# our Benefit Summarv

HSA Qual	ified Plan		Health Plan		
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
<b>20%</b> coinsurance (after deductible)	<b>40%</b> coinsurance (after deductible; UCR applies)	\$6,750 per person \$13,500 per family (2 or more)	\$13,500 per person \$27,000 per family (2 or more)	\$3,000 per person \$6,000 per family (2 or more)	\$6,000 per person \$12,000 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.

- 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.
- 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:		
$\checkmark$ 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			
<ul> <li>Virtual visits to a Primary Care Provider by phone &amp; video (ExpressCare</li> </ul>	Covered in full	Not covered	
Virtual) or by Web-direct Visits (where available)			
<ul> <li>Providence ExpressCare Retail Health Clinic</li> </ul>	Covered in full	Not applicable	
<ul> <li>Virtual visits to a Specialist by phone &amp; video</li> </ul>	5%	Not covered	
Preventive Care			
<ul> <li>Periodic health exams and well-baby care</li> </ul>	Covered in full	40%	
Routine immunizations; shots	Covered in full	40%	
<ul> <li>Colonoscopy (age 50 +)</li> </ul>	Covered in full	40%	
Gynecological exams (calendar year) and Pap tests	Covered in full	40%	
Mammograms	Covered in full	40%	
Nutritional counseling	Covered in full	40%	
<ul> <li>Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	Covered in full	Not covered	
Physician / Provider Services			
Office visits to Primary Care Provider	20%	40%	
<ul> <li>Office visits to Alternative Care Provider (such as Naturopath)</li> </ul>	20%	40%	
(Chiropractic manipulation & acupuncture services are covered only if a separate benefit			
has been purchased by your employer. Consult your member materials for these benefits.)	2004	100/	
Office visits to Specialists/Other Providers	20%	40%	
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%	
Diagnostic Services	2001	4004	
• X-ray, lab services, and testing services (includes ultrasound)	20%	40%	
High-tech imaging services (such as PET, CT or MRI)	20%	40%	

VIDEN

Prescription Drugs (up to a 30-day supplyated) and preferred retail pharmades; bark Harbor drugs are exempt from the deductible, subject to the formulary and applicable tire cost share ACA Preventive drugs A CA Preventive drugs A CA Preventive drugs A CA Preventive drugs A CA Preventive drugs Definition of the second state of the seco	HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Bit Also drives         20%         20%           Self Harbor drives         20%         Not covered           ACA Preventive drugs         20%         Not covered           Non-preferred generic drugs         20%         Not covered           Non-preferred generic drugs         20%         Not covered           Specially drugs opcolly drugs are limited to 30 day supply and must be drained trungs in converted brand-name drugs         50%         Not covered           Compounded drugs compounded drugs are limited to 30 day supply and must be drained at multipreferred trainaly in convertices (on manage and limited) to 30 day supply and must be drained at multipreferred trainaly in convertices (on manage and limited) to 30 day supply and must be drained at multipreferred trainaly in convertices (on manage and limited) to 30 day supply and must be drained at multipreferred trainaly in convertices (on manage and limited) to 30 day supply and must be drained at multipreferred trainaly in convertices (on manage and limited) to 30 days per calendar year.         20%         20%         20%           Compounded drugs compounded drugs are limited to not apply to Mana litem services (on manage and limited) to 30 days per calendar year.         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%	Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies;		
and applicable fer cost share       Covered in full <sup>7</sup> Not covered         ACA Prevented generic drugs       20%       Not covered         Preferred generic drugs       20%       Not covered         Specially drugs (socially drugs companded drugs exclusted to a 30 day supply and must be obtained       50%       Not covered         Compounded drugs (socially drugs companded drugs exclusted to a 30 day supply and must be obtained       50%       Not covered         Compounded drugs (socially drugs exclusted to a 30 day supply and must be obtained       50%       Not covered         Compounded drugs (socially drugs exclusted to a 30 day supply and must be obtained       50%       Not covered         Compounded drugs (socially drugs (socially drugs exclusted to a 30 day supply and must be obtained       20%       20%       20%         Emergency medical transportation (s andor ground)       generation (the transportation (s andor ground)       20%       20%       20%         Virgent Care Services       10 motified to 30 days per calendar year. Limits do not apply to Menial transports       20%       40%         Integration for (the services)       20%       40%       40%         Integration for (the services)       20%       40%       40%         Integration for (the services)       20%       40%       40%       40%       40%       40%       40% </td <td>90-day supply/mail-order and preferred retail pharmacies)</td> <td></td> <td></td>	90-day supply/mail-order and preferred retail pharmacies)		
