Your Benefit Summary

HSA Qualified Plan

Intel - Connected Care
HDHP

Providence Health Plan

What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
5% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$2,400 employee $4,800 employee + child(ren) $5,750 family	$1,720 employee $3,450 employee + child(ren) $4,300 family

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.

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-Network and Out-of-Network services accumulate toward your common deductible and common out-of-pocket maximum.
- To find if a drug is covered under your plan, check online at www.providenceoregon.org/intel.
- Prior authorization is required for some services when received outside of the Connected Care network.
- To get the most out of your benefits, use providers within the Connected Care network. View a list of network providers and pharmacies at www.providenceoregon.org/intel.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Intel Pay, Stock and Benefits Handbook for details.

HSA Qualified Plan Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	**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)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full ✓	40%
• Routine immunizations; shots	Covered in full ✓	40%
• Colonoscopy	Covered in full ✓	40%
• Gynecological exams (calendar year) and Pap tests	Covered in full ✓	40%
• Mammograms	Covered in full ✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Physician (PCP)-Including phone & video visits	5%	40%
• Providence ExpressCare Retail Health Clinics	5%	Not applicable
• Office visits to specialist	5%	40%
• Office visits to Alternative Care Provider	5%	40%
• Allergy shots, serums, infusions, and injectable medications	5%	40%
• Inpatient hospital visits	5%	40%
• Surgery; anesthesia	5%	40%
Prescription Drugs (Up to a 34-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
• Preventive drugs (deductible waived)	Covered in full ✓	40%
• Generic and brand-name drugs	5%	40%
• Compounded drugs	5%	40%
• Specialty drugs (Up to a 30-day supply, in-network specialty pharmacies only)	5%	Not covered
Diagnostic Services		
• X-ray; lab services	5%	40%
• High-tech imaging services (such as PET, CT or MRI)	5%	40%
• Sleep studies	5%	40%
Emergency and Urgent Services		
• Emergency services	5%	5%
• Urgent care services (for non-life threatening illness/minor injury)	5%	40%
• Emergency medical transportation (air and/or ground)	5%	5%

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Hospital Services		
• Inpatient/Observation care	5%	40%
• Rehabilitative care	5%	40%
• Skilled nursing facility (in-network no limit; out-of-network limited to 100 days)	5%	40%
• Bariatric surgery	5%	40%
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	5%	40%
• Temporomandibular joint (TMJ) service	5%	40%
• Outpatient rehabilitative services; physical, occupational or speech therapy	5%	40%
• Outpatient rehabilitative services for treatment of developmental delay	5%	40%
• Chiropractic manipulation (limited to 30 visits per calendar year)	5%	40%
• Acupuncture treatment (limited to 30 visits per calendar year)	5%	40%
Maternity Services		
• Prenatal office visits	Covered in full ✓	40%
• Delivery and postnatal services	Covered in full	40%
• Inpatient hospital/facility services	5%	40%
• Routine newborn nursery care	5%	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	5%	40%
• Diabetes supplies (lancets, test strips, needles, insulin and glucose monitors)	Covered in full ✓	40%
• Prosthetic and orthotic devices	5%	40%
Behavioral Health / Chemical Dependency (To initiate services, call 800-878-4445.)		
• Inpatient and residential services	5%	40%
• Partial Hospitalization Services (requires authorization out-of-network)	5%	40%
• Intensive outpatient services (requires authorization if facility is out of network)	5%	40%
• Applied behavioral analysis (no authorization required)	5%	5%
• Transcranial Magnetic Stimulation (requires authorization if provider is out of network)	5%	40%
• Outpatient provider office visits (no authorization required)	5%	40%
Home Health and Hospice		
• Home health care	5%	40%
• Hospice care	Covered in full	40%

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

ACA Preventive drug
Preventive drugs are generic or brand medications included on the formulary, and are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.

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.

Brand-name drug / Preferred brand-name drug
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 Brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Common deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. 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

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

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

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.

Generic drug / Preferred generic drug
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 Generic or Preferred generic drugs. Generally your out-of-pocket costs will be less for Preferred generic drugs.

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.

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.

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.

Preventive drugs
HSA-Qualified health plans typically provide benefits only after the deductible has been met. The Internal Revenue Code governing HSA-Qualified plans provides for qualifying preventive medications, allowing these preventive medications to be exempt from the deductible. The preventive drugs do not include any drug or medications used to treat an existing illness, injury or condition. Preventive drugs are subject to formulary and tier status, as well as pharmacy management programs such as prior authorization, step therapy and/or quantity limits.

Primary Care Physician (PCP)
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.

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 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

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.

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).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ຊືນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).