Your Benefit Summary

HSA Qualified Plan



What You Pay In-Network

20% coinsurance (after deductible) What You Pay Out-of-Network

40%
coinsurance
(after deductible; UCR
applies)

Calendar Year In-Network Out-of-Pocket Maximum

\$5,500 per person \$11,000 per family (2 or more) Calendar Year Out-of-Network Out-of-Pocket Maximum

\$11,000 per person \$22,000 per family (2 or more) Calendar Year In-Network Deductible \$4,000 per person

\$8,000 per family

(2 or more)

Calendar Year Out-of-Network Deductible

\$8,000 per person **\$16,000** 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 www.myProvidence.com.

- When two or more family members are enrolled, the in-network per person annual limit on cost-sharing is \$7,900.
- The 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 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.
- 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 www.ProvidenceHealthPlan.com/providerdirectory.
- 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 to your benefits. See your Member Handbook for details.

HSA Qualified Plan 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 benefit.	In-Network Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Coinsurance (after deductible, when you see a non-network provider)
 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 	Covered in full	Not covered Not applicable
Virtual visits to a Specialist by phone & video	5%	Not covered
 Preventive Care Periodic health exams and well-baby care Routine immunizations; shots Colonoscopy (age 50 +) Gynecological exams (calendar year) and Pap tests Mammograms Nutritional counseling Tobacco cessation, counseling/classes and deterrent medications 	Covered in full'	40% 40% 40% 40% 40% 40% Not covered
 Physician / Provider Services Office visits to Primary Care Provider Office visits to Alternative Care Provider (such as Naturopath) (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.) Office visits to Specialists/Other Providers Allergy shots and serums Infusions and injectable medications 	20% 20% 20% 20% 20%	40% 40% 40% 40% 40%
 Surgery; anesthesia in an office or facility Inpatient hospital visits 	20% 20% 20%	40% 40%
 Diagnostic Services X-ray, lab services, and testing services (includes ultrasound) High-tech imaging services (such as PET, CT or MRI) 	20% 20%	40% 40%

Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies) drafe Harbor drugs are exempt from the deductible, subject to the formulary and applicable ter cost share: A CA Preventive drugs Preferred generic drugs Preferred brand-name drugs Preferred brand-	HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
or day supplymal-iorder and preferred retail pharmacles) as let Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share ACA Preventive drugs Preferred generic drugs Non-preferred generic drugs Non-preferred prand-name drugs Non-preferred brand-name drugs preferred brand-name name ground brand-name name ground brand-name drugs preferred brand-name name ground-name name ground-name grand-name name ground-name grand-name name ground-name grand-name grand-name name grand-name name grand-name name grand-name name grand-name name grand-name name grand-name	Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies;		Comparance
and applicable tier cost share ACA Preventive drugs Preferred generic drugs Preferred brand-name brand-name brand-name brand-name brand-name brand-name brand-name brand-name brand-name drugs Preferred brand-name bran	90-day supply/mail-order and preferred retail pharmacies)		
ACA Preventive drugs Preferred generic drugs Non-preferred generic drugs Preferred preneric drugs 20% Not covered Non-preferred generic drugs 20% Not covered Non-preferred branch-name drugs 20% Not covered Non-preferred branch-name drugs 20% Not covered Non-preferred branch-name drugs 20% Not covered Specially driving Sweally drugs are limited to a 30-day supply and must be obtained through a cantinuted spaceally pharmacy) Compounded drugs semanded drugs are limited to 30-day supply and must be obtained at a retalipparted retail pharmacy) Compounded drugs semanded drugs are limited to 30-day supply and must be obtained at a retalipparted retail pharmacy) Compounded drugs semanded drugs are limited to 30-day supply and must be obtained at a retalipparted retail pharmacy) Compounded drugs semanded drugs are limited to 30-day supply and must be obtained at a retalipparted retail pharmacy) Compounded drugs semanded drugs are limited to 30-day supply and must be obtained as a retalipparted retail pharmacy Compounded drugs semanded drugs are limited to 30-day supply and must be obtained as a retailparted retail pharmacy Compounded drugs semanded and the semanded of the	Safe Harbor drugs are exempt from the deductible, subject to the formulary		
Preferred generic drugs Non-preferred premit drugs Non-preferred brand-name drugs Specialty drugs (seedaby drugs are minted to a 30-day supply and must be obtained truthing to contracted specialty produces are limited to a 30-day supply and must be obtained truthing to contracted specialty produces are limited to a 30-day supply and must be obtained truthing to contracted specialty produces are limited to 30-day supply and must be obtained to a catalphoretimer claim planmacy) Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at an estalphoretimer claim planmacy) Emergency and Urgent Services Emergency services for emergency medical transportation of use and/or ground Emergency medical transportation of use and/or ground Emergency medical transportation in and/or ground Emergency medical transportation in and/or ground Emergency medical transportation in an under ground Emergency medical transportation in covered under your in-relevork benefit, regardless of whether or not the grouder is an in-network provider Inspiral Services Skilled nursing facility Umited to 60 days per calendar year. Limits do not apply to Mental Health Services. Skilled nursing facility Umited to 60 days per calendar year. Limits do not apply to Mental Health Services Uttpatient Services Outpatient Services Outpatient Surgery at an Ambulatory Surgical Center (ASC) Outpatient Tenhabilitative services provised in speech therapy (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services) Outpatient habilitative services provised in speech therapy (Limited to 30 days and 30	and applicable tier cost share		
Non-preferred generic drugs Preferred brand-harme drugs Non-preferred brand-harme drugs Non-preferred brand-harme drugs Specially furthers she with the preferred brand-harme drugs Specially furthers she with the preferred brand-harme drugs Specially furthers she with the preferred brand-harme drugs Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained the statistic of the preferred crail pharmacy) Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a catalytectoric crail pharmacy) Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained to the compounded drugs are limited to 30-day supply and must be obtained to the compounded drugs are limited to 30-day supply and must be obtained to the compounded drugs (compounded drugs are limited to 30-day supply and must be obtained to 10 the state of 10 the state	ACA Preventive drugs	Covered in full	Not covered
Non-preferred generic drugs Preferred brand-harme drugs Non-preferred brand-harme drugs Non-preferred brand-harme drugs Specially furthers she with the preferred brand-harme drugs Specially furthers she with the preferred brand-harme drugs Specially furthers she with the preferred brand-harme drugs Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained the statistic of the preferred crail pharmacy) Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a catalytectoric crail pharmacy) Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained to the compounded drugs are limited to 30-day supply and must be obtained to the compounded drugs are limited to 30-day supply and must be obtained to the compounded drugs (compounded drugs are limited to 30-day supply and must be obtained to 10 the state of 10 the state	Preferred generic drugs	20%	Not covered