ACA Preventive drugs     AcA Preventive drugs     Covered in full <sup>®</sup> Not covered     Non-preferred generic drugs     Not covered     Non-preferred generic drugs     Not covered     Non-preferred branch-name drugs     Z0%     Not covered     Non-preferred branch-name drugs     Z0%     Not covered     Non-preferred branch-name drugs     Z0%     Not covered     SopeCally drugs (secuty drugs are limited to 30 day supply and must be obtained     through a corracted specialty parmacy)     Compounded drugs removement of all and any supply and must be     sopeCally drugs (secuty drugs are limited to 30 day supply and must be     othanie at a realignement of that plasmacy)     Compounded drugs removements     SopeCally drug (secuty drugs or gound)     (Emergency arehites for emergency medical transportation (ar andre ground)     (Emergency arehites for anergone) medical transportation (ar andre ground)     (Emergency medical transportation (ar andre ground)     (Emergency andread transportation (ar andre ground)     (Emergency and transportation (ar andre ground)     (Emergency and the provides in a andread year. Limits do not apply to Mental     Inabitient UND services impact andrea or autory services     (Prior authinization required for outpattent thospital-based influsion)     Outpatient Surgery at an Ambulatory Surgical Center (ASC)     Z0%     Z0			
Preferred generic drugs     Non-preferred generic drugs     Non-preferred brand-name drugs     20%     Not covered     Sompounded drugs (sempounded trugs are limited to 30 day supply and must be     datared at articlaphored phorms)     Compounded drugs (sempounded trugs are limited to 30 day supply and must be     datared at articlaphored phorms)     Compounded drugs (sempounded trugs are limited to 30 day supply and must be     datared at articlaphored phorms)     Compounded trugs serveres     Some structs to move the thereating limes/minor limity)     Emergency medical transportation draw are growth     Inspital services     Some structs to move the thereating limes/minor limity)     Emergency medical transportation draw and growth     Emergency medical transportation     Emergency medical transportation     Emergency medical transportraw and transportation     Emergency		(	
Not covered     Sopecially during security during are limited to 30 day supply and must be obtained     through a contracted specially planmacy     Compounded drugs are limited to 30 day supply and must be     obtained at a retalignetimer tetal planmacy     Compounded drugs are limited to 30 day supply and must be     obtained at a retalignetimer tetal planmacy     Compounded drugs are limited to 30 day supply and must be     obtained at a retalignetimer tetal planmacy     Compounded drugs are limited to 30 day supply and must be     obtained at a retalignetimer tetal planmacy     Compounded drugs are limited to 30 day supply and must be     obtained at a retalignetimer tetal planmacy     Compounded drugs are limited to 30 day supply and must be     obtained at a retalignetimer tetal planmacy     Compounded in the provide is an in-extent provide is     Insplicit(Notesvition care     (are retained to 30 day per calendar year. Limits do not apply to Muttal     Hablitative care (limited to 30 days per calendar year. Limits do not apply to Muttal     Hablitative care (limited to 30 days per calendar year.     Inits do not apply to Muttal     Compounded buller (inff)     Selide nursing facility (Limited to 60 days per calendar year)     Outpatient Surgery at an Ambulatory Surgical Center (ASC)     Colonoscopy (non-securite)     Colonation year and year or apply to Muttal     Temporonmantibular (inff)     Selide nursing facility privices (inpatient and/or outpatient sevices     Solide     Convered yearSJ, 200 per literned     Outpatient tetal billitative privices (inpatient and/or outpatient sevices     Solide     Converding year Ambulatory Surgical Center (ASC)     Colonoscopy (non-securite)     Colonation year and apply to Mental sevices     Solide     Convered sevices     S		Covered in full	
Preferred brand-name drugs     Iono-preferred brand-name drugs     Somo-preferred brand-name     Somo-preferred brand-nam     Somo-preferred brand-name     Somo-preferred brand-name     S			
• Non-prefered branchame drugs         20%         Not covered           • Specially drugs (specially drugs are limited to 30-day supply and must be oblighed drugs compared fungs are limited to 30-day supply and must be oblighed drugs (specially drugs the supple drug drugs)         50%         Not covered           Emergency and Urgent Services         50%         20%         20%           Emergency and Urgent Services for on-life metonic provide         20%         20%         20%           Emergency and Urgent Services for on-life metonic provide         20%         20%         20%           Emergency medical transportation (arrandor ground)         20%         20%         40%           Impatient Visition and the static provide)         20%         40%         40%           Impatient Visition are         20%         40%         40%         40%           Impatient Visition are         20%         40%         20%         40%         40% <td></td> <td>20%</td> <td>Not covered</td>		20%	Not covered
