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)	\$6,350 per person \$12,700 per family (2 or more)	\$12,700 per person \$25,400 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 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 • Routine immunizations; shots • Colonoscopy (age 50+) • Gynecological exam (calendar year) and PAP test • Mammograms • Nutritional counseling • Tobacco cessation, counseling/classes and deterrent medications	Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full	40% 40% 40% 40% 40% Not covered	
 Physician / Provider Services Office visits to Primary Care Provider Office visits to Alternative Care Provider (such as Naturopath) (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.) Office visits to Specialists/Other Providers Allergy shots and serums Infusions and injectable medications Surgery; anesthesia in an office or facility Inpatient hospital visits 	\$25 / visit \$25 / visit \$50 / visit 20% 20% 20% 20% 20%	40% 40% 40% 40% 40% 40%	

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	 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 VSP Choice Network (for Customer Service call 800-877-7195) Your copays do not apply to your plan's medical out-of-pocket m • Pediatric WellVision Exam® (under age 19) - Every 12 months	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 explain Coinsurance The percentage of the cost that you may need to pay for a covered service. Copay The fixed dollar amount you pay to a health care provider for a covered service 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 sefore your plan pays any benefits within a calendar year. 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 ohysicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary ncludes both brand-name and generic medications. n-Network Refers to services received from an extensive network of highly qualified ohysicians, 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. Jinitations 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. Medical Home A referral Home referral A referral from your Medical Home to receive services from an in-network provider that is not part of you medical home.	Out-of-ne Refers to s Your out-of- services ou does not h balance bi Providence Out-of-Po The limit of covered ha do not app Handbook Primary Ca A qualified and, wher convenien Prior autho Some serv request pr obtaining Retail Hea A walk-in pharmacy A Retail Hei injuries. Usual, Cus Describes y Out-of-Net UCR amoun Virtual visi Visit with Providence A consulta collect info	twork services you receive from provid of-pocket costs are generally hig utside of your plan's network. A nave contracted rates with Provi illing may apply. To find an in-n eHealthPlan.com/findaprovider. cket Maximum on the dollar amount you will ha ealth services in a calendar year ply to the out-of-pocket maxim c for details. are Provider d physician or practitioner that on necessary, will coordinate care it and cost-effective manner. orization vices must be pre-approved. In-re- ior authorization. Out-of-netwo prior authorization. Out-of-netwo prior authorization. Ith Clinic health clinic, other than an offi- or 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 it a Network Provider using secure e Express Care phone and video	gher when you receive covere an out-of-network provider idence Health Plan and so etwork provider, go to ave to spend for specified . Some services and expenses um. See your Member can provide most of your care e with other providers in a network, your provider will ork, you are responsible for ce, urgent care facility, cated within a retail operation visits for basic illness and ces that you receive from an ut-of-Network services exceeds the provider any difference. e internet technology such as o visits or Web-direct Visits. ng an online questionnaire to common conditions such as

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.



Portland Metro Area: **503-574-7500** All other areas: **800-878-4445** TTY: 503-574-8702 or 888-244-6642 Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
 - 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)