Preferred brand-name drugs Specially drugs (specially drugs) are limited to a 30-day supply and must be obtained at an establytic experience of the stability		20%	Not covered
Specialty drugs (specialty arrugs are limited to a 30-day supply and must be obtained through a contracted specialty plarmarcy) Compounded drugs (sempounded drugs are limited to 30-day supply and must be obtained at a realizilyselend relial pharmarcy) Emergency and Urgent Services Emergency services (for mempergency medical conditions only. If admitted to hospital, all services subget to impained benefits) Urgent care services for non-left interesting illness/minor injury) Emergency medical transportation (air and/or ground) Emergency medical transportation (air (TMI) services impetent and/or outpatient services Outpatient Surgery at an Ambulatory Surgical Center (ASC) Outpatient for a post of the provide of the ground of ground (air ground) Emergency medical transportation (air ground) Emergency medical transpor		20%	Not covered
Specialty drugs (specialty arrugs are limited to a 30-day supply and must be obtained through a contracted specialty plarmarcy) Compounded drugs (sempounded drugs are limited to 30-day supply and must be obtained at a realizilyselend relial pharmarcy) Emergency and Urgent Services Emergency services (for mempergency medical conditions only. If admitted to hospital, all services subget to impained benefits) Urgent care services for non-left interesting illness/minor injury) Emergency medical transportation (air and/or ground) Emergency medical transportation (air (TMI) services impetent and/or outpatient services Outpatient Surgery at an Ambulatory Surgical Center (ASC) Outpatient for a post of the provide of the ground of ground (air ground) Emergency medical transportation (air ground) Emergency medical transpor	Non-preferred brand-name drugs	20%	Not covered
through a contracted progress pocally pharmacy? Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a retality referred relate pharmacy?) mergency and Urgent Services Emergency services (for emergency medical conditions only, if admitted to hospital, all services subject to impatite the intentity) Urgent Care services (for non-life threatlering illness/minor injury) Emergency medical transportation (ar ander ground) (Emergency medical transportation (are ander ground) (Emergency medical transportation (are ander ground) (Emergency medical transportation (are ander ground) (Emergency medical transportation) (are ander ground) (Emergency medical transportation (are ander ground) (Emergency medical transportation) (Emergency medical transportation (are ander ground) (Emergency medical transportation) (Emergency medical transportation (are ander ground) (Emergency medical transportation) (Emergency medical transportation) (Emergency medical transportation) (Emergency medical transportation (are ander ground) (Emergency medical transportation) (Emergency medical t		50% up to \$200	Not covered
regrency and Urgent Services Emergency services (for emergency medical conditions only, if admitted to hospital, all services solights to insplaint benefits) - Urgent Care Services (for non-life threatening illness/minor injury) - Emergency medical transportation is covered under your in network benefit, regardless of whether or not let transportation is covered under your in network benefit, regardless of whether or not let transportation care (including your in network benefit, regardless of whether or not let transportation care - Inpatient/Observation care - Inpatient/Observation care - Inpatient/Observation care - Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) - Habilitative care (Limited to 30 days per calendar year) - Habilitative care (Limited to 30 days per calendar year) - Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar years) (so per lifetime) - Outpatient Services - Outpatient Surgery, Infusion, dialysis, chemotherapy, radiation therapy - (Prior authorization required for outpatient hospital-based infusions) - Outpatient Surgery at an Ambulatory Surgical Center (ASC) - Colonoscopy (non-precentive) - Temporomandibular joint (TMJ) services (Inpatient anxibro outpatient services combined wint of \$1,000 per calendar years) - Outpatient in \$1,000 per calendar years (Limited to 30 visits combined with of \$1,000 per calendar years (Limited to 30 visits combined with of \$1,000 per calendar years (Limited to 30 visits combined with of \$1,000 per calendary years (Limited to 30 visits combined with of \$1,000 per calendary years (Limited to 30 visits combined with of \$1,000 per calendary years (Limited to 30 visits per calendary years) - Outpatient habilitative expresses (Limited to 30 visits combined with of \$1,000 per calendary years (Limited to 30 visits per calendary years) - Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per cal	through a contracted specialty pharmacy)	•	
Emergency services for emergency medical conditions only. If admitted to hospital, all services subject to inpaintent benefits.) Urgent care services (for non-life threatening illness/minor injury) Emergency medical transportation (air and/or ground) (firenegency medical transportation is covered under your in-network benefit, regardless of whether of not the provider is an in-network provider) Inpaintent/Observation care Inpaintent/Observation care Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Inpaintent care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Exilied nursing facility (Limited to 60 days per calendar year) Exilied nursing facility (Limited to 60 days per calendar year) Urgatient Services Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Outpatient Fervices Outpatient rehabilitative services: physical therapy (Limited to 30 wists combined with 07 and 31 per calendar year. Limits do not apply to Mental Health Services) Outpatient rehabilitative services: physical derapy (Limited to 30 wists combined with 07 and 31 per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical derapy (Limited to 30 wists combined with 17 per calendar year. Limits do not apply to Mental Health Services.) Prenatal office visits Delivery and postnatal services Prenatal office visits Delivery and postnatal services and postnate office visits, must	 Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a retail/preferred retail pharmacy) 	50%	Not covered