Specially drugs (specially drugs are limited to a 30-day supply and must be obtained through a contracted secially drumancy)     Compounded drugs (compounded nugs are limited to 30-day supply and must be obtained at a realizative dred reliable dram dred lightmancy)     Finergency and Urgent Services     inergency services for menagency medical conditions only, if admitted to hospital, at     imergency services for menalizative dred reliable dram dred ground)     Emergency medical transportation (air and/or ground)     them services (or mellic broatening lines/minor injury)     Emergency medical transportation (air and/or ground)     them benefit, regardles of     vertices     inpatient/Observation care     inpatient/Observation     intervation is a start way supply and nust be     inpatient/Observation     intervation is a more start way supply and must be     inpatient is supply and must be     inpatient of the provide the data way and must be     inpatient/Observation care     inpatient/Observation care     inpatient/Observation care     inpatient is supply and must be     inpa			Not covered
titrongia is contracted greating barmary)     50%     Not covered       compounded drugs (componed drugs an initied to 30-day supply and must be obtained at a test/prefered real pharmacy)     50%     Not covered       Emergency and Urgent Services     20%     20%       i (Integrency services for non-file threating intest/minor injury)     20%     40%       i (Integrency medical transportation (ar match ground) (threngency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match ground)     20%     40%       i (Integrency medical transportation (ar match grout		20%	Not covered
entergency and Urgent Services         20%         20%           • Imargency and Urgent Services for energency medical conditions only. If admitted to hospital, all services sliptics in patient endelta transportation (ar and/or ground)         20%         20%           • Urgent Cate Services for non-life threatening illness/minor injury)         20%         20%         20%           • Emergency medical transportation is a covered under your innetwork benefit, regardless of individual to 20 days per calendar year. Limits do not apply to Mental Health Services.)         20%         40%           • Inpatient/Observation care         20%         40%         20%         40%           • Rehabilitations of all days per calendar year. Limits do not apply to Mental Health Services.)         20%         40%         40%           • Silield nutring facility (Limited to 60 days per calendar year.         20%         40%         20%         40%           • Urpatient to 13 (Joug per calendar year.         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%         40%         20%	<ul> <li>Specialty drugs (specialty drugs are limited to a 30-day supply and must be obtained through a contracted specialty pharmacy)</li> </ul>		Not covered
Emergency services for emergency medical conditions only. If admitted to hospital, all services subjects to inpation to methods:     Emergency medical transportation is an and/or ground (thereprice) medical transportation is an and/or ground (thereprice) medical transportation is an and/or ground (thereprice) medical transportation are and/or ground (thereprice) me		50%	Not covered
severies subject to inpatient benefits.)       20%       40%         Urgent care services for non-life threating illnessminor injury)       20%       20%         Hespital Services       20%       20%         Hospital Services       20%       40%         Inpatient/Observation care       20%       40%         Netherber or not the provider is an in-network provider)       20%       40%         Hospital Services       20%       40%         Inpatient/Observation care       20%       40%         Instantion/Observation care       20%       40%         Iskilled nursing facility (limited to 30 days per calendar year)       20%       40%         Outpatient Surgery at na Ambulatory Surgical Centre (ASC)       20%       40%         Outpatient Surgery at na Ambulatory Surgical Centre (ASC)       20%       40%         Outpatient rehabilitative care landar year/S,000 per lifetime)       20%       40%         Outpatient rehabilitative care landar year/S,000 per lifetime)       20%       40%         Outpatient Surgery at an Ambulatory Surgical Centre (ASC)       20%       40%         Outpatient thabilitative care limits do not apply to Mental Health Services.)       20%       40%         Outpatient rehabilitative care limits do not apply to Mental Health Services.)       20%       40%	Emergency and Urgent Services		
