WHA INSURANCE

West Slope Water District

Benefits Resource Guide

West Slope Water District

PLAN YEAR | 2024

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WHA INSURANCE

YOUR SERVICE TEAM

BENEFITS

It is our desire to work with you and your personnel to establish direct, efficient communications with our office. We are committed to serving your insurance and risk management needs with excellence.

PRIMARY CONTACTS

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FULL TEAM

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CONTACT

LOCAL OFFICE	TOLL FREE	FAX
(541) 342-4441	(800) 852-6140	(541) 484-5434

Eugene Office – 2930 Chad Drive, Eugene, OR 97408
Wilsonville Office – 29100 SW Town Center Loop, Suite 160, Wilsonville, OR 97070

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Eligibility Information

Who is Eligible and When:
Employees are eligible for benefits as full-time employees or as permanent part-time employees who work 30 hours per week. Benefits begin on the date of hire.

Employer Pays:
West Slope Water District pays 100% of the Medical, Vision and Dental premiums for employees and their qualified dependents and domestic partners. The district also provides employer sponsored Life and AD&D and Long-Term Disability benefits to their employees.

Contact Information

Refer to this list when you need to contact one of your benefit vendors. For general information contact Human Resources.

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Medical Insurance Providence

Your Benefit Summary

Total Enhanced 250 Platinum

Providence Health Plan

Providence Signature Network	In-Network	Out-of-Network
Individual Calendar Year Deductible (family amount is 2 times individual)	$250 Common	
Individual Out-of-Pocket Maximum (family amount is 2 times individual) This amount includes the Deductible.	$3,500 Common	

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and login at myProvidence.com .

- In-Network and Out-of-Network Services accumulate toward your common Deductible and common Out-of-Pocket Maximum.
- Some Services and penalties do not apply to the Out-of-Pocket Maximum.
- Prior Authorization is required for some Services.
- View a list of In-Network Providers and pharmacies at ProvidenceHealthPlan.com/findaprovider.
- To get the most out of your benefits, use the providers within the Providence Signature network.
- 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. See your handbook for details.
- Medicare Part D creditable.
- Find important information about how to use your plan at ProvidenceHealthPlan.com/usingyourplan.
- Learn more about PHP's covered preventive services rated "A" or "B" by the U.S. Preventive Services Task Force at ProvidenceHealthPlan.com/PreventiveCare.

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
On-Demand Visits		
Providence ExpressCare Virtual	Covered in full ✓	Not covered
Providence ExpressCare Retail Health Clinic visits	Covered in full ✓	Not applicable
Preventive Care		
Periodic health exams and well-baby care	Covered in full ✓	30% ✓
Routine immunizations and shots	Covered in full ✓	30% ✓
Colonoscopy (preventive, age 45+)	Covered in full ✓	30%
Gynecological exams (1 per calendar year), breast exams and Pap tests	Covered in full ✓	30%
Mammograms	Covered in full ✓	30%
Nutritional Counseling	Covered in full ✓	30%
Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not covered
Diabetes Self-Management Education	Covered in full ✓	Covered in full ✓
Physician/Professional Services		
Office visits to a Primary Care Provider or Naturopath	First 3 visits $5 ✓ then	30% ✓

Your Benefit Summary

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Physician/Professional Services		
In-Person	$10 ✓	
Virtually	$10 ✓	
Office visits to an Alternative Care Provider (In-Person or Virtually) (Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.)	$10 ✓	30% ✓
Office visits to specialists (In-Person or Virtually)	$25 ✓	30% ✓
Inpatient Hospital visits	10%	30%
Allergy shots and allergy serums, injectable and infused medications	10%	30%
Surgery and anesthesia in an office or facility	10%	30%
Diagnostic Services		
X-ray, lab and testing services (includes ultrasound)	10% ✓	30%
High-tech imaging Services (such as PET, CT or MRI)	10%	30%
Sleep studies	10% ✓	30%
Diagnostic and Supplemental Breast Exams	Covered in full ✓	30%
Emergency Care and Urgent Care Services		
Emergency Services (For Emergency Medical Conditions only. If admitted to the Hospital, all Services subject to inpatient benefits.)	$250 then 10% ✓	$250 then 10% ✓
Emergency medical transportation (air and/or ground) (Emergency transportation is covered under your In-Network benefit, regardless of whether or not the provider is an In-Network Provider.)	10%	10%
Urgent Care visits (for non-life threatening illness/minor injury)	$25 ✓	30% ✓
Hospital Services		
Inpatient/Observation care	10%	30%
Skilled Nursing Facility (limited to 60 days per calendar year)	10%	30%
Inpatient rehabilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health and Substance Use Disorder Services.)	10%	30%
Inpatient habilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health and Substance Use Disorder Services.)	10%	30%
Outpatient Services		
Outpatient surgery at an Ambulatory Surgery Center	5%	30%
Outpatient surgery at a Hospital-based facility	10%	30%
Colonoscopy (non-preventive) at an Ambulatory Surgery Center	5%	30%
Colonoscopy (non-preventive) at a Hospital-based facility	10%	30%
Outpatient dialysis, infusion, chemotherapy and radiation therapy	10%	30%