services subject to inpatient benefits.) Urgent Care services (for non-life threatening illness/minor injuny) Erregency medical transportation (air and/or ground) (filmergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider) Inpatient/Observation care Inpatient/Observation Inpatient/Observation care Inpatient/Observation Inpati	Emergency and Urgent Services		
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) dospital Services Inpatient/Observation care Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services) Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services) Skilled nursing facility (Limited to 60 days per calendar year) Skilled nursing facility (Limited to 60 days per calendar year) Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per ratendar year\$5,000 per infetimo) Outpatient Services Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Outpatient in 61,000 per calendar year\$5,000 per lifetimo) Outpatient rehabilitative physical therapy (Limited to 30 vists combined with OT and ST per calendar year\$5,000 per lifetimo) Outpatient rehabilitative calendar year. Limits do not apply to Mental Health Services.) Outpatient method where preventional and speech therapy (Limited to 30 vists combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 vists per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services physical, occupational or speech therapy (Limited to 30 vists per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services Perenatal office visits Outpatient habilitative services physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services physical, occupational per calendar ye	• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%	20%
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) Inpatient/Observation care Inpatient/Observation care Inpatient/Observation care Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services) Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services) Skilled nursing facility (Limited to 60 days per calendar year) Skilled nursing facility (Limited to 60 days per calendar year) Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year) Outpatient Services Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Outpatient rehabilitative physical therapy (Limited to 30 visits combined with 07 and 51 per calendar year) Who Mental Health Services) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits per visits on otappty to Mental Health Services) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per visits on otappty to Mental Health Services) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits port of year of yea		20%	40%
(Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider) Iospital Services Inpatient/Observation care Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Skilled nutrion (Timited to 60 days per calendar year) Temporomandibular joint (TiMl) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Dutpatient Services Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Temporomandibular joint (TiMl) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year. Limit of on otaphy to Mental Health Services Outpatient rehabilitative calendar year. Limits do not apply to Mental Health Services Outpatient rehabilitative calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative physical therapy (Limited to 30 visis combined with Fi per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visis combined with Fi per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visis combined with Fi per calendar year. Limits do not apply to Mental Health Services.) Valeterrity Services Prenatal office visits Delivery and postnatal services described by a down of		20%	20%
Inpatient/Observation care 20% 40% Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) 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)	(Emergency medical transportation is covered under your in-network benefit, regardless of		
Réhabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Skilled nursing facility (Limited to 60 days per calendar year) • Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Dutpatient Services • Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) • Outpatient Surgery at an Ambulatory Surgical Center (ASC) • Colonoscopy (non-preventive) • Colonoscopy (non-preventive) • Outpatient frehabilitative physical therapy (Limited to 30 visits combined limit of \$1,000 per calendar year/\$5,000 per lifetime) • Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and \$1 per calendar year. Limits do not apply to Mental Health Services.) • Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with OT and \$1 per calendar year. Limits do not apply to Mental Health Services.) • Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Outpatient phabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Outpatient phabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Outpatient phabilitative services physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Outpatient provider office visits on the provider office visits and supplies (Such as lancets, test strips and needles) • Prenatal office visits • Delivery and postnatal services • Medical Equipment, Supplies and Devices • M	Hospital Services		