Emergency medical transportation (ar and/or groun)     Emergency medical transportation is overed under your in-network benefit, regardless of     whether or not the provider is an in-network provider)  Hospital Services     inpatient/Observation care     ehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental     heath Services)     ehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental     heath Services)     ehabilitative care (Limited to 30 days per calendar year)     ehabilitative care (Limited to 30 days per calendar year)     ehabilitative care (Limited to 30 days per calendar year)     ehabilitative care (Limited to 30 days per calendar year)     eliverses)     eliverses)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     eliverses     enditive care (Limited to 30 days per calendar year)     enditive care (Limited to 30 days per calendar year)     enditive care (Limited to 30 days per calendar year)     enditive care (Limited to 30 days per calendar year)     enditive care (Limited to 30 days per calendar year)     enditive care (Limited to 30 days per calendar		20%	20%
(Emerginery medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)         Hospital Services       20%       40%         Inpatient/Observation care       20%       40%         Inhabilitative Care (Limited to 30 days per calendar year, Limits do not apply to Mental Health Services)       20%       40%         Inhabilitative Care (Limited to 30 days per calendar year)       20%       40%         Skilled nursing facility (Limited to 60 days per calendar year)       20%       40%         Intraining of 1000 per calendar year/S.DooD per lifetime)       20%       40%         Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hespital-based infusions)       20%       40%         Intraorization required for outpatient and/or outpatient services combined intim of 31.000 per calendar year/S.DooD per lifetime)       20%       40%         Outpatient Surgery at an Ambulatory Surgical Center (ASC)       20%       40%       40%         Intraorization required for outpatient and/or outpatient services formating to a to apply to Mental Health Services)       20%       40%         Outpatient rehabilitative physical therapy (Limited to 30 vists combined with OT and Spreceth therapy (Limited to 30 vists combined with OT and Spreceth therapy (Limited to 30 wists combined with PT per calendar year. Limits do not apply to Mental Health Services)       20%       40% <td><ul> <li>Urgent care services (for non-life threatening illness/minor injury)</li> </ul></td> <td>20%</td> <td>40%</td>	<ul> <li>Urgent care services (for non-life threatening illness/minor injury)</li> </ul>	20%	40%
Whether or not the provider is an in-network provider)         Hospital Services       20%       40%         Inpatient/Observation care       20%       40%         Inhabilitative care (limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)       20%       40%         Ishilled nursing facility (limited to 60 days per calendar year)       20%       40%         Itemporomandibular joint (TMI) services (inpatient and/or outpatient services combined limit of 31.000 per calendar year)       20%       40%         Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)       20%       40%         Outpatient surgery, infusion, dialysis, chemotherapy, radiation under outpatient services combined limit of 31.000 per calendar year/5000 per lifetime)       20%       40%         Outpatient rehabilitative physical therapy (limited to 30 visits combined with OT and STpe calendar year. Limits do not apply to Mental Health Services.)       20%       40%         Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits combined with OT aclendar year. Limits do not apply to Mental Health Services.)       20%       40%         Outpatient hospital/facility services       20%       40%       40%         Outpatient weborn nursery care       20%       40%       40%         Outpatient mehabilitative services: physical, occupational o		20%	20%
<ul> <li>Inpatient/Observation care</li> <li>Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Heath Services.)</li> <li>Habilitative Care (Limited to 30 days per calendar year. Limits do not apply to Mental Heath Services.)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>Skilled nursing facility (Limited to 70 days per calendar year)</li> <li>Skilled nursing facility (Limited to 70 days per calendar year)</li> <li>Skilled nursing facility (Limited to 70 days per calendar year)</li> <li>Skilled nursing facility (Limited to 70 days per calendar year)</li> <li>Skilled nursing facility (Limited to 70 days per calendar year)</li> <li>Skilled nursing facility (Limited to 70 days per calendar year)</li> <li>Skilled nursing facility (Limited to 70 days per calendar year)</li> <li>Skilled nursis do natapply to Mental Health Services.)</li> <li>Skilled to 30 days per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Skilled to also sept calendar year. Limits do not apply to Mental Health Services.)</li> <l< td=""><td>whether or not the provider is an in-network provider)</td><td></td><td></td></l<></ul>	whether or not the provider is an in-network provider)		
