## Your Benefit Summary

### HSA Qualified Plan - Formulary F

### What You Pay

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% coinsurance (after deductible)</td>
<td>40% coinsurance (after deductible; UCR applies)</td>
</tr>
</tbody>
</table>

### Calendar Year

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$6,900 per person</td>
<td>$13,800 per person</td>
</tr>
<tr>
<td>$13,800 per family (2 or more)</td>
<td>$27,600 per family (2 or more)</td>
</tr>
</tbody>
</table>

### Calendar Year Deductible

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>$3,000 per person</td>
<td>$6,000 per person (2 or more)</td>
</tr>
<tr>
<td>$6,000 per family (2 or more)</td>
<td>$12,000 per family (2 or more)</td>
</tr>
</tbody>
</table>

## 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](http://www.myProvidence.com).

- When two or more family members are enrolled, the in-network per person annual limit on cost-sharing is $8,150.
- The aggregate individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the family deductible amount applies before the plan provides benefits for covered services.
- The aggregate individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the family out-of-pocket maximum amount applies before the plan provides benefits for covered services.
- 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.
- To find if a drug is covered under your plan, check online at [www.ProvidenceHealthPlan.com/pharmacy](http://www.ProvidenceHealthPlan.com/pharmacy).
- Not Medicare Part D creditable
- If you or your provider request or prescribe 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.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at [http://phppd.providence.org](http://phppd.providence.org).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

## HSA Qualified Plan Benefit Highlights

<table>
<thead>
<tr>
<th>Benefit Highlight</th>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepaid Health Care Plan</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
<tr>
<td>Quality Health Care Plan</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
<tr>
<td>Preferred Provider Network</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
<tr>
<td>Value Health Care Plan</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
<tr>
<td>Value Health Care Plan II</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### On-Demand Provider Visits

- Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits (where available)
- Providence ExpressCare Retail Health Clinic
- Virtual visits to a Specialist by phone & video

### Preventive Care

- Periodic health exams and well-baby care
- Routine immunizations; shots
- Colonoscopy (age 50 +)
- Gynecological exam (calendar year) and PAP test
- Mammograms
- Nutritional counseling
- Tobacco cessation, counseling/classes and deterrent medications

### Physician / Provider Services

- Office visits to Primary Care Provider
- Office visits to Alternative Care Provider (such as Naturopath)
- Office visits to Specialists/Other Providers
- Allergy shots and serums
- Infusions and injectable medications
- Surgery; anesthesia in an office or facility
- Inpatient hospital visits

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**HSA 514**

**PGC-OR 0120 LG HSA SD**

**Oregon - Large Group**

**HSA 20/40/6900/3000sd/20/20/2X/SIG**
## HSA Qualified Plan Benefit Highlights (continued)

### Diagnostic Services
- X-ray, lab services, and testing services (includes ultrasound)
  - In-Network: 20%
  - Out-of-Network: 40%
- High-tech imaging services (such as PET, CT or MRI)
  - In-Network: 20%
  - Out-of-Network: 40%

### Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)
Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share
- **ACA Preventive drugs**
  - Covered in full
- **Preferred generic drugs**
  - In-Network: 20%
  - Out-of-Network: Not covered
- **Non-preferred generic drugs**
  - In-Network: 20%
  - Out-of-Network: Not covered
- **Preferred brand-name drugs**
  - In-Network: 20%
  - Out-of-Network: Not covered
- **Non-preferred brand-name drugs**
  - In-Network: 20%
  - Out-of-Network: Not covered
- **Specialty drugs** (Specialty drugs are limited to a 30-day supply and must be obtained through a contracted specialty pharmacy)
  - In-Network: 50% up to $200
  - Out-of-Network: Not covered
- **Compounded drugs** (Compounded drugs are limited to 30-day supply and must be obtained at a retail/preferred retail pharmacy)
  - In-Network: 50%
  - Out-of-Network: Not covered

### Emergency and Urgent Services
- **Emergency services** (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)
  - In-Network: 20%
  - Out-of-Network: 20%
- **Urgent care services** (for non-life threatening illness/minor injury)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Emergency medical transportation** (air and/or ground)
  - In-Network: 20%
  - Out-of-Network: 20%

### Hospital Services
- **Inpatient/Observation care**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Rehabilitative care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Habilitation care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Skilled nursing facility** (Limited to 60 days per calendar year)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Temporomandibular joint (TMJ) services** (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)
  - In-Network: 50%
  - Out-of-Network: Not covered

