| Benefit Highlights (continued) | In-Network Copay or Coinsurance | Out-of-Network Copay or Coinsurance |
|---|---|---|
| **Mental Health / Chemical Dependency** | | |
| **All in-plan chemical dependency services listed below are covered in full.** | | |
| Services except outpatient provider office visits must be prior authorized. | | |
| • Inpatient, residential services | $50 per day, up to $250 per admission | $500 then 30%* |
| • Day treatment, intensive outpatient and partial hospitalization services | $10 / visit✓ | 30% |
| • Applied behavior analysis | $10 / visit✓ | 30% |
| • Outpatient provider visits | $10 / visit✓ | 30% |
| **Hospital Services** | | |
| • Inpatient care | $50 per day, up to $250 per admission | $500 then 40%* |
| • Observation care | $50 per day, up to $250 per admission | $500 then 40%* |
| • Maternity care | $50 per day, up to $250 per admission | $500 then 40%* |
| • Routine newborn nursery care | $50 per day, up to $250 per admission | $500 then 40%* |
| • Rehabilitative care (30 days per calendar year; 60 days head or spinal cord injuries) | $50 per day, up to $250 per admission | $500 then 40%* |
| • Skilled nursing facility (180 days per calendar year) | $50 per day, up to $250 per admission | $500 then 30%* |
| • Bariatric surgery | $50 per day, up to $250 per admission | Not covered |
| **Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices** | | |
| • Durable medical equipment and supplies | 15% | 30% |
| • Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived) | 15% | 30% |
| • Diabetic supplies and insulin | Covered in full✓ | Covered in full✓ |
| **Emergency / Urgent Care / Emergency Medical Transportation** | | |
| (In-network deductible applies) | | |
| • Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.) | $150 / visit* | $150 / visit* |
| • Urgent care visits (for non-life threatening illness/minor injury) | $25 / visit | $25 / visit |
| • Emergency medical transportation | $75 / trip | $75 / trip |
| **Other Covered Services** | | |
| • X-ray; lab services | Covered in full✓ | 30% |
| • Imaging services (such as PET, CT, MRI) (copayments do not apply to services related to cancer diagnosis and treatment) | $100* | $100 then 30%* |
| • Outpatient rehabilitative services (60 visits per calendar year. Limits do not apply to Mental Health or Substance Abuse services) | $10 / visit | 30% |
| • Outpatient surgery | $10 / visit | $100 then 40%* |
| • Outpatient dialysis, infusion, chemotherapy, radiation therapy | $10 / visit | 30% |
| • Cardiac rehabilitation | $10 / visit | 30% |
| • Temporomandibular joint (TMJ) service | See handbook | Not covered |
| • Home health care (up to 180 visits per calendar year) | $10 / visit | 30% |
| • Hospice care | Covered in full✓ | Covered in full✓ |
| • Hearing exam | $10 / visit* | 30%○ |
| • Hearing aids (one per ear every three calendar years; in-plan deductible applies) | 10% | 10% |
| • Sleep studies | $100* | $100 then 30%* |
| • Chiropractic manipulation (Limited to 20 visits per calendar year) | $10 / visit* | 30%○ |
| • Acupuncture (Limited to 12 visits per calendar year) | $10 / visit* | 30%○ |
| • Massage Therapy (Limited to $1,000 per calendar year) | $10 / visit* | 30%○ |
| • Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) | | |
| -Generic drugs | $5✓ | Not covered |
| -Formulary brand-name drugs | $5✓ | Not covered |
| -Non-formulary brand-name drugs | $5✓ | Not covered |

*Copayment does not apply to out-of-pocket maximums.
○Coinsurance does not apply to out-of-pocket maximums.
**Copayment does not apply to out-of-pocket maximums. Not cancer related.

| Benefit Highlights (continued) | In-Network Copay or Coinsurance | Out-of-Network Copay or Coinsurance |
|---|---|---|
| **Additional Cost Tier (Inpatient or Outpatient)**<br>(Additional cost tier does not apply to services related to cancer diagnosis and treatment. These copayments/coinsurance apply to provider services only. Other services are covered at the applicable benefit level stated in this summary.) | | |
| • Bunionectomy | $100* | $100 then 30%* |
| • Hammertoe surgery | $100* | $100 then 30%* |
| • Morton's neuroma | $100* | $100 then 30%* |
| • Spinal injections for pain | $100* | $100 then 30%* |
| • Upper GI endoscopy | $100* | $100 then 30%* |
| • Knee arthroscopy | $500* | $500 then 30%* |
| • Knee, hip replacement | $500* | $500 then 30%* |
| • Knee, hip resurfacing | $500* | $500 then 30%* |
| • Shoulder arthroscopy | $500* | $500 then 30%* |
| • Sinus surgery | $500* | $500 then 30%* |
| • Spine procedures | $500* | $500 then 30%* |
| • Bariatric surgery | $500* | Not covered |
| **Fertility Services**<br>Infertility diagnosis not required. | | |
| • Assistive reproductive technology (All services except prescription drugs. Limited to $25,000 per calendar year) | Covered in full✓ | Covered in full✓ |
| • Artificial insemination (Limited to 6 cycles per lifetime) | Covered in full✓ | Covered in full✓ |

*Copayment does not apply to out-of-pocket maximums.
○Coinsurance does not apply to out-of-pocket maximums.
**Copayment does not apply to out-of-pocket maximums. Not cancer related.

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

**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.

**Deductible**
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. 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

**Deductible carryover**
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

**In-Network**
Refers to services received from an extensive network of highly qualified physicians and health care providers in the Providence Choice Medical Home network, available to you by your plan. Generally, your out-of-pocket cost will be less when you establish a medical home and receive covered services coordinated by your medical home. To find an in-network provider, go to www.ProvidenceHealthPlan.com/pebbmedicalhomes. For details on establishing a medical home go to www.ProvidenceHealthPlan.com/pebb.

**In-Network provider**
A physician or provider of health care services who belongs to the Providence Health Plan in-network provider panel. To find an in-network provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

**Maximum Cost Share**
Maximum Cost Share means the annual limit on cost sharing for Essential Health Benefits as established by the Patient Protection and Affordable Care Act (ACA). Deductibles, copayments and coinsurance paid by the member for Essential Health Benefit covered services received in-network apply to the Maximum Cost Share.

**Medical home provider**
A full service health care clinic within the Providence Choice Network which provides and coordinates members' medical care.

**Out-of-network**
Refers to services received without a referral or from a non-network provider. Your out-of-pocket costs are generally higher when you receive covered services from non-network providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

**Out-of-Network provider**
Any health care professional who does not participate within Providence Health Plan's in-network panel of physicians and providers of health care services.

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

**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.

**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 predefined charges established by your plan 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 coinsurance maximums.

**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, sexual orientation, religion, gender identity, marital status 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, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides 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)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status 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
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: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*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.