• 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%           • Skilled nursing facility (Limited to 60 days per calendar year)         20%         40%           • Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)         20%         40%           • Outpatient Surgery at an Ambulatory Surgical Center (ASC)         20%         40%           • Colonoscopy (non-preventive)         20%         40%           • Outpatient rehabilitative physical therapy (Limited to 30 wists combined with OT and ST per calendar year. S5,000 per lifetime)         20%         40%           • Outpatient rehabilitative services: ombined with PT per calendar year. Limits do not apply to Mental Health Services.)         20%         40%           • Outpatient rehabilitative services: on bined office visits         Covered in full <sup>1</sup> 40%           • Outpatient rehabilitative services: on bined with PT per calendar year. Limits do not apply to Mental Health Services.)         20%         40%           • Outpatient habilitative services         20%         40%         40% <td< td=""><td></td><td></td><td></td></td<>			
Habilitative 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)       20%       40%         • Eremporomantibular joint (TML) services (inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)       20%       40%         Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)       20%       40%         • Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)       20%       40%         • Outpatient Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)       20%       40%         • Outpatient Surgery, and Ambulatory Surgical Center (ASC)       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.)       20%       40%         • Outpatient rehabilitative physical, occupational or speech therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)       20%       40%         • Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)       20%       40%			
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)       20%       40%         • Outpatient Services       • Outpatient Services       20%       40%         • Outpatient Surgery at an Ambulatory Surgical Center (ASC)       20%       40%         • Colonoscopy (non-preventive)       20%       40%         • Outpatient rehabilitative physical therapy (Limited to 30 visits combined with Of accelendar year/\$5,000 per lifetime)       20%       40%         • Outpatient rehabilitative coupactional and speech therapy (Limited to 30 visits combined with Of accelendar year. Limits do not apply to Mental Health Services.)       20%       40%         • Outpatient nebabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)       20%       40%         • Prenatal office visits       Covered in full       40%         • Delivery and postnatal services       20%       40%         • Inpatient hospital/facility services       20%       40%         • Delivery and postnatal services, prosthetics/orthotics and supplies       20%       40%         • Delivery and postnatal services, exprosthetics/orthotics and supplies	Health Services.)		
• 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 Surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)       20%       40%         • Outpatient Surgery at an Ambulatory Surgical Center (ASC)       20%       40%         • Colonoscopy (non-preventive)       20%       40%         • Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)       20%       40%         • Outpatient rehabilitative occupational and speech therapy (limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)       20%       40%         • Outpatient habilitative services: physical, occupational on speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)       20%       40%         • Outpatient habilitative services: physical, occupational on speech therapy (20%       40%       40%         • Prenatal office visits       Covered in full       40%         • Delivery and postnatal services       20%       40%         • Diabeters supplies and Devices       20%       40%         • Medical Equipment, supplies and Devices       20%       40%         • Medical Equipment, appliances, pros	Health 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)20%40%Outpatient Surgery at an Ambulatory Surgical Center (ASC)20%40%Colonoscopy (non-preventive)20%40%Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)20%40%Outpatient rehabilitative physical therapy (limited to 30 visits combined with of and \$1 per calendar year. Limits do not apply to Mental Health Services.)20%40%Outpatient rehabilitative occupational and speech therapy (limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)20%40%Outpatient rehabilitative occupational and speech therapy (limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)20%40%Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)20%40%Maternity Services • Prenatal office visits20%40%40%Delivery and postnatal services • Routine newborn nursery care20%40%Medical equipment, appliances, prosthetics/orthotics and supplies • Diabetes Supplies (such as lancets, test strips and needles) • 20%20%40%Metal Health / Chemical Dependency All services, except outpatient and residential services • Removable custom show outpatient and partial hospitalization services <b< td=""><td></td><td></td><td>40%</td></b<>			40%
