

# Your Benefit Summary

## HSA Qualified Plan

Oregon Society of Certified Public Accountants



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
20% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	\$7,000 per person \$14,000 per family (2 or more)	\$14,000 per person \$28,000 per family (2 or more)	\$3,500 per person \$7,000 per family (2 or more)	\$7,000 per person \$14,000 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](http://myprovidence.com).

- Once you have registered, you can select your medical home online or by calling customer service.
- When two or more family members are enrolled, the in-network per person annual limit on cost-sharing is \$9,100.
- The aggregate individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the family deductible amount applies before the plan provides benefits for covered services.
- The aggregate individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the family out-of-pocket maximum amount applies before the plan provides benefits for covered services.
- 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.
- To find if a drug is covered under your plan, check online at [ProvidenceHealthPlan.com/pharmacy](http://ProvidenceHealthPlan.com/pharmacy).
- Not Medicare Part D creditable
- If you or your provider request or prescribe a brand-name drug when a generic is available, regardless of the reason, you will be responsible for the cost difference between the brand-name and generic drug.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Choice network and obtain referrals from your medical home. View a list of in-network providers and pharmacies at [ProvidenceHealthPlan.com/findaprovider](http://ProvidenceHealthPlan.com/findaprovider).
- If you choose to go outside the Choice network 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).
- HSA enrollment and eligibility is not automatic with enrollment in this High Deductible Health Plan (HDHP). See your handbook for more details.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.
- Learn more about covered preventive services rated "A" or "B" by the U.S. Preventive Services Task Force at [ProvidenceHealthPlan.com/PreventiveCare](http://ProvidenceHealthPlan.com/PreventiveCare)

HSA Qualified Plan Benefit Highlights	After you pay your calendar year deductible(s), 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)
✓ No deductible needs to be met prior to receiving this benefit.		
<b>On-Demand Provider Visits</b>		
<ul style="list-style-type: none"> <li>Providence ExpressCare Virtual</li> <li>Providence ExpressCare Retail Health Clinic</li> </ul>	Covered in full Covered in full	Not covered Not applicable
<b>Preventive Care</b>		
<ul style="list-style-type: none"> <li>Periodic health exams and well-baby care</li> <li>Routine immunizations; shots</li> <li>Colonoscopy (Age 45+)</li> <li>Gynecological exam (calendar year) and PAP test</li> <li>Mammograms</li> <li>Nutritional counseling</li> <li>Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	Covered in full✓ Covered in full✓ Covered in full✓ Covered in full✓ Covered in full✓ Covered in full✓ Covered in full✓	50% 50% 50% 50% 50% 50% Not covered

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
<b>Physician / Provider Services</b>		
• Office visits to Primary Care Provider (In-person & Virtually)	20%	50%
• Office visits to Specialists/Other Providers (In-person & Virtually)	20%	50%
• Office visits to an Alternative Care Provider (such as a Naturopath, In-person and Virtually)	20%	50%
• Chiropractic Manipulations (limited to 20 visits per calendar year)	20%	20%
• Acupuncture (limited to 12 visits per calendar year)	20%	20%
• Allergy shots and serums	20%	50%
• Infusions and injectable medications	20%	50%
• Surgery; anesthesia in an office or facility	20%	50%
• Inpatient hospital visits	20%	50%
<b>Diagnostic Services</b>		
• X-ray, lab services, and testing services (includes ultrasound)	20%	50%
• High-tech imaging services (such as PET, CT or MRI)	20%	50%
<b>Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)</b>		
Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share		
Insulin cost share capped at \$80 for a 30-day supply, after deductible is met.		
• ACA Preventive drugs	Covered in full✓	Not covered
• Tier 1	20%	Not covered
• Tier 2	20%	Not covered
• Tier 3	20%	Not covered
• Tier 4	20%	Not covered
• Tier 5	50% up to \$200	Not covered
• Tier 6	50% up to \$200	Not covered
• Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a retail/preferred retail pharmacy)	50%	Not covered
<b>Emergency and Urgent Services</b>		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%	50%
• 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)	20%	20%
<b>Hospital Services</b>		
• Inpatient/Observation care	20%	50%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	50%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	50%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)	50%	Not covered
<b>Outpatient Services</b>		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy, osteopathic manipulation, pain management (multi-disciplinary) program	20%	50%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	50%
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	50%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	50%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)	20%	50%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%	50%
• Cardiac rehabilitation	20%	50%
• Biofeedback for specified diagnosis (limited to 10 visits per lifetime, limits do not apply to Mental Health Services)	20%	50%
• Vision therapy (convergence insufficiency) (Limited to 12 visits per lifetime)	20%	50%

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
<b>Maternity Services</b>		
<ul style="list-style-type: none"> <li>• Prenatal office visits</li> <li>• Delivery and postnatal services</li> <li>• Inpatient hospital/facility services</li> <li>• Routine newborn nursery care</li> </ul>	Covered in full ✓ 20% 20% 20%	50% 50% 50% 50%
<b>Medical Equipment, Supplies and Devices</b>		
<ul style="list-style-type: none"> <li>• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)</li> <li>• Diabetes supplies (Such as lancets, test strips, needles, blood and continuous glucose monitors)</li> <li>• Removable custom shoe orthotics (Limited to \$200 per calendar year)</li> <li>• Oral Sleep Apnea Appliance (Out-of-Network limited to \$2,000 per calendar year)</li> </ul>	20% 20% ✓ 20% 20%	50% 50% 50% 50%
<b>Mental Health / Chemical Dependency</b>		
Services except outpatient provider office visits may require prior authorization.		
<ul style="list-style-type: none"> <li>• Inpatient and residential services</li> <li>• Day treatment, intensive outpatient and partial hospitalization services</li> <li>• Applied behavior analysis</li> <li>• Outpatient provider office visits (In-person and Virtually)</li> </ul>	20% 20% 20% 20%	50% 50% 50% 50%
<b>Home Health and Hospice</b>		
<ul style="list-style-type: none"> <li>• Home health care</li> <li>• Hospice care</li> </ul>	20% Covered in full	50% Covered in full
<b>Routine Vision Exam</b>		
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 maximums		
<ul style="list-style-type: none"> <li>• Pediatric WellVision Exam® (under age 19) - Every 12 months</li> <li>• Adult WellVision Exam® - Every 12 months</li> </ul>	Covered in full ✓ \$10 ✓	Covered up to \$45 ✓ Covered up to \$45 ✓

## 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.

### Compound Drug

Compounded medications are prescriptions that are custom prepared by your pharmacist and must contain at least one FDA-approved drug to be eligible for coverage. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.

### 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 that an individual or family pays for covered services before 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 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 [ProvidenceHealthPlan.org/findaprovider](http://ProvidenceHealthPlan.org/findaprovider).

### 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.

### Office Visits Virtually

Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom.

### 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 [ProvidenceHealthPlan.com/findaprovider](http://ProvidenceHealthPlan.com/findaprovider).

### Out-of-Pocket Maximum

The limit on the dollar amount that an individual or family pays for specified covered services in a calendar year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

### 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.

### Prescription drug tier

The prescription drug tier number correlates to a drug's placement on the formulary. Tier 1 consists of ACA Preventive and other select preventive drugs. Tier 2 consists of mainly generic drugs while Tier 3 and Tier 4 contains both generic and brand-name drugs. Specialty drugs are listed in Tier 5 and Tier 6.

### 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.

### Providence ExpressCare 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.

### Providence ExpressCare Virtual

Services for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments.

### 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.

### 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.

### 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](http://www.ProvidenceHealthPlan.com/contactus)