer service call 800-877-7195)	Below is the amount you pay after you have met your calendar year deductible In-Network	Out-of-Network
Pediatric Vision Services (under age 19)		
Routine eye exam (limited to 1 exam per calendar year)	Covered in full✓	Covered up to $45✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full ✓	Covered up to $30✓
Lined bifocal	Covered in full✓	Covered up to $50✓
Lined trifocal	Covered in full✓	Covered up to $70✓
Lenticular lenses	Covered in full✓	Covered up to $100✓
Frames (limited to 1 pair per calendar year; select from VSP's Otis &Piper ™ Eyewear Collection)	Covered in full✓	Covered up to $70✓
Contact lens services and materials in place of glasses Standard: 1 pair per calendar year (1 contact lens per eye) Monthly: 6 month supply per calendar year (6 lenses per eye) Bi-weekly: 3 month supply per calendar year (6 lenses per eye) Dailies: 3 month supply per calendar year (90 lenses per eye)	Covered in full✓	Covered up to $105✓
Adult Vision Services (Copayments do not apply to your out-of-pocket maximums)		
Routine eye exam (limited to 1 exam per 1 calendar year)	$30✓	Covered up to $45✓
Lenses (limited to 1 pair per 1 calendar year)		
Single vision	Covered in full ✓	Covered up to $30✓
Lined bifocal	Covered in full✓	Covered up to $50✓
Lined trifocal	Covered in full✓	Covered up to $70✓
Lenticular lenses	Covered in full✓	Covered up to $100✓
Progressive lenses	$50✓	Covered up to $50✓
Frames (limited to 1 pair per 1 calendar year)	Covered up to $130✓ retail	Covered up to $70✓
Contact lens services and materials in place of glasses (Limited to every 1 calendar year)	Covered up to $130✓ retail	Covered up to $105✓

Pediatric Dental Service (under age 19)

For customer service, including dental prior authorizations and claims, call 800-878-4445	Below is the amount you pay after you have met your calendar year deductible In-Network	Out-of-Network
Preventive		
Routine Exams 1 per six months	Covered in full✓	30%✓
Bitewing X-rays 1 set per 12 months	Covered in full✓	30%✓
Cleanings 2 per 12 months	Covered in full✓	30%✓
Topical Fluoride 2 per 12 months	Covered in full✓	30%✓
Fissure sealants Under age 16 for 1 service per tooth (molar) every 36 months	Covered in full✓	30%✓
Space Maintainers 1 per arch every 24 months	Covered in full✓	30%✓
Basic		
Restorative fillings	50%	70%
Major		
Oral surgery (extractions and other minor surgical procedures)	50%	70%
Endodontics and Periodontics	50%	70%
Stainless Steel Crowns/Primary tooth 1 service per tooth in a 7-year period	50%	70%
Porcelain Crowns 1 service per anterior tooth in a 7-year period for children ages 16 and older	50%	70%
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures) Limited to once every 10 years for members ages 16 and older	50%	70%

Explanation of terms and phrases

ACA Preventive Drugs – ACA Preventive drugs are medications, including contraceptives that are listed in our formulary. They are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

Coinsurance – The percentage of the cost that you may need to pay for covered services.

Copay – The fixed dollar amount you pay to a healthcare 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 the plan pays any benefits within a calendar year. The following expenses do not apply to the individual or family deductible: services not covered by the plan; fees that exceed usual, customary and reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the 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. 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 member handbook 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.

Out-of-pocket maximum – The limit on the dollar amount that an individual or family pays for specified covered services in a calendar year. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook or contract 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.

Preferred brand-name drugs/Non-preferred brand-name drugs –
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 Preferred brand-name or Non-preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

Preferred generic drugs/Non-preferred generic drugs –
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 Preferred generic drugs and Non-preferred generic drugs. Generally your lowest out-of-pocket cost will be for Preferred generic drugs.

Prescription drug 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.

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 differences. These amounts do not apply to your out-of-pocket maximums.

Contact us

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY:711

www.ProvidenceHealthPlan.com/contactus

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, 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, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide 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)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, 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

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 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*.

Language Access Services

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

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 11-800-878-4445 (телетайп: 711).

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

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: TTY:711).

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

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

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می‌شود، تسهیلات زبانی بصورت رایگان برای شما فراهم می‌باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)