<ul> <li>Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)</li> <li>Outpatient Surgery at an Ambulatory Surgical Center (ASC)</li> <li>Colonoscopy (non-preventive)</li> <li>Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/55,000 per lifetime)</li> <li>Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient rehabilitative corcupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient nehabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services:</li> <li>Prenatal office visits</li> <li>Prenatal office visits</li> <li>Delivery and postnatal services</li> <li>Postnatal services</li> <li>Outpatient newborn nursery care</li> <li>Medical Equipment, Supplies and Devices</li> <li>Medical Equipment, supplies and Devices</li> <li>Medical Equipment, supplies and needles)</li> <li>Removable custom shoe orthotics (limited to \$200 per calendar year)</li> <li>A0%</li> <li>A0%</li> <li>Mental Health / Chemical Dependency</li> <li>Mental Health services.</li> <li>Co%</li> <li>A0%</li> <li>A0%<td></td><td>50%</td><td>Not covered</td></li></ul>		50%	Not covered
(Prior authorization required for outpatient hospital-based infusions)20%40%• Outpatient Surgery at an Ambulatory Surgical Center (ASC)20%40%• Colonoscopy (non-preventive)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 rehabilitative physical therapy (limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)20%40%• Outpatient rehabilitative occupational and speech therapy (limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)20%40%• Outpatient habilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)20%40%• Prenatal office visitsCovered in full40%• Delivery and postnatal services20%40%• Inpatient hospital/facility services20%40%• Routine newborn nursery care20%40%• Medical equipment, supplies and Devices20%40%• Medical equipment, supplies and needles)20%40%• Removable custom shoe orthotics (limited to \$200 per calendar year)20%40%• Medical equipment, appliances, prosthetics/orthotized. For information, please call 800-711-4577.)20%40%• Inpatient and residential services20%40%• Day treatment, intensive outpatient and partial hospitalization services20%40%• Diaptient and	Outpatient Services		
<ul> <li>Outpatient Surgery at an Ambulatory Surgical Čenter (ASC)</li> <li>Colonoscopy (non-preventive)</li> <li>Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> <li>Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient rehabilitative services: physical, occupational or speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services:</li> <li>Prenatal office visits</li> <li>Prenatal office visits</li> <li>Covered in full<sup>4</sup></li> <li>40%</li> <li>Belivery and postnatal services</li> <li>Routine newborn nursery care</li> <li>Medical Equipment, Supplies and Devices</li> <li>Medical Equipment, appliances, prosthetics/orthotics and supplies</li> <li>Diabetes supplies (such as lancets, test strips and needles)</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>Mental Health / Chemical Dependency</li> <li>All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)</li> <li>Inpatient and residential services</li> <li>Applied behavior analysis</li> <li>Outpatient provider office visits</li> <li>Applied behavior analysis</li> <li>Outpatient provider office visits</li> <li>Applied behavior analysis</li> <li>Outpatient provider office visits</li> <li>Applied beh</li></ul>		20%	40%
<ul> <li>Colonoscopy (non-preventive)</li> <li>Temporomandibular joint (TMJ) services (inpatient and/or outpatient services combined limit of 1,000 per calendar year/5,000 per lifetime)</li> <li>Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient hospital/facility services</li> <li>Prenatal office visits</li> <li>Prenatal office visits</li> <li>Prenatal office visits</li> <li>Routine newborn nursery care</li> <li>Medical Equipment, Supplies and Devices</li> <li>Medical equipment, appliances, prosthetics/orthotics and supplies</li> <li>Diabetes supplies (such as lancets, test strips and needles)</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>Morest exists</li> <li>Cowé 40%</li> <li>Mental Health / Chemical Dependency</li> <li>Maternity ST1-4577.)</li> <li>Inpatient and residential services</li> <li>Day treatment, intensive outpatient and partial hospitalization services</li> <li>Applied behavior analysis</li> <li>Outpatient provider office visits</li> <li>Dutpatient provider office visits</li> <li>Maternity Strips</li> <li>Outpatient and hospitalization services</li> <li>Applied behavior analysis</li> <li>Outpatient provider office visits</li> <li>Home health care</li> <li>20%</li> <li>40%</li> </ul>	<ul> <li>Outpatient Surgery at an Ambulatory Surgical Center (ASC)</li> </ul>	20%	40%