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Outpatient Services		
Cardiac Rehabilitation (post-surgery)	First 16 visits Covered in full ✓ then 10% after deductible	30%
Outpatient rehabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health and Substance Use Disorder Services.)		
Physical Therapy	10% ✓	30%
Occupational or Speech Therapy	10% ✓	30%
Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health and Substance Use Disorder Services.)	10% ✓	30%
Vision Therapy (convergence insufficiency) (Limited to 12 visits per lifetime)	10%	30%
Maternity Services		
Prenatal visits	Covered in full ✓	30%
Delivery and postnatal physician/provider visits	10%	30%
Inpatient Hospital/facility services	10%	30%
Routine newborn nursery care	10%	30%
Medical Equipment, Supplies and Devices		
Medical equipment, appliances, prosthetics/orthotics and supplies	10%	30%
Diabetes supplies (such as lancets, test strips, needles and glucose monitors)	10% ✓	30%
Hearing aids (Limited to one aid per ear every 3 calendar years)	10%	30%
Removable custom shoe orthotics (Limited to $200 per calendar year)	10% ✓	30% ✓
Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	10%	30%
Mental Health and Substance Use Disorder (Services, except outpatient provider office visits, may require prior authorization.)		
Inpatient and residential services	10%	30%
Day treatment, intensive outpatient, and partial hospitalization services	10%	30%
Outpatient provider visits	First 3 visits $5 ✓ then	30% ✓
In-Person	$10 ✓	
Virtually	$10 ✓	
Applied Behavior Analysis	10%	30%

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Home Health and Hospice		
Home health care	10%	30%
Hospice care	Covered in full ✓	Covered in full ✓
Respite care (limited to Members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime)	10%	30%
Biofeedback		
Biofeedback for specified diagnosis (limited to 10 visits per lifetime)	10%	30%
Chiropractic Manipulation and Acupuncture (Massage therapy not covered)		
Chiropractic manipulations (limited to 20 visits per calendar year)	$25 ✓	50% ✓
Acupuncture (limited to 12 visits per calendar year)	$25 ✓	50% ✓

Prescription Drugs

Formulary P

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible
Up to a 30-Day Supply (From a participating retail, preferred or specialty pharmacy)	
Tier 1	Covered in full ✓
Tier 2	$10 ✓
Tier 3	$25 ✓
Tier 4	30% ✓
Tier 5	50% ✓ with $200 per script cap
Tier 6	50% ✓
90-Day Supply (From a participating preferred retail pharmacy)	
Tier 1	Covered in full ✓
Tier 2	$30 ✓
Tier 3	$75 ✓
Tier 4	30% ✓
90-Day Supply (From a participating mail order pharmacy)	
Tier 1	Covered in full ✓
Tier 2	$20 ✓
Tier 3	$50 ✓
Tier 4	25% ✓

Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a Participating Pharmacy. There are four types of participating pharmacies:

- Retail: a Participating Pharmacy that allows up to a 30-day supply as outlined in your handbook of short-term and maintenance prescriptions.
- Preferred Retail: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home. To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your Member identification number to one of our participating mail-order pharmacies.
- View a list of our participating pharmacies ProvidenceHealthPlan.com/planpharmacies.

Using your prescription drug benefit

Prescription Drugs

Formulary P

- To find if a drug is covered under your plan check online at ProvidenceHealthPlan.com/pharmacy. Note that your plan's formulary includes ACA Preventive drugs which are medications that are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.
- FDA-approved women's contraceptives, as listed on your formulary, are covered at no cost for up to a 12-month supply, after a 3-month initial fill, at any Participating Pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- If you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the Tier 4 or Tier 6 copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Approved non-formulary non-specialty drugs will be covered at the Tier 4 cost sharing tier. Approved non-formulary specialty drugs will be covered at the Tier 6 cost sharing tier.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% after the deductible. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs, which can be found in Tier 5 and Tier 6, are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Diabetes supplies may be obtained at your participating pharmacy, and are covered under your prescription benefit. Refer to your formulary and Member Handbook for details.
- Certain drugs, devices, and supplies obtained from your pharmacy may apply towards your medical benefit.
- Insulin cost share capped at $85 for a 30-day supply, $255 for a 90-day supply. Deductible does not apply.
- Some prescription drugs require Prior Authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Handbook for more information.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
- If you take an eligible specialty medication, the Specialty Pharmacy Variable Copay Program helps lower your out-of-pocket costs to $0. The list of medications eligible for this program is available at ProvidenceHealthPlan.com/smartrxassist. Refer to your handbook for more information.
- Be sure you present your current Providence Health Plan Member identification card.