### Outpatient Services
- **Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy** (Prior authorization required for outpatient hospital-based infusions)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Outpatient Surgery at an Ambulatory Surgical Center (ASC)**
  - In-Network: 10%
  - Out-of-Network: 40%
- **Colonoscopy (Non-preventive) at a Hospital-based facility**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)**
  - In-Network: 10%
  - Out-of-Network: 40%
- **Temporomandibular joint (TMJ) services** (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)
  - In-Network: 50%
  - Out-of-Network: 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)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Outpatient habilitative services: physical, occupational and speech therapy** (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Cardiac rehabilitation**
  - In-Network: 20%
  - Out-of-Network: Not covered

### Maternity Services
- **Prenatal office visits**
  - Covered in full
  - Out-of-Network: 40%
- **Delivery and postnatal services**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Inpatient hospital/facility services**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Routine newborn nursery care**
  - In-Network: 20%
  - Out-of-Network: 40%

### Medical Equipment, Supplies and Devices
- **Medical equipment, appliances, prosthetics/orthotics and supplies** (Hearing aids limited to 1 per ear every 3 calendar years)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Diabetes supplies** (such as lancets, test strips and needles)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Removable custom shoe orthotics** (Limited to $200 per calendar year)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Oral Sleep Apnea Appliance** (Out-of-Network limited to $2,000 per calendar year)
  - In-Network: 20%
  - Out-of-Network: 40%
<table>
<thead>
<tr>
<th>HSA Qualified Plan Benefit Highlights (continued)</th>
<th>In-Network Coinsurance</th>
<th>Out-of-Network Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mental Health / Chemical Dependency</strong> (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Inpatient and residential services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>● Day treatment, intensive outpatient and partial hospitalization services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>● Applied behavior analysis</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>● Outpatient provider office visits</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Home Health and Hospice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Home health care</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>● Hospice care</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
<tr>
<td><strong>Routine Vision Exam</strong> Provided by VSP</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VSP Choice Network (for Customer Service call 800-877-7195)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Your copays do not apply to your plan’s medical out-of-pocket maximums</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Pediatric WellVision Exam® (under age 19) - Every 12 months</td>
<td>Covered in full</td>
<td>Covered up to $45</td>
</tr>
<tr>
<td>● Adult WellVision Exam® - Every 12 months</td>
<td>$10</td>
<td>Covered up to $45</td>
</tr>
</tbody>
</table>
Your guide to the words or phrases used to explain your benefits

ACA Preventive drug
Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, that are listed in our formulary as such, and are covered at no cost when received from Participating Pharmacies.

Over-the-counter preventive drugs received from Participating Pharmacies require a written prescription from your Qualified Provider to be covered in full under this benefit.

Annual Limit on Cost Sharing
The maximum amount a member pays out-of-pocket per calendar year for in-network essential health benefit covered services, when two or more family members are enrolled in this plan.

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Compound Drug
Compounded medications are prescriptions that are custom prepared by your pharmacist and must contain at least one FDA-approved drug to be eligible for coverage. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.

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 an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. 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.

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.

Health Savings Account (HSA)
Employee-owned bank accounts where money is deposited — by employees, employers and even family members — to be used for employees’ current and future health care expenses. Contributions can be deducted pre-tax from paychecks, and the money rolls over year to year and stays with the employee even with job changes and retirement.

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. Balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

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 http://phpdp.providence.org.

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a calendar year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details.

Preferred generic drug / Non-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. Generally your out-of-pocket costs will be less for Preferred generic drugs.

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

Prescription Drug Prior Authorization
The process used to request an exception to the Providence Health Plan drug formulary. This can be 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.

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.

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.

Safe Harbor Preventive drugs
The Internal Revenue Code governing HSA-Qualified plans provides for a “safe harbor” for qualifying preventive medications, allowing these medications to be exempt from the deductible. Safe Harbor Preventive drugs do not include any medication used to treat an existing illness, injury or condition. Safe Harbor Preventive drugs are subject to formulary and tier status, as well as pharmacy management programs (i.e. prior authorization, step therapy, quantity limits).

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

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

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.
**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).

ATENCION: 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).

请注意：如果你们是用简体中文的，我们可以为您提供免费的语言支持服务。请拨打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.

주의사항: 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。

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。

MLHUÔZHòng: Ėnza ēnkt ná dartz lěngzhà, fà ne kõnmà nàmsà de m̃sàumà l̃ngzhà tò tõw̃fr l̃k m̃ml̃n.نان bù̃ch 4445-878-4445 (1-800).

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


دويريگ: شما ایکارا یاکشورت وزبان لاتی خودکان ویچویکرش ویفارس زبان به‌باغ‌توجه فیم باشند بیا (1-800-878-4445 (TTY: 711).

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