<ul> <li>Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> <li>Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with P per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Maternity Services</li> <li>Prenatal office visits</li> <li>Delivery and postnatal services</li> <li>Routine newborn nursery care</li> <li>Medical equipment, Supplies and Devices</li> <li>Medical equipment, appliances, prosthetics/orthotics and supplies</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>Mental Health / Chemical Dependency</li> <li>(All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)</li> <li>Inpatient and residential services</li> <li>Day treatment, intensive outpatient and partial hospitalization services</li> <li>QO%</li> <li>Ad0%</li> <li>Applied behavior analysis</li> <li>Outpatient and residential services</li> <li>Applied behavior analysis</li> <li>Outpatient and residential services</li> <li>Home health care</li> <li>A0%</li> </ul>			
combined limit of \$1,000 per calendar year/\$5,000 per lifetime)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.)20%40%• Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)20%40%• Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)20%40%• Prenatal office visitsCovered in full"40%• Delivery and postnatal services20%40%• Inpatient hospital/facility services20%40%• Routine newborn nursery care20%40%• Medical Equipment, Supplies and Devices20%40%• Medical equipment, appliances, prosthetics/orthotics and supplies • Diabetes supplies (such as lancets, test strips and needles)20%40%• Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)40%• Inpatient and residential services20%40%• Day treatment, intensive outpatient and partial hospitalization services20%40%• Outpatient provider office visits20%40%• Day treatment, intensive outpatient and partial hospitalization services20%40%• Outpatient provider office visits20%40%• Outpatient provider office visits20%40%			
<ul> <li>Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Maternity Services</li> <li>Prenatal office visits</li> <li>Delivery and postnatal services</li> <li>Inpatient hospital/facility services</li> <li>Medical equipment, appliances, prosthetics/orthotics and supplies</li> <li>Diabetes supplies (such as lancets, test strips and needles)</li> <li>Diabetes supplies (such as lancets, test strips and needles)</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>Auge and the services</li> <li>Diabeters supplies (such as lancets, test strips and needles)</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>Auge and the services</li> <li>Auge a</li></ul>	combined limit of \$1,000 per calendar year/\$5,000 per lifetime)		
<ul> <li>Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> <li>Maternity Services         <ul> <li>Prenatal office visits</li> <li>Delivery and postnatal services</li> <li>Inpatient hospital/facility services</li> <li>Routine newborn nursery care</li> <li>Medical Equipment, Supplies and Devices</li> <li>Medical equipment, appliances, prosthetics/orthotics and supplies</li> <li>Diabetes supplies (such as lancets, test strips and needles)</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> </ul> </li> <li>Mental Health / Chemical Dependency         <ul> <li>Applied behavior analysis</li> <li>Applied behavior analysis</li> <li>Cow</li> <li>Applied behavior analysis</li></ul></li></ul>	• 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 Merital 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 Neutine 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) Medical Health / Chemical Dependency (All services, except outpatient and partial hospitalization services Applied behavior analysis Outpatient provider office visits Medical services Medical services Diabetes supplies (such as lancets, test strips and needles) Diabetes 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 Home health and Hospice Home health care 20% 40%			
(Limits do not apply to Mental Health Services.)Maternity ServicesCovered in full*Prenatal office visits20%Delivery and postnatal services20%Inpatient hospital/facility services20%Routine newborn nursery care20%Medical Equipment, Supplies and Devices20%Medical equipment, appliances, prosthetics/orthotics and supplies20%Diabetes supplies (such as lancets, test strips and needles)20%Removable custom shoe orthotics (limited to \$200 per calendar year)20%Metal Health / Chemical Dependency20%(All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)20%Inpatient and residential services20%Applied behavior analysis20%Outpatient provider office visits20%Applied behavior analysis20%Outpatient provider office visits20%Home Health and Hospice20%Home health care20%Au%	visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)		
<ul> <li>Prenatal office visits</li> <li>Prenatal office visits</li> <li>Delivery and postnatal services</li> <li>Delivery and postnatal services</li> <li>Inpatient hospital/facility services</li> <li>Routine newborn nursery care</li> <li>20%</li> <li>40%</li> </ul>	(Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
