Your Benefit Summary

HSA Qualified Plan

PROVIDENCE Health Plan

What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
Covered in full (after deductible)	Covered in full (after deductible; UCR applies)	$6,650 per person $13,300 per family (2 or more)	$6,650 per person $13,300 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 $7,350.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- 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

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then you pay the following for covered services: 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	Covered in full	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full	Not applicable
• Virtual visits to a Specialist by phone & video	Covered in full	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	Covered in full
• Routine immunizations; shots	Covered in full✓	Covered in full
• Colonoscopy (age 50 +)	Covered in full✓	Covered in full
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	Covered in full
• Mammograms	Covered in full✓	Covered in full
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	Covered in full	Covered in full
• Office visits to Alternative Care Provider (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	Covered in full	Covered in full
• Office visits to Specialists/Other Providers	Covered in full	Covered in full
• Allergy shots and serums	Covered in full	Covered in full
• Infusions and injectable medications	Covered in full	Covered in full
• Surgery; anesthesia in an office or facility	Covered in full	Covered in full
• Inpatient hospital visits	Covered in full	Covered in full
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share		
• ACA Preventive drugs	Covered in full✓	Not covered
• Preferred generic drugs	Covered in full	Not covered
• Non-preferred generic drugs	Covered in full	Not covered
• Preferred brand-name drugs	Covered in full	Not covered
• Non-preferred brand-name drugs	Covered in full	Not covered
• Specialty drugs (specialty drugs are limited to a 30-day supply and must be obtained through a contracted specialty pharmacy)	Covered in full	Not covered
• Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a retail/preferred retail pharmacy)	Covered in full	Not covered

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Diagnostic Services		
• X-ray; lab services	Covered in full	Covered in full
• High-tech imaging services (such as PET, CT or MRI)	Covered in full	Covered in full
• Sleep studies	Covered in full	Covered in full
Emergency and Urgent Services		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	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 (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)	Covered in full	Covered in full
Hospital Services		
• Inpatient/Observation care	Covered in full	Covered in full
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
• Skilled nursing facility (Limited to 60 days per calendar year)	Covered in full	Covered in full
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	Covered in full	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	Covered in full	Covered in full
• Colonoscopy (non-preventive)	Covered in full	Covered in full
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	Covered in full	Not covered
• Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
• Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
• Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	Covered in full	Covered in full
Maternity Services		
• Prenatal office visits	Covered in full✓	Covered in full
• Delivery and postnatal services	Covered in full	Covered in full
• Inpatient hospital/facility services	Covered in full	Covered in full
• Routine newborn nursery care	Covered in full	Covered in full
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	Covered in full	Covered in full
• Diabetes supplies (such as lancets, test strips and needles)	Covered in full	Covered in full
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year)	Covered in full	Covered in full
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	Covered in full	Covered in full
• Day treatment, intensive outpatient and partial hospitalization services	Covered in full	Covered in full
• Applied behavior analysis	Covered in full	Covered in full
• Outpatient provider office visits	Covered in full	Covered in full
Home Health and Hospice		
• Home health 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.

Common deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. 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

Common out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-network services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

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

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.

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.

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 or preventive services.

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: 711

Have questions about your benefits and want to contact us via email? Go to our website at:
www.ProvidenceHealthPlan.com/contactus