Your Benefit Summary
Providence Health & Services
2019 OR EPO Medical Plan

<table>
<thead>
<tr>
<th>Copay</th>
<th>What You Pay In Network</th>
<th>Calendar Year In-Network Medical/Pharmacy Out-of-Pocket Maximum</th>
<th>Calendar Year In-Network Medical/Pharmacy Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$20</td>
<td>20% coinsurance (after deductible)</td>
<td>$2,500 per person</td>
<td>$300 per person</td>
</tr>
<tr>
<td></td>
<td></td>
<td>$7,500 per family</td>
<td>$900 per family</td>
</tr>
</tbody>
</table>

Important information about your plan
This summary provides only highlights of your benefits. Certain limitations and exclusions apply. To view all of your plan details, including your Summary Plan Description, register for myProvidence at www.ProvidenceHealthPlan.com/getstarted.

- Not sure what a word or phrase means? See the last page for the definitions used in this summary.
- Your Calendar Year Medical/Pharmacy Deductible applies to your Calendar Year Medical/Pharmacy Out-of-Pocket Maximum.
- Some services and penalties do not apply to out-of-pocket maximums.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- Medical Home is a team based healthcare model, led by a primary care provider that allows for comprehensive and ongoing care with the end goal of optimal health outcomes for our patients.
- Selection process for the medical home is as follows: When enrolled in the EPO, you must select a Medical Home. You medical home is a primary care provider that you will contact for all your medical care. You can see what medical homes are available by going online to www.ProvidenceHealthPlan.com/providerdirectory. You must either designate the medical home in your myProv account or contact customer service at 800-878-4445 to make the selection.

Benefit Highlights

<table>
<thead>
<tr>
<th>Preventive Health and Wellness Services</th>
<th>After you pay your calendar year deductible, then you pay the following for covered services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic health exams; well-baby care</td>
<td>In-Network Providers: Covered in full*</td>
</tr>
<tr>
<td>Gynecological exams (calendar year) and Pap tests</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Mammogram</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Prostate screening exam (calendar year)</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Colorectal exam</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Colorectal cancer screening: sigmoidoscopy, colonoscopy (for members age 50 and over)</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>The following tests (when received with your periodic health exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>The following services (for members with diabetes): HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Pneumococcal vaccine</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Flu vaccine</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Routine immunizations/shots</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Nutritional counseling</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Vision and hearing screening</td>
<td>Covered in full*</td>
</tr>
<tr>
<td>Tobacco use cessation; counseling/classes, and deterrent medications, including prescription and over the counter. Medications must be purchased at an in-network pharmacy.</td>
<td>Covered in full*</td>
</tr>
</tbody>
</table>

Physician / Provider Services

<table>
<thead>
<tr>
<th>Physician / Provider Services</th>
<th>After you pay your calendar year deductible, then you pay the following for covered services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Office visits to Primary Care Provider</td>
<td>$20 / visit*</td>
</tr>
<tr>
<td>Providence ExpressCare Retail Health Clinics</td>
<td>$10 / visit*</td>
</tr>
<tr>
<td>Office visits to specialist</td>
<td>$40 / visit*</td>
</tr>
<tr>
<td>Inpatient hospital visits</td>
<td>20%</td>
</tr>
<tr>
<td>Surgery; anesthesia</td>
<td>20%</td>
</tr>
<tr>
<td>Allergy shots, serums, infusions, and injectable medications</td>
<td>20%</td>
</tr>
</tbody>
</table>

Outpatient Diagnostic Services

<table>
<thead>
<tr>
<th>Outpatient Diagnostic Services</th>
<th>After you pay your calendar year deductible, then you pay the following for covered services:</th>
</tr>
</thead>
<tbody>
<tr>
<td>X-ray; lab services</td>
<td>20%</td>
</tr>
<tr>
<td>High-tech imaging services (such as PET, CT, MRI)</td>
<td>20%</td>
</tr>
</tbody>
</table>
## Benefit Highlights (continued)

### Hospital Services
- Acute care 20%
- Rehabilitative care 20%
- Skilled nursing facility 20%

### Maternity
- Prenatal services Covered in full✓
- Delivery and postnatal services Covered in full✓
- Routine newborn nursery care Covered in full✓
- Hospital services 20%
- Infertility services 20%
  (limited to $500 per calendar year; testing and counseling only)

### Medical Equipment, Supplies and Devices
- Durable medical equipment and appliances 20%
- Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $500 per calendar year) 20%
- Diabetic supplies (See SPD for details) Covered in full✓
- Hearing Aids ($1,500 maximum rolling 36 months) 20%

### Emergency / Urgent Care / Emergency Medical Transportation
- Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.) $250✓
- Urgent care services (for non-life threatening illness/minor injury) $60 / visit✓
- Emergency medical transportation 20%

### Other Covered Services
- Outpatient rehabilitative services (75 visits per calendar year) 20%
- Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy 20%
- Spinal manipulations and acupuncture (limited to 12 visits combined per calendar year) 20%
- Bariatric surgery (Only available at PSJH facilities. Limitations apply.) 20%
- Temporomandibular joint (TMJ) service (limited to $3,000 per lifetime) 20%
- Home health care (limited to 130 visits per calendar year) Covered in full
- Hospice care 20%

### Mental Health / Chemical Dependency
(To initiate services, you must call 800-711-4577. All inpatient, residential, and day or partial hospitalization treatment services must be prior authorized.)
- Inpatient, residential services 20%
- Day treatment, intensive outpatient and partial hospitalization services 20%
- Applied behavior analysis 20%
- Outpatient provider office visits Covered in full✓

### Prescription drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)
- Safe Harbor preventive drugs (not subject to deductible) Covered in full✓
- Formulary generic drugs $10✓
- Non-formulary generic drugs $10✓
- Formulary brand-name drugs 20% (max $75 per 30-day supply)✓
- Non-formulary brand-name drugs 40% (max $125 per 30-day supply)✓
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.

**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 benefit**
The in-network benefit is an extensive network of highly qualified physicians and health care providers, also known as network providers, available to you by your plan. To find an in-network provider, go to www.providencehealthplan.com/phs-employees

**In-Network provider**
A physician or provider of health care services who belongs to the Providence Health Plan in-network provider panel. To find an in-network provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

**Medical/pharmacy 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
- 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 routine vision care
- Copays and coinsurance for services that do not apply to the deductible.

**Medical/pharmacy 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 common out-of-pocket maximum. See your Summary Plan Description for details.

**Primary Care Provider**
A qualified practitioner who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics or gynecology.

**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.

**Virtual visit**
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

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
**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](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)

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).

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 1-800-878-4445 (телефай: 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 (телефай: 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 اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 444-878-1-800.

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

>,</td>
<td>ပိုမို နားလည်သစ်သော လိုင်စင်မှာ ဖော်ပြပါလိုက်နာစောင်ပါသည်။ ပိုမို လိုင်စင်မှာ ဖော်ပြပါလိုက် (TTY: 711)

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


دوري بيك. شما چرا کانی برای تهیه خدمات زبان لاتین، به کمک گرفتار می‌شوید؟ بهترین سازنده ویژگی زبان به اگر توجه فرم باشند (TTY: 711)

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