Your Benefit Summary

Connect Plan

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Сорау	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
\$25	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	\$3,500 per person \$7,000 per family (2 or more)	\$7,000 per person \$14,000 per family (2 or more)	\$2,000 per person \$4,000 per family (2 or more)	\$4,000 per person \$8,000 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 myprovidence.com.

- Once you have registered, you can select your medical home online or by calling customer service.
- 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.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Connect network and obtain referrals from your medical home. View a list of in-network providers and pharmacies at **ProvidenceHealthPlan.com/findaprovider**
- If you choose to go outside the Connect network or do not obtain a referral, use providers who have contracted rates with Providence Health Plan. This ensures that you will not be subject to billing for charges that are above contracted rates. When seeing providers who are not contracted with Providence Health Plan, benefits for out-of-network services are based on Usual, Customary and Reasonable charges (UCR).
- Qualified Out-of-Area Dependents who meet eligibility requirements have access to providers in the Providence Signature network.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Connect 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 service	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or 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) 	Covered in full	Not covered	
 Providence ExpressCare Retail Health Clinic Virtual visits to a Specialist by phone & video 	Covered in full' \$35 / visit'	Not applicable Not covered	
Preventive Care			
 Periodic health exams and well-baby care 	Covered in full	40%	
 Routine immunizations; shots 	Covered in full	40%	
 Colonoscopy (age 50+) 	Covered in full	40%	
 Gynecological exam (calendar year) and PAP test 	Covered in full	40%	
Mammograms	Covered in full	40%	
 Nutritional counseling 	Covered in full	40%	
 Tobacco cessation, counseling/classes and deterrent medications 	Covered in full	Not covered	
Physician / Provider Services			
Office visits to Primary Care Provider	\$25 / visit ´	40%	
 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.) 	\$25 / visit	40%	
Office visits to Specialists/Other Providers	\$50 / visit ´	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%	

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Diagnostic Services 20% 40% - K-ray, lab services, and testing services (includes altaxound) 20% 40% - High-tech imaging services (such as PCI, CT or M8) 20% 40% - Emergency and Urgent Services 5250 \$250 - Urgent care services for non-flo thranking illucationing illucationing interaction ground to host host interaction host interaction ground to host host host host host host host h	Connect Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
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Removable custom shoe orthotics (Limited to \$200 per calendar year) 20% 40%			
	 Removable custom shoe orthotics (Limited to \$200 per calendar year) 		
Oral Sleep Apnea Appliance (Out-of-Network limited to \$2,000 per calendar year) 20% 40%	Oral Sleep Apnea Appliance (Out-of-Network limited to \$2,000 per calendar year)	20%	40%
Mental Health / Chemical Dependency			
Services except outpatient provider office visits must be prior authorized.			
Inpatient and residential services 20% 40%		20%	40%
• Day treatment, intensive outpatient and partial hospitalization services 20% 40%		20%	
• Applied behavior analysis 20% 40%			
• Outpatient provider office visits \$25 / visit 40%			

Connect Benefit Highlights (continued)		In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
 Home Health and Hospice Home health care Hospice care 		20% Covered in full ´	40% Covered in full √
Routine Vision Exam			
Provided by VSP			
/SP Choice Network (for Customer Service call 800-877-7195) Your copays do not apply to your plan's medical out-of-pocket m	avimums		
• Pediatric WellVision Exam® (under age 19) - Every 12 months	aximums	Covered in full	Covered up to \$45
Adult WellVision Exam® - Every 12 months		\$10	Covered up to \$45
Your guide to the words or phrases used to explai	n your b	enefits	
 Coinsurance The percentage of the cost that you may need to pay for a covered ervice. Copay The fixed dollar amount you pay to a health care provider for a covered ervice at the time care is provided. What you need to know about drug coverage categories The dollar amount that an individual or family pays for covered services ereor gour plan pays any benefits within a calendar year. The following xpenses 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 shysicians and pharmacists, designed to offer drug treatment choices or covered medical conditions. The Providence Health Plan formulary ncludes both brand-name and generic medications.	Out-of-nee Refers to s Your out-of- services out does not h balance bi Providence Out-of-Po The limit of covered hi do not ap Handbook Primary Ca A qualifiee and, wher convenien Prior auth Some serv request pr obtaining Retail Hea A walk-in pharmacy A Retail Hea A walk-in pharmacy A Retail Hea Current Describes y Out-of-Net UCR amoun Virtual visi Visit with Providence A consulta collect infe	twork services you receive from provid of-pocket costs are generally hig utside of your plan's network. A nave contracted rates with Provi lling may apply. To find an in-me eHealthPlan.com/findaprovider. cket Maximum on the dollar amount you will ha ealth services in a calendar year oly to the out-of-pocket maximus of details. are Provider d physician or practitioner that of n necessary, will coordinate care t and cost-effective manner. orization ices must be pre-approved. In-rr ior authorization. Out-of-netwo prior authorization. Out-of-netwo prior authorization. Out-of-netwo prior authorization. In-rr ior independent clinic that is loc ealth Clinic provides same-day w stomary & Reasonable (UCR) our plan's allowed charges for servi- work provider. When the cost of Ou- nts, you are responsible for paying t t a Network Provider using secure e Express Care phone and video	gher when you receive cover an out-of-network provider dence Health Plan and so etwork provider, go to ave to spend for specified . Some services and expense um. See your Member can provide most of your car e with other providers in a network, your provider will ork, you are responsible for ce, urgent care facility, cated within a retail operatio <i>is</i> its for basic illness and ces that you receive from an ut-of-Network services exceeds he provider any difference. e internet technology such as o visits or Web-direct Visits. ang an online questionnaire to common conditions such as



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 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).

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: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)