Routine Vision Services

Provided by VSP

VSP Choice Network (For Customer Service call 800-877-7195) ✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Pediatric Vision Services (under age 19)		
Routine eye exam (limited to 1 exam per calendar year)	Covered in full ✓	Covered up to $45 ✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full ✓	Covered up to $30 ✓
Lined bifocal	Covered in full ✓	Covered up to $50 ✓
Lined trifocal	Covered in full ✓	Covered up to $70 ✓
Lenticular lenses	Covered in full ✓	Covered up to $100 ✓
Frames (limited to 1 pair per calendar year; select from VSP's Otis & Piper ™ Eyewear Collection)	Covered in full ✓	Covered up to $70 ✓
Contact lens services and materials in place of glasses Standard: 1 pair per calendar year (1 contact lens per eye) Monthly: 6 month supply per calendar year (6 lenses per eye) Bi-weekly: 3 month supply per calendar year (6 lenses per eye) Dailies: 3 month supply per calendar year (90 lenses per eye)	Covered in full ✓	Covered up to $105 ✓
Adult Vision Services (Copayments do not apply to your Out-of-Pocket Maximum)		
Routine eye exam (limited to 1 exam per calendar year)	$30 ✓	Covered up to $45 ✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full ✓	Covered up to $30 ✓
Lined bifocal	Covered in full ✓	Covered up to $50 ✓
Lined trifocal	Covered in full ✓	Covered up to $70 ✓
Lenticular lenses	Covered in full ✓	Covered up to $100 ✓
Progressive lenses	$50 ✓	Covered up to $50 ✓
Frames (limited to 1 pair per calendar year)	Covered up to $130 ✓	Covered up to $70 ✓
Contact lens services and materials in place of glasses (limited to every calendar year)	Covered up to $130 ✓	Covered up to $105 ✓

Pediatric Dental Service (under age 19)
Delta Dental Premier Network

For customer service, including dental prior authorizations and claims, call 833-212-5035. ✓ Deductible does not apply	[Below is the amount you pay after you have met your calendar year deductible] In-Network	Out-of-Network
Preventive		
Routine Exams One per 6 months	Covered in full ✓	Covered in full ✓
Bitewing X-rays One set per 12 months	Covered in full ✓	Covered in full ✓
Cleanings One per 6 months	Covered in full ✓	Covered in full ✓
Topical Fluoride One per 6 months	Covered in full ✓	Covered in full ✓
Fissure sealants One service per tooth(molar) every 5 years (Limited to the unrestored occlusal surfaces of permanent molars)	Covered in full ✓	Covered in full ✓
Space Maintainers Once per space	Covered in full ✓	Covered in full ✓
Basic		
Restorative fillings	50%	50%
Endodontics and Periodontics	50%	50%
Major		
Oral surgery (extractions and other minor surgical procedures)	50%	50%
Stainless Steel Crowns Once per lifetime for primary teeth; once per 24 months for permanent teeth	50%	50%
Porcelain Crowns One service per tooth in a 7-year period	50%	50%
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures) Limited to once every 7 years. Dentures not covered for members under age 16. Partial dentures if placed within 2 months of the extraction of an anterior tooth or for missing anterior teeth for members age 16 and under.	50%	50%
Occlusal guard (nightguard) covered up to $200 every five years	50%	50%
Athletic mouthguards Limited to once every 12 months for under age 16 and once every 24 months for ages 16 and over	50%	50%
Orthodontia is covered to treat cleft palate with or without cleft lip	50%	50%

Explanation of terms and phrases

ACA Preventive Drugs - ACA Preventive drugs are medications, including contraceptives, which are listed in our formulary, and are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

Brand-name drugs - Brand-name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them.

Coinsurance - The percentage of the cost that you may need to pay for Covered Service.

Copay - The fixed dollar amount you pay to a healthcare provider for a Covered Service at the time care is provided.

Deductible - The dollar amount that an individual or family pays for Covered Service before the plan pays any benefits within a Calendar Year. The following expenses do not apply to the individual or family deductible: Services not covered by the plan; fees that exceed Usual, Customary and Reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the plan's Prior Authorization requirements; copays and Coinsurance for Services that do not apply to the deductible.

NOTE: No Member will ever pay more than an Individual Deductible before the Plan begins paying for covered services for that Member.

