Your Benefit Summary

Connect Plan

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$15	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$3,000 per person $6,000 per family (2 or more)	$6,000 per person $12,000 per family (2 or more)	$500 per person $1,000 per family (2 or more)	$1,000 per person $2,000 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.

- Once you have registered, you can select your medical home online or by calling customer service.
- The individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network deductibles and out-of-pocket maximums accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Connect network and obtain referrals from your medical home. View a list of in-network providers and pharmacies at ProvidenceHealthPlan.com/findaprovider
- If you choose to go outside the Connect network or do not obtain a referral, use providers who have contracted rates with Providence Health Plan. This ensures that you will not be subject to billing for charges that are above contracted rates. When seeing providers who are not contracted with Providence Health Plan, benefits for out-of-network services are based on Usual, Customary and Reasonable charges (UCR).
- Qualified Out-of-Area Dependents who meet eligibility requirements have access to providers in the Providence Signature network.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Connect Benefit Highlights	After you pay your calendar year deductible(s), then you pay the following for covered services	
✓ No deductible needs to be met prior to receiving this service	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Providence ExpressCare Virtual	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%
• Colonoscopy (Age 45+)	Covered in full✓	40%
• Gynecological exam (calendar year) and PAP test	Covered in full✓	40%
• Mammograms	Covered in full✓	40%
• Nutritional counseling	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider (In-person)	$15 / visit✓	40%
• Office visits to Primary Care Provider (Virtually)	$10 / visit✓	40%
• Office visits to Specialists/Other Providers (In-person & Virtually)	$30 / visit✓	40%
• Office visits to Alternative Care Provider (such as Naturopath)	$15 / visit✓	40%
• Chiropractic Manipulations (limited to 20 visits per calendar year)	$15 / visit✓	$15 / visit✓
• Acupuncture (limited to 12 visits per calendar year)	$15 / visit✓	$15 / visit✓
• Allergy shots and serums	20%✓	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%

Connect Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	20%✓	40%
• High-tech imaging services (such as PET, CT or MRI)	20%	40%
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$250	$250
• Urgent care services (for non-life threatening illness/minor injury)	$30 / visit✓	40%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy, osteopathic manipulation, pain management (multi-disciplinary) program	20%	40%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	40%
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	40%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)	20%✓	40%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%✓	40%
• Cardiac rehabilitation (In-network, first 16 visits covered in full, deductible waived, then deductible and coinsurance)	20%	40%
• Biofeedback for specified diagnosis (limited to 10 vists per lifetime, limits do not apply to Mental Health Services)	20%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services		
◦ Certified nurse midwife	10%	40%
◦ Primary Care Provider	10%	40%
◦ OB/GYN Physician/Provider	20%	40%
◦ All other licensed maternity providers	20%	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)	20%	40%
• Diabetes supplies (Such as lancets, test strips, needles, blood and continuous glucose monitors)	20%✓	40%
• Removable custom shoe orthotics (Limited to $200 per calendar year)	20%✓	40%✓
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	20%	40%
Mental Health / Chemical Dependency Services except outpatient provider office visits may require prior authorization.		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%✓	40%
• Applied behavior analysis	20%✓	40%
• Outpatient provider office visits (In-person)	$15 / visit✓	40%
• Outpatient provider office visits (Virtually)	$10 / visit✓	40%

Connect Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full✓	Covered in full✓
Routine Vision Exam		
Provided by VSP		
VSP Choice Network (for Customer Service call 800-877-7195)		
Your copays do not apply to your plan's medical out-of-pocket maximums		
• Pediatric WellVision Exam® (under age 19) - Every 12 months	Covered in full✓	Covered up to $45✓
• Adult WellVision Exam® - Every 12 months	$10✓	Covered up to $45✓

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.

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.

Medical Home
A full service health care clinic which has been designated as a Medical Home providing and coordinating members' medical care.

Medical Home referral
A referral from your Medical Home to receive services from an in-network provider that is not part of you medical home.

Office Visits Virtually
Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom.

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 ProvidenceHealthPlan.com/findaprovider.

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 Member Handbook for details.

Primary Care 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. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Providence ExpressCare Retail Health Clinic
A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries.

Providence ExpressCare Virtual
Sevices for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments.

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 difference.

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*, 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 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 (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។ ចូរ ទូរស័ព្ទ 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 می کنید، تسهیلات زبانی بصورت رایگان برای شما بگیرید.
ف می باشد. با (TTY: 711) 1-800-878-4445 تماس

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)