Your Benefit Summary



Connect

Multnomah Bar Association Connect Platinum Plan

Сорау	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/\$40	20% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	\$5,850 per person \$11,700 per family (2 or more)	\$11,700 per person \$23,400 per family (2 or more)	\$500 per person \$1,000 per family (2 or more)	\$1,000 per person \$2,000 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.

- Once you have registered, you can select your medical home online or by calling customer service.
- The individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- 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.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Connect network. View a list of in-network providers and pharmacies at ProvidenceHealthPlan.com/findaprovider
- If you choose to go outside the Connect 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).
- Qualified Out-of-Area Dependents who meet eligibility requirements have access to providers in the Providence Signature network.
- 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**.

Connect Benefit Highlights

Connect Benefit Highlights	the following for covered services		
✓ No deductible needs to be met prior to receiving this service	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)	
On-Demand Provider Visits			
 Providence ExpressCare Virtual 	Covered in full	Not covered	
 Providence ExpressCare Retail Health Clinic 	Covered in full	Not applicable	
Preventive Care			
 Periodic health exams and well-baby care 	Covered in full	50%	
 Routine immunizations; shots 	Covered in full	50%	
 Colonoscopy (Age 45+) 	Covered in full	50%	
 Gynecological exam (calendar year) and PAP test 	Covered in full	50%	
• Mammograms	Covered in full	50%	
Nutritional counseling	Covered in full	50%	
 Tobacco cessation, counseling/classes and deterrent medications 	Covered in full	Not covered	
Diabetes self management education	Covered in full	Covered in full	

After you pay your calendar year deductible(s) then you pay

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All other licensed maternity providers 20% 50%			
Routine newborn nursery care 20% 50%			

Connect Benefit Highlights (continued)	In-Network Copay or	Out-of-Network Copay or Coinsurance
	Coinsurance	Consurance
Medical Equipment, Supplies and Devices	2221	500/
• Medical equipment, appliances, prosthetics/orthotics and supplies	20%	50%
(Hearing aids limited to 1 per ear every 3 calendar years, in-network deductible waived)	00%	50%
 Diabetes supplies (Such as lancets, test strips, needles, blood and continuous glucose monitors) 	20%	50%
 Removable custom shoe orthotics 	20%	50%
• Oral Sleep Apnea Appliance (Out-of-Network limited to \$2,000 per calendar year)	20%	50%
Mental Health / Substance Use Disorder		
Services except outpatient provider office visits may require prior		
authorization.		
 Inpatient and residential services 	20%	50%
• Day treatment, intensive outpatient and partial hospitalization services	20%	50%
• Applied behavior analysis	20%	50%
• Outpatient provider office visits (In-person) (First 3 in-network virtual and	\$20 / visit	50%
in-person visits: \$5, deductible waived, then copay.)		
 Outpatient provider office visits (Virtually) (First 3 in-network virtual and 	\$10 / visit	50%
in-person visits: \$5, deductible waived, then copay.)		
Home Health and Hospice		
 Home health care 	20%	50%
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

Coinsurance

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

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
- \bullet Copays and coinsurance for services that do not apply to the deductible. 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.

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.

Medical Home

A full service health care clinic which has been designated as a Medical Home providing and coordinating members' medical care.

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.

Out-of-Pocket Maximum

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

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.

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

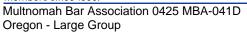
Sevices for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-based platform through a tablet,

smartphone, or computer for same day appointments.

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.

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



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:
 - o 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 <u>http://www.hhs.gov/ocr/office/file/index.html</u>.

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 می کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می شود. با (TTY: 711) TTY-878-878-608 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 नि:शुल्क 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: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອ ດ້ານພາສາ

ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).