Your Benefit Summary

Intel - Connected Care Primary Care Plus Plan

Providence Health Plan | POWERED BY Collective Health

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$15/$25	5% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$1,500 per person $3,000 per family (2 or more)	$250 per person $500 per family (2 or more)	$250 per person $500 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 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 deductibles accumulate separately and are not combined.
- 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.

Open Option 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 Copay or Coinsurance** (after deductible, when you see an in-network provider)	**Out-of-Network Copay or 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	$10 / visit	40%
Providence ExpressCare Retail Health Clinics	$10 / visit	Not applicable
Office visits to specialist	$25 / visit	40%
Office visits to Alternative Care Provider	5%	40%
Infusions and injectible medications	5%	40%
Allergy shots and serums	Covered in full	40%
Inpatient hospital visits	5%	40%
Surgery; anesthesia	5%	40%
Diagnostic Services		
X-ray; lab services		
- Office visit	$10	40%
- Specialist	$25	40%
- Other	5%	40%
High-tech Imaging services (such as PET, CT, 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%

Open Option Plan Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or 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	$25 / visit	40%
Outpatient rehabilitative services for treatment of developmental delay	5%	40%
Chiropractic manipulation (limited to 30 visits per calendar year)	$25 / visit	40%
Acupuncture treatment (limited to 30 visits per calendar year)	$25 / visit	40%
Maternity Services		
Initial visit to confirm pregnancy $10, deductible waived, then the following:		
Prenatal office visits	Covered in full	40%
Delivery and postnatal services	Covered in full	40%
Inpatient hospital/facility services	Covered in full	40%
Routine newborn nursery care	Covered in full	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)	$10 / visit	40%
Outpatient provider office visits (no authorization required)	5% up to $10	40%
Home Health and Hospice		
Home health care	5%	40%
Hospice care	Covered in full	40%

Prescription Drugs - All Network Pharmacies (for up to a 34 day supply) - Deductible waived

Preventive drugs - Covered in full
Generic - $10
Formulary brand - $20
Non-formulary brand - $35

Prescription Drugs - All Network Pharmacies (for up to a 90 day supply of maintenance drugs) - Deductible waived

Preventive drugs - Covered in full
Generic - $30
Formulary brand - $60
Non-formulary brand - $105

Prescription Drugs - All Mail Order and Preferred Network Pharmacies (for up to a 90 day supply of maintanence prescriptions) - Deductible waived

Preventive drugs - Covered in full
Generic - $25
Formulary brand - $50
Non-formulary brand - $90

Prescription Drugs - All Network Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs) - Deductible waived

Specialty drugs - $20

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.

Deductible
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

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.

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.

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

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

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

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