Your Benefit Summary

HSA Qualified Plan

Formulary F
Pacific Northwest Consulting Engineers Health & Welfare Trust
Plan 15

PROVIDENCE Health Plan

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)	40% coinsurance (after deductible; UCR applies)	$5,500 per person $11,000 per family (2 or more)	$11,000 per person $22,000 per family (2 or more)	$1,500 per person $3,000 per family (2 or more)	$3,000 per person $6,000 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 www.myProvidence.com.

- When two or more family members are enrolled, the in-network per person annual limit on cost-sharing is $8,150.
- 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.
- Not Medicare Part D creditable
- To find if a drug is covered under your plan, check online at www.ProvidenceHealthPlan.com/pharmacy.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at http://phppd.providence.org.
- 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 Member Handbook for details.

HSA Qualified Plan Benefit Highlights	After you pay your calendar year deductible(s), 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)
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	Covered in full	Not applicable
• Virtual visits to a Specialist by phone & video	5%	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Gynecological exam (calendar year) and PAP test	Covered in full✓	40%
• Mammograms	Covered in full✓	40%
• Nutritional counseling	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	20%	40%
• 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.)	20%	40%
• Office visits to Specialists/Other Providers	20%	40%
• Allergy shots and serums	20%	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	20%	40%
• High-tech imaging services (such as PET, CT or MRI)	20%	40%
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share		
• ACA Preventive drugs	Covered in full✓	Not covered
• Preferred generic drugs	20%	Not covered
• Non-preferred generic drugs	20%	Not covered
• Preferred brand-name drugs	20%	Not covered
• Non-preferred brand-name drugs	20%	Not covered
• Specialty drugs (specialty drugs are limited to a 30-day supply and must be obtained through a contracted specialty pharmacy)	50%	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
Emergency and Urgent Services		
• 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%	40%
• 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%
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	40%
• 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 Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	20%	40%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	40%
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	40%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	40%
• 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%	40%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Cardiac rehabilitation	20%	Not covered
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	20%	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)	20%	40%
• Diabetes supplies (such as lancets, test strips and needles)	20%✓	40%
• Removable custom shoe orthotics (Limited to $200 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 (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	40%

• Outpatient provider office visits	20%	40%

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full	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 maximums		
• 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 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 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

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 www.ProvidenceHealthPlan.com/providerdirectory.

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 http://phppd.providence.org.

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

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

Preferred brand-name drug / Non-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. Generally your out-of-pocket costs will be less for preferred brand-name 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. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses.

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.

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.

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.

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.

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

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

Your Benefit Summary

Chiropractic Manipulations and Acupuncture Plus

Pacific Northwest Consulting Engineers Health & Welfare Trust

Copay	Maximum Calendar Year Benefit
$15	$1,500 per member

Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at www.myProvidence.com.

- With this benefit you have access to licensed qualified practitioners, including licensed chiropractors and licensed acupuncturists, for chiropractic manipulations and acupuncture.
- For most plans, your medical plan deductible does not apply to these benefits, and copayment or coinsurance does not apply to your medical plan out-of-pocket maximum.
- For Health Savings Account (HSA) plans, your deductible applies to these benefits. The deductible, copayment, or coinsurance accumulated toward these services do not apply to your plan out-of-pocket maximum and the annual limit on cost sharing.
- Benefits are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your chiropractic and acupuncture benefits

This plan covers chiropractic manipulations and acupuncture when they are:

- Received from a licensed qualified practitioner, including licensed chiropractic physicians or acupuncturists, who is practicing within the scope of his or her license;
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- You do not need a physician's referral to receive these benefits.
- Routine preventive care in the absence of an illness, injury, or disease is not covered.
- A copay is required per provider, per date of service. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- In order to ensure the timely processing of claims, you are encouraged to submit a claim for treatment within 60 days of the date of service. Providence Health Plan will not pay claims received more than 365 days after the date of service; however, exceptions will be made if we receive documentation of your legal incapacitation.
- Submit your itemized claims to:

  Providence Health Plan
  Attn: Claims Department
  P.O. Box 3125
  Portland, OR 97208-3125

Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.

Acupuncture covered services

- Acupuncture

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

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

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.

Maximum calendar year benefit
The total dollar amount of benefits that you can receive, per calendar year.

Out-of-network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to http://phppd.providence.org

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.

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