

# Your Benefit Summary

## Connect 7150 Bronze



Providence Connect Network	In-Network	Out-of-Network
Individual Calendar Year Deductible (family amount is 2 times individual)	\$7,150	\$28,600
Individual Out-of-Pocket Maximum (family amount is 2 times individual) This amount includes the deductible.	\$7,150	\$28,600

### 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](http://www.myProvidence.com).

- Once you have registered, you can select your medical home online or by calling customer service.
- 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.
- View a list of network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- To get the most out of your benefits, use the providers within the Providence Connect Network and obtain referrals from your medical home.
- If you choose to go outside the Providence 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).
- Limitations and exclusions apply. See your contract for details.

Below is the amount you pay after you have met your calendar year deductible

	In-Network	Out-of-Network
<b>Preventive Care</b>		
Periodic health exams and well-baby care	Covered in full✓	Covered in full
Routine immunizations and shots	Covered in full✓	Covered in full
Colonoscopy (preventive, age 50+)	Covered in full✓	Covered in full
Gynecological exams (1 per 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
<b>Physician/Professional Services</b>		
Office visits to Personal Physician/Provider	\$50✓	Covered in full
Visits to a Personal Physician/Provider by phone or video	Covered in full✓	Not Covered
Office visits to an Alternative Care Provider (Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.)	\$50✓	Covered in full
Office visits to specialists	Covered in full	Covered in full
Visits to a specialist by phone or video	Covered in full	Not Covered
Inpatient hospital visits	Covered in full	Covered in full
Allergy shots, allergy serums, injectable and infused medications	Covered in full	Covered in full
Surgery and anesthesia	Covered in full	Covered in full
<b>Diagnostic Services</b>		
X-ray and 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

## Your Benefit Summary (continued)

		Below is the amount you pay after you have met your calendar year deductible	
		In-Network	Out-of-Network
Emergency and Urgent Services			
Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits.)	Covered in full		Covered in full
Emergency medical transportation (air and/or ground)	Covered in full		
Emergency transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider			
Urgent care visits (for non-life threatening illness/minor injury)	Covered in full		Covered in full
Hospital Services			
Inpatient/Observation care	Covered in full		Covered in full
Skilled nursing facility (limited to 60 days per calendar year)	Covered in full		Covered in full
Inpatient rehabilitative care (limited to 30 days per calendar year; 60 days for head/spinal injuries; limits do not apply to Mental Health Services)	Covered in full		Covered in full
Inpatient habilitative care (limited to 30 days per calendar year; 60 days for head/spinal injuries; limits do not apply to Mental Health Services)	Covered in full		Covered in full
Outpatient Services			
Outpatient surgery at an ambulatory surgery center or a hospital-based facility	Covered in full		Covered in full
Colonoscopy (non-preventive) at an ambulatory surgery center or a hospital-based facility	Covered in full		Covered in full
Outpatient dialysis, infusion, chemotherapy and radiation therapy	Covered in full		Covered in full
Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year; up to 30 additional visits per specified condition; 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; up to 30 additional visits per specified condition; limits do not apply to Mental Health Services)	Covered in full		Covered in full
Maternity Services			
Prenatal visits	Covered in full✓		Covered in full
Delivery and postnatal physician/provider visits			
Certified nurse midwife	Covered in full		Covered in full
Personal Physician/Provider	Covered in full		Covered in full
OB/GYN Physician/Provider	Covered in full		Covered in full
All other licensed maternity providers	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 (lancets, test strips and needles)	50%✓		Covered in full
Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)	Covered in full		Covered in full
Mental Health and Chemical Dependency (To initiate services, call 800-711-4577. All services, except outpatient provider office visits, must be prior authorized.)			
Inpatient and residential services	Covered in full		Covered in full
Day treatment, intensive outpatient, and partial hospitalization services	Covered in full		Covered in full
Outpatient provider visits	\$50✓		Covered in full
Applied Behavior Analysis	Covered in full		Covered in full

## Your Benefit Summary (continued)

Below is the amount you pay after you have met your calendar year deductible

	In-Network	Out-of-Network
<b>Home Health and Hospice</b>		
Home health care	Covered in full	Covered in full
Hospice care	Covered in full✓	Covered in full✓
Respite care (limited to members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime)	Covered in full	Covered in full
<b>Biofeedback</b>		
Biofeedback for specified diagnosis (limited to 10 visits per lifetime)	Covered in full	Covered in full
<b>Chiropractic Manipulation and Acupuncture</b> (Copayments and coinsurance do not apply to your out-of-pocket maximums)		
Chiropractic manipulations and acupuncture (limited to 3 visits combined per calendar year)	\$25✓	50%
<b>Additional Cost Tier for Professional Services (Inpatient or Outpatient)</b> (Additional cost tier does not apply to services related to cancer diagnosis/treatment or tissue injuries resulting from an external force which require immediate repair. Your out-of-network copayments do not apply to your out-of-network out-of-pocket maximum.)		
Knee arthroscopy	Covered in full	\$500
Knee, hip resurfacing	Covered in full	\$500
Knee, hip replacement	Covered in full	\$500
Shoulder arthroscopy	Covered in full	\$500
Sinus Surgery	Covered in full	\$100
Spinal injections for pain	Covered in full	\$100
Spine procedures	Covered in full	\$500
Upper GI endoscopy	Covered in full	\$100

## Prescription Drugs

Below is the amount you pay after you have met your calendar year deductible

<b>Up to a 30-Day Supply</b> (From a participating retail, preferred or specialty pharmacy)	
Preferred generic	\$30✓
Non-preferred generic	\$60✓
Preferred brand name	Covered in full
Non-preferred brand name	Covered in full
Specialty	Covered in full
<b>90-Day Supply</b> (From a participating mail order or preferred retail pharmacy)	
Preferred generic	\$60✓
Non-preferred generic	\$180✓
Preferred brand name	Covered in full
Non-preferred brand name	Covered in full

### Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply as outlined in your handbook of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home. To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- View a list of our participating pharmacies [www.ProvidenceHealthPlan.com/planpharmacies](http://www.ProvidenceHealthPlan.com/planpharmacies).

