Your Benefit Summary

HSA Qualified Plan

Intel - Connected Care
HDHP

Providence Health Plan | POWERED BY Collective Health

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)	$2,550 employee $5,050 employee + child(ren) $6,050 family	$1,850 employee $3,650 employee + child(ren) $4,550 family

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at http://join.collectivehealth.com/intel-php .

- 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 http://join.collectivehealth.com/intel-php .
- 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%
• Office visits to Primary Care Provider	5%	40%
• Providence ExpressCare Retail Health Clinics	5%	Not applicable
• Office visits to specialist	5%	40%
• Office visits to Alternative Care Provider	5%	40%
• Virtual visits to Primary Care Provider, Alternative Care Provider, or a Specialist	Covered in full ✓	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		

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
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%
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%
• Virtual outpatient provider visits (no authorization required)	Covered in full✓	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 join.collectivehealth.com/intel-php

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 join.collectivehealth.com/intel-php.

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.

(855) 346-5057

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
http://providencehealthplan.collectivehealth.com