Health Services.) Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services). Skilled nursing facility (Limited to 60 days per calendar year) Skilled nursing facility (Limited to 60 days per calendar year) Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Colonoscopy (non-preventive) Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical therapy (Limited to 30 vists combined with 07 and \$51 per calendar year. Limits do not apply to Mental Health Services) Outpatient rehabilitative occupational and speech therapy (Limited to 30 vists combined with PT per calendar year. Limits do not apply to Mental Health Services) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 vists combined with PT per calendar year. Limits do not apply to Mental Health Services) Prenatal office visits P	 Inpatient/Observation care 	20%	40%
Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.) Skilled nursing facility (Limited to 60 days per calendar year) Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Dutpatient Services Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (one-preventive) Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical therapy (Limited to 30 visits combined with 07 and \$1 per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with 07 and \$1 per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with 07 and \$1 per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits combined with 07 and 51 per calendar year. Limits do not apply to Mental Health Services.) Vaternity Services Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits combined with 07 per calendar year. Limits do not apply to Mental Health Services.) Vaternity Services Prenatal office visits Oew 40% Health And Howe And Andrews Andr		20%	40%
Skilled nursing facility (Limited to 60 days per calendar year) Temporomandibular joint (TIM)) services (onpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient Services Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Colonoscopy (non-preventive) Outpatient rehabilitative physical Herapy (Limited to 30 visits combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical Herapy (Limited to 30 visits combined with OT and \$1 per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative scrucies: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Vaternity Services Prenatal office visits Ouvered in full' 40% Overed in f	• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental	20%	40%
Temporomandibular joint (TMJ) services (inpatient and/or outpatient services combined limit of \$1,000 per calendar year(\$5,000 per lifetime) Outpatient Services Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Temporomandibular joint (TMJ) services (inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Atternity Services Prenatal office visits Oelivery and postnatal services Delivery and postnatal services Notices (20% 40% Politation newborn nursery care Medical Equipment, Supplies and Devices Neddical Equipment, appliances, prosthetics/orthotics and supplies Neddical Equipment, appliances, prosthetics/orthotics and supplies Neddical Health / Chemical Dependency Nental Health	•	20%	40%
Combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and \$5 per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) **Maternity Services** Prenatal office visits Delivery and postnatal services Prenatal effice visits Covered in full* 40% Delivery and postnatal services Prenatal fleatith / Supplies and Devices **Medical Equipment, Supplies and Devices** **Medical Equipment, appliances, prosthetics/orthotics and supplies **Diabetes supplies (such as lancets, test strips and needles) Diabetes supplies (such as lancets, test strips and needles) **Diabetes supplies (such as lancets, test strips and needles) **Diabetes supplies (such as lancets, test strips and needles) **Diabetes supplies (such as lancets, test strips and needles) **Diabetes supplies (such as lancets, test strips and needles) **Diabetes supplies (such as lancets, test strip			
Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions) Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Temporomandibular joint (TIMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Vaternity Services Prenatal office visits Delivery and postnatal services Prenatal office visits Ocovered in full' 40% Delivery and postnatal services Prenatal office visits Delivery and postnatal services Prenatal office visits Delivery and postnatal services Prenatal office visits Ocovered in full' 40% Overed in full'	combined limit of \$1,000 per calendar year/\$5,000 per lifetime)		Not covered
(Prior authorization required for outpatient hospital-based infusions) • Outpatient Surgery at an Ambulatory Surgical Center (ASC) • Colonoscopy (non-preventive) • Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) • Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and \$T per calendar year Limits do not apply to Mental Health Services.) • Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Prenatal office visits • Prenatal office visits • Prenatal office visits • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Prenatal hospital/facility services • Prenatal nospital/facility services • Prenatal office visits • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Delivery and postnatal services • Prenatal office visits • Delivery and postnatal services • Delivery and postnata	·		