### Using your prescription drug benefit

- To find if a drug is covered under your plan check online at [www.ProvidenceHealthPlan.com/planpharmacies](http://www.ProvidenceHealthPlan.com/planpharmacies). Note that your plan's formulary includes ACA Preventive drugs which are medications that are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy at 3 times the copay. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% coinsurance after the deductible.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefit limitations, and coinsurance. See your Member Handbook for details.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Handbook for more information.
- Be sure you present your current Providence Health Plan member identification card.

## Routine Vision Services

Provided by VSP

Below is the amount you pay after you have met your calendar year deductible		
VSP Advantage Network (For customer service call 800-877-7195)	In-Network	Out-of-Network
<b>Pediatric Vision Services (under age 19)</b>		
Routine eye exam (limited to 1 exam per calendar year)	Covered in full✓	Covered up to \$47✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full✓	Covered up to \$30✓
Lined bifocal	Covered in full✓	Covered up to \$50✓
Lined trifocal	Covered in full✓	Covered up to \$60✓
Lenticular lenses	Covered in full✓	Covered up to \$75✓
Frames (limited to 1 pair per calendar year; select from VSP's Otis & Piper™ Eyewear Collection)	Covered in full✓	Covered up to \$45✓
Contact lens services and materials in place of glasses	Covered in full✓	Covered up to \$100✓
Standard: 1 pair per calendar year (1 contact lens per eye)		
Monthly: 6 month supply per calendar year (6 lenses per eye)		
Bi-weekly: 3 month supply per calendar year (6 lenses per eye)		
Dailies: 3 month supply per calendar year (90 lenses per eye)		
<b>Adult Vision Services</b>		
(Copayments do not apply to your out-of-pocket maximums)		
Routine eye exam (limited to 1 exam per 1 calendar year)	\$25✓	Covered up to \$47✓

## Pediatric Dental Service (under age 19)

For customer service, including dental prior authorizations and claims, call 800-878-4445

Below is the amount you pay after you have met your calendar year deductible

	In-Network	Out-of-Network
<b>Preventive</b>		
Routine Exams 1 per six months	Covered in full✓	30%✓
Bitewing X-rays 1 set per 12 months	Covered in full✓	30%✓
Cleanings 2 per 12 months	Covered in full✓	30%✓
Topical Fluoride 2 per 12 months	Covered in full✓	30%✓
Fissure sealants Under age 16 for 1 service per tooth (molar) every 36 months	Covered in full✓	30%✓
Space Maintainers 1 per arch every 24 months	Covered in full✓	30%✓
<b>Basic</b>		
Restorative fillings	Covered in full	Covered in full
<b>Major</b>		
Oral surgery (extractions and other minor surgical procedures)	Covered in full	Covered in full
Endodontics and Periodontics	Covered in full	Covered in full
Stainless Steel Crowns/Primary tooth 1 service per tooth in a 7-year month period	Covered in full	Covered in full
Porcelain Crowns – Pre-Authorization Required 1 service per anterior tooth in a 7-year period for children ages 16 and older	Covered in full	Covered in full
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures) Limited to once every 10 years for members ages 16 and older	Covered in full	Covered in full

## Explanation of terms and phrases

**ACA Preventive Drugs** – ACA Preventive drugs are medications, including contraceptives that are listed in our formulary. They are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

**Accidental injury** – An accidental injury means an injury that is due directly to an unintentional act, independent of all other causes.

**Coinsurance** – The percentage of the cost that you may need to pay for covered services.

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

**Deductible** – The dollar amount that an individual or family pays for covered services before the plan pays any benefits within a calendar year. The following expenses do not apply to the individual or family deductible: services not covered by the plan; fees that exceed usual, customary and reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the 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.

**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.

**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.

**Medical Home** – A full service healthcare clinic which has been designated as a Medical Home providing and coordinating members' medical care.

**Medical Home Referral** – A referral from your Medical Home to receive services from an in-network provider that is not part of your medical home.

**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 may or may not have contracted rates with Providence Health Plan. If an out-of-network provider does not have contracted rates with Providence Health Plan, balance billing may apply. To find an in-network provider, go to

[www.ProvidenceHealthPlan.com/providerdirectory](http://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. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook or contract for details.

**Personal Physician/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.

**Preferred brand-name drugs/Non-preferred brand-name drugs** – Brand-name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Preferred brand-name or Non-preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

**Preferred generic drugs/Non-preferred generic drugs** – Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Preferred generic drugs and Non-preferred generic drugs. Generally your lowest out-of-pocket cost will be 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 or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

**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.

**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 differences. These amounts do not apply to your out-of-pocket maximums.

## Contact us

Portland Metro Area: 503-574-7500

All other areas: 800-878-4445

TTY:711

[www.ProvidenceHealthPlan.com/contactus](http://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:
  - 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 <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, 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 Services

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 1-800-878-4445 (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).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់អ្នក។ 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).

1-800-878-4445 (TTY: 711) ت ماس ب گ یرید. شما ب رای رایگان ب صورت زبانی ت سه یلات ک نید، می گ ف تگوف ار سی زبانی ب ه اگ ر ت وجه ف می ب اشد ب ا (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)