Delivery and postnatal services20%40%Inpatient hospital/facility services20%40%Routine newborn nursery care20%40%Medical Equipment, Supplies and Devices20%40%Medical equipment, appliances, prosthetics/orthotics and supplies20%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 (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)20%40%Inpatient and residential services20%40%40%Outpatient provider office visits20%40%40%Outpatient provider office visits20%40%40%Home Health and Hospice • Home health care20%40%40%			
<ul> <li>Inpatient hospital/facility services</li> <li>Routine newborn nursery care</li> <li>20%</li> <li>40%</li> <li>40%</li> <li>20%</li> <li>40%</li> <li>40%</li> <li>20%</li> <li>40%</li> <li>40%</li> <li>20%</li> <li>40%</li> <li>40%</li> <li>40%</li> <li>20%</li> <li>40%</li> <li>40%</li> <li>40%</li> <li>20%</li> <li>40%</li> </ul>			
Routine newborn nursery care20%40%Medical Equipment, Supplies and Devices			
Medical Equipment, Supplies and Devices20%40%• Medical equipment, appliances, prosthetics/orthotics and supplies20%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 (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)20%40%• Inpatient and residential services20%40%• Day treatment, intensive outpatient and partial hospitalization services20%40%• Outpatient provider office visits20%40%• Outpatient provider office visits20%40%• Mome Health and Hospice • Home health care20%40%			
<ul> <li>Medical equipment, appliances, prosthetics/orthotics and supplies</li> <li>Diabetes supplies (such as lancets, test strips and needles)</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>20%</li> <li>40%</li> </ul>		20%	40%
<ul> <li>Medical equipment, appliances, prosthetics/orthotics and supplies</li> <li>Diabetes supplies (such as lancets, test strips and needles)</li> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>20%</li> <li>40%</li> </ul>	Medical Equipment, Supplies and Devices		
• Removable custom shoe orthotics (Limited to \$200 per calendar year)20%40%Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)20%40%• Inpatient and residential services20%40%• Day treatment, intensive outpatient and partial hospitalization services20%40%• Applied behavior analysis • Outpatient provider office visits20%40%• Home Health and Hospice • Home health care20%40%	<ul> <li>Medical equipment, appliances, prosthetics/orthotics and supplies</li> </ul>		40%
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)20%40%• Inpatient and residential services • Day treatment, intensive outpatient and partial hospitalization services • Applied behavior analysis • Outpatient provider office visits20%40%• Outpatient provider office visits20%40%• Mome Health and Hospice • Home health care20%40%	<ul> <li>Diabetes supplies (such as lancets, test strips and needles)</li> </ul>	20%	40%
(All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)20%40%• Inpatient and residential services20%40%• Day treatment, intensive outpatient and partial hospitalization services20%40%• Applied behavior analysis20%40%• Outpatient provider office visits20%40%Home Health and Hospice20%40%• Home health care20%40%	<ul> <li>Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> </ul>	20%	40%
• Inpatient and residential services20%40%• Day treatment, intensive outpatient and partial hospitalization services20%40%• Applied behavior analysis20%40%• Outpatient provider office visits20%40%Home Health and Hospice20%40%• Home health care20%40%	Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information,		
<ul> <li>Day treatment, intensive outpatient and partial hospitalization services</li> <li>Applied behavior analysis</li> <li>Outpatient provider office visits</li> <li>Outpatient provider office visits</li> <li>Constant of the service of th</li></ul>	please call 800-711-4577.)		
• Applied behavior analysis20%40%• Outpatient provider office visits20%40%Home Health and Hospice • Home health care20%40%			
• Outpatient provider office visits20%40%Home Health and Hospice • Home health care20%40%			
Home Health and Hospice20%40%			
Home Health and Hospice20%40%	<ul> <li>Outpatient provider office visits</li> </ul>	20%	40%
• Home health care 20% 40%	Home Health and Hospice		
		20%	40%
	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.

#### 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

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 guestionnaire 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.

PGC-OR 0119 LG HSA SD Oregon - Large Group



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:
  - o 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 <u>https://ocrportal.hhs.gov/ocr/portal/lobby.jsf</u>, 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 <u>http://www.hhs.gov/ocr/office/file/index.html</u>.

# 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).

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

ប្រយ័ក្ខ៖ 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 بگ. شما ی برا گانی را بصورت ی زبان لاتی تسبه ،دی کن یم گفتگ و ی ارس زبان به اگر : توجه فی م باشد . با (TTY: 711) فی م باشد . با (TTY: 711)

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

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