 Outpatient Surgery at an Ambulatory Surgical Center (ASC) Colonoscopy (non-preventive) Colonoscopy (non-preventive) Outpatient a pint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Pernatal office visits Covered in full 40% Delivery and postnatal services Routine newborn nursery care Medical Equipment, Supplies and Devices Medical equipment, supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Wental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, lease call 800-711-4377.) Inpatient and residential services Auge call 800-711-4377.) Inpatient and residential se		20%	40%
Colonoscopy (non-preventive) Important (TIMI) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime) Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Prenatal office visits per calendar year. Limits do not apply to Mental Health Services. Prenatal office visits Prenatal office visits Prenatal office visits Inpatient hospital/facility services Prenatal office visits Prenatal office visits on the prenature visits on	(Prior authorization required for outpatient hospital-based infusions)		
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lefterine) • Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and \$T per calendar year. Limits do not apply to Mental Health Services.) • Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Prenatal office visits • Prenatal office visits • Delivery and postnatal services • Routine newborn nursery care • Routine newborn nursery care • Medical Equipment, Supplies and Devices • Medical equipment, supplies and Devices • Medical equipment, appliances, prosthetics/orthotics and supplies • Diabetes supplies (such as lancets, test strips and needles) • Removable custom shoe orthotics (Limited to \$200 per calendar year) Wental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, lease call 800-711-4577.) • Inpatient and residential services • Day treatment, intensive outpatient and partial hospitalization services • Applied behavior analysis • Outpatient provider office visits • Outpatient provider office visits • Home Health and Hospice • Home health care	 Outpatient Surgery at an Ambulatory Surgical Center (ASC) 	20%	40%
combined limit of \$1,000 per calendar year/\$5,000 per lifetime) • Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.) • Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) • Outpatient Services • Prenatal office visits • Prenatal office visits • Delivery and postnatal services • Inpatient hospital/facility services • Routine newborn nursery care • Medical Equipment, Supplies and Devices • Medical equipment, appliances, prosthetics/orthotics and supplies • Diabetes supplies (such as lancets, test strips and needles) • Removable custom shoe orthotics (Limited to \$200 per calendar year) • Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, loace acid Boot, 711-4577.) • Inpatient and residential services • Applied behavior analysis • Outpatient provider office visits • Outpatient provider office visits • Home Health and Hospice • Home health care	 Colonoscopy (non-preventive) 	20%	40%
 Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.) Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Maternity Services Prenatal office visits Delivery and postnatal services Inpatient hospital/facility services Routine newborn nursery care Medical Equipment, Supplies and Devices Medical Equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, lease call 800-711-4577.) Inpatient and residential services Applied behavior analysis Outpatient provider office visits 		50%	Not covered
and ST per calendar year. Limits do not apply to Mental Health Services.) • Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) **Maternity Services** • Prenatal office visits • Delivery and postnatal services • Inpatient hospital/facility services • Routine newborn nursery care **Medical Equipment, Supplies and Devices** • Medical equipment, appliances, prosthetics/orthotics and supplies • Diabetes supplies (such as lancets, test strips and needles) • Removable custom shoe orthotics (Limited to \$200 per calendar year) **Mental Health / Chemical Dependency** All services, except outpatient provider office visits, must be prior authorized. For information, lease call 800-711-4577.) • Inpatient and residential services • Applied behavior analysis • Outpatient provider office visits • Outpatient provider office visits • Outpatient provider office visits • Home health and Hospice • Home health care			
 Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Waternity Services • Prenatal office visits • Delivery and postnatal services • Inpatient hospital/facility services • Routine newborn nursery care • Medical Equipment, Supplies and Devices • Medical equipment, appliances, prosthetics/orthotics and supplies • Diabetes supplies (such as lancets, test strips and needles) • Diabetes supplies (such as lancets, test strips and needles) • Removable custom shoe orthotics (Limited to \$200 per calendar year) Wental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) • Inpatient and residential services • Day treatment, intensive outpatient and partial hospitalization services • Applied behavior analysis • Outpatient provider office visits • Outpatient provider office visits • Outpatient provider office visits • Home Health and Hospice • Home health care 	• Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT	20%	40%
visits combined with PT per calendar year. Limits do not apply to Mental Health Services.) • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) **Maternity Services** • Prenatal office visits • Delivery and postnatal services • Inpatient hospital/facility services • Routine newborn nursery care • Medical Equipment, Supplies and Devices • Medical equipment, appliances, prosthetics/orthotics and supplies • Diabetes supplies (such as lancets, test strips and needles) • Removable custom shoe orthotics (Limited to \$200 per calendar year) **Mental Health / Chemical Dependency** All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) • Inpatient and residential services • Applied behavior analysis • Outpatient provider office visits • Home health and Hospice • Home health care		2001	400/
 Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Maternity Services Prenatal office visits Delivery and postnatal services Inpatient hospital/facility services Routine newborn nursery care Medical Equipment, Supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) Inpatient and residential services Applied behavior analysis Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 		20%	40%
(Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.) Waternity Services Prenatal office visits Prenatal office visits Outpatient hospital/facility services Inpatient hospital/facility services Neutine newborn nursery care Wedical Equipment, Supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Medical equipment, appliances, prosthetics/orthotics and supplies Nemovable custom shoe orthotics (Limited to \$200 per calendar year) Wental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, lease call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care Ocevered in full' 40% 40% 40% 40% 40% 40% 40% 40%		200/	400/
Maternity Services • Prenatal office visits Covered in full ✓ 40% • Delivery and postnatal services 20% 40% • Inpatient hospital/facility services 20% 40% • Routine newborn nursery care 20% 40% Medical Equipment, Supplies and Devices 20% 40% • Medical equipment, appliances, prosthetics/orthotics and supplies 20% 40% • Diabetes supplies (such as lancets, test strips and needles) 20% ✓ 40% • Removable custom shoe orthotics (Limited to \$200 per calendar year) 20% ✓ 40% Mental Health / Chemical Dependency 40% 40% All services, except outpatient provider office visits, must be prior authorized. For information, lease call 800-711-4577.) 40% 40% • Day treatment, intensive outpatient and partial hospitalization services 20% ✓ 40% • Applied behavior analysis 20% ✓ 40% • Outpatient provider office visits 20% ✓ 40% Home Health and Hospice 40% 40% • Home health care 20% ✓ 40%		20%	40%
 Prenatal office visits Delivery and postnatal services Inpatient hospital/facility services Routine newborn nursery care Medical Equipment, Supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, places call 800-711-4577.) Inpatient and residential services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 			
 Delivery and postnatal services Inpatient hospital/facility services Routine newborn nursery care Medical Equipment, Supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 40% 40% 		Covered in full	1094
 Inpatient hospital/facility services Routine newborn nursery care Medical Equipment, Supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, olease call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 40% 40% 			
 Routine newborn nursery care Medical Equipment, Supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care Home health care 			
Medical Equipment, Supplies and Devices Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, blease call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 20% 40%			
 Medical equipment, appliances, prosthetics/orthotics and supplies Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 40% 40% 	, and the state of	20%	40%
 Diabetes supplies (such as lancets, test strips and needles) Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, olease call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 40% 40% 	· · · · · · · · · · · · · · · · · · ·	/	
 Removable custom shoe orthotics (Limited to \$200 per calendar year) Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care 40% 40% 			
Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care A0% 40% 40%			
All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.) Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Outpatient provider office visits Home Health and Hospice Home health care A0% 40% 40%	 Removable custom shoe orthotics (Limited to \$200 per calendar year) 	20%	40%
 Inpatient and residential services Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Home Health and Hospice Home health care 40% 40% 	Mental Health / Chemical Dependency All services, except outpatient provider office visits, must be prior authorized. For information,		
 Day treatment, intensive outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Home Health and Hospice Home health care 20% 40% 40% 40% 		200/	409/
 Applied behavior analysis Outpatient provider office visits Home Health and Hospice Home health care 20% 40% 40% 40% 			
 Outpatient provider office visits Home Health and Hospice Home health care 20% 40% 40% 			
Home Health and Hospice • Home health care 20% 40%			
• Home health care 20% 40%		20%	40%
• Hospice care Covered in full Covered in full			
	Hospice care	Covered in full	Covered in full

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
- \bullet 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

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. 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 process 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.

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 4445-878-800-1 (رقم هاتف الصم والبكم: (TTY: 711).

ATENŢIE: 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).

دی ری ہے. شما ی ہرا گانی را بصورت ی زبان لاتی تسے ،دی کن ی مگفتگ و ی فارس زبان بے اگر : توجہ ف ی م باشد . با (371) 4445 (771) 878-878 نصاس

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

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