Your Benefit Summary

HSA Plan - Small Group

PROVIDENCE Health Plan

What You Pay In-Plan	What You Pay Out-of-Plan	Calendar Year Combined Medical/Pharmacy Deductible and Out-Of-Pocket Maximum
Covered in full after combined deductible/out-of-pocket maximum	**Covered in full** after combined deductible/out-of-pocket maximum;UCR applies	$5,500 per person $11,000 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for myProvidence at www.providence.org/php/getstarted.

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- The per person deductible and out-of-pocket maximum apply when only the employee is enrolled. The family deductible and out-of-pocket maximum apply when an employee and dependent(s) are enrolled.
- A pre-existing condition exclusion applies to this plan. This exclusion does not apply to members who are under the age of 19. See the back for more information.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

HSA Plan Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Plan (when you use a participating provider)	Out-of-Plan (when you use a non-participating provider)
Physician / Provider Services		
• Office visits	Covered in full	Covered in full
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	Covered in full
• Routine immunizations; shots	Covered in full✓	Covered in full
• Maternity services; pre- and postnatal visits (Subscriber and spouse only)	Covered in full	Covered in full
• Allergy shots; serums; injectable medications	Covered in full	Covered in full
• Inpatient hospital visits	Covered in full	Covered in full
• Surgery; anesthesia	Covered in full	Covered in full
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	Covered in full
• Mammograms	Covered in full✓	Covered in full
Hospital Services		
• Inpatient care	Covered in full	Covered in full
• Observation care	Covered in full	Covered in full
• Maternity care (Subscriber and spouse only)	Covered in full	Covered in full
• Routine newborn nursery care	Covered in full	Covered in full
• Rehabilitative care (30 days per calendar year)	Covered in full	Covered in full
• Skilled nursing facility (60 days per calendar year)	Covered in full	Covered in full
Outpatient Diagnostic Services		
• X-ray; lab services	Covered in full	Covered in full
• Imaging services (such as PET, CT, MRI)	Covered in full	Covered in full
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics, for conditions other than diabetes, are limited to $200 per calendar year)	Covered in full	Covered in full
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only)	Covered in full	Covered in full
• Urgent care services (for non-life threatening illness/minor injury)	Covered in full	Covered in full
• Emergency medical transportation	Covered in full	Covered in full

HSA Plan Benefit Highlights (continued)	In-Plan	Out-of-Plan
Prescription drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
• Generic and brand-name drugs	Covered in full	Not covered
• Compounded drugs	Covered in full	Not covered
Other Covered Services		
• Outpatient rehabilitative services (30 visits per calendar year)	Covered in full	Covered in full
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	Covered in full	Covered in full
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	Covered in full	Not covered
• Home health care (130 visits per calendar year)	Covered in full	Covered in full
• Neurodevelopmental therapy for children aged six and under (30 visits per calendar year)	Covered in full	Covered in full
• Hospice care	Covered in full	Covered in full
• Spinal manipulations (12 visits per calendar year)	Covered in full	Covered in full
• Acupuncture (12 visits per calendar year)	Covered in full	Covered in full
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full ✓	Not covered
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	Covered in full	Not covered
-Formulary brand-name drugs	Covered in full	Not covered
-Non-formulary brand-name drugs	Covered in full	Not covered
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	Covered in full	Covered in full
• Residential services (limited to 60 visits per calendar year)	Covered in full	Covered in full
• Outpatient provider visits	Covered in full	Covered in full

Your guide to the words or phrases used to explain your benefits

Combined medical/pharmacy deductible and out-of-pocket maximum
The maximum amount that an individual or family pays for covered services within a calendar year. The combined deductible and out-of-pocket maximum can be met by using in-plan or out-of plan providers, or the combination of both. The following expenses do not apply to an individual or family combined deductible and out-of-pocket maximum:
- 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 or coinsurance for any supplemental benefits provided by your employer, such as routine vision care

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

In-plan benefit
The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to www.providence.org/php/providerdirectory.

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-plan
Refers to services you receive from a non-participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to www.providence.org/php/providerdirectory.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at www.providence.org/php/providerdirectory.

Pre-existing condition exclusion
A pre-existing condition is any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your enrollment date. Coverage for pre-existing conditions is excluded for a period of six months following your enrollment date. This exclusion period can be reduced by qualifying Creditable Coverage. The pre-existing condition exclusion does not apply to members who are under the age of 19. See your Member Handbook for details.

Prior authorization
Some services must be pre-approved. In-Plan, your provider will request prior authorization. Out-of-Plan, you are responsible for obtaining prior authorization.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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