Formulary - A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer effective drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drugs - Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires.

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 Service 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.

Medicare Part D creditable - Coverage is creditable when the plan payout for prescription drugs is, on average for all plan participants, as much as the average payout under the standard Medicare Part D benefit.

Not Medicare Part D creditable - Coverage is non-creditable when the plan payout for prescription drugs is, on average for all plan participants, less than what standard Medicare Part D prescription drug coverage would be expected to pay.

Non-Formulary Medication - An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require a Prior Authorization by the health plan and, if approved, will pay at either the highest non-specialty or specialty cost sharing tier.

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 that an individual or family pays for specified Covered Services in a Calendar Year. Some Services and expenses do not apply to the individual or family Out-of-Pocket Maximum. See your Member handbook or contract for details.

NOTE: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

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.

Prescription drug Prior Authorization - The process used to request an exception to the Providence Health Plan drug formulary. A Prior Authorization can be requested by the prescriber, member or pharmacy. Some drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information at ProvidenceHealthPlan.com.

Explanation of terms and phrases

Maintenance Prescriptions - 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. Compounded and specialty medications are excluded from this definition; and are limited to a 30 day supply.

Maximum Allowable Charge (MAC) - A limitation on the billed charges as determined by Providence Health Plan or its authorizing agent by geographic area where the expenses are incurred and may not be less than the negotiated fee for the same Service when provided by a Network Dental Provider.
MAC charges do not include sales taxes, handling fees and similar surcharges, and such taxes, fees and surcharges are not covered expenses.

Medicare Part D creditable

Prescription drug Tier - The prescription drug tier number correlates to a drug's placement on the formulary. Tier 1 and Tier 2 consists of mainly generic drugs while Tier 3 and Tier 4 contains both generic and brand-name drugs. Specialty drugs are listed in Tier 5 and Tier 6.

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 Virtual - Services for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-bases platform through a tablet, smartphone, or computer for same day appointments.

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 or preventive services.

Explanation of terms and phrases

Specialty Drugs - Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Your benefits include specialty drugs listed on our formulary in Tier 5 and Tier 6. Generally your out-of-pocket costs will be less for Tier 5 drugs.

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 differences. These amounts do not apply to your Out-of-Pocket Maximums.

Contact us

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY:711

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:

- Provide 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)
- Provide 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 or 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
E-mail: 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.

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Dental Insurance
SDIS (Delta Dental)

DELTA DENTAL

Delta Dental of Oregon & Alaska

Special Districts Insurance Services (SDIS)

Plan 1 - Constant Dental Plan

Calendar year costs	
Calendar year maximum, per member (age 19+)	$1,500
Calendar year deductible, per member	$25
Calendar year maximum deductible, per family	$75
Calendar year out-of-pocket maximum, one member (under age 19)	$400
Calendar year out-of-pocket maximum, two or more members (under age 19)	$800
Class 1* (Services do not apply to the calendar year max)	
Exam and prophylaxis/cleanings (twice per year)	100%
Bitewing X-rays (once per year)	
Topical application of fluoride (under age 19)	
Sealants	
Space maintainers (ages under 14)	
Class 2	
Fillings	80%
Oral surgery (extractions & certain minor surgical procedures)	
Endodontics (treatment of teeth with diseased or damaged nerves)	
Periodontics (treatment of diseases of the gums and supporting structures of the teeth)	
Class 3	
Implants	50%
Crowns and other cast restorations	
Dentures and bridges (construction or repair of fixed bridges, partial, and complete dentures)	

* Deductible waived for preventive services

This is a benefit summary only. For a more detailed description of benefits, refer to your member handbook.

How to use this dental plan

When you visit your dental provider, tell them you are a Delta Dental member.

When the member visits:

Delta Dental Premier Dentist:

Members are held harmless from balance billing (will not be billed for the difference between the dentist's billed charge and the Delta Dental negotiated fee).

Non Participating Dentists:

Members may be held liable for the difference between the dentist's billed charge and the non-participating allowable.

Advantages

- **Freedom to choose your dentist** With more than 2,400 contracted Delta Dental providers in Oregon and over 157,000 Delta Dental Premier Dentists nationwide, you have the freedom to choose the dentist that's best for you.
- **Professional Arrangements** Delta Dental of Oregon has specific negotiated fees with our participating dentists to ensure that actual charges made by the dentist do not exceed his or her accepted or contracted fees on file. We believe that the underlying unique feature inherent to all Delta Dental programs is every participating dentist
- **Member Dashboard** Through our online service, you can download your member handbook, view claims status and payment information, search for participating providers, order ID cards, view personal information, and email dental customer service. You can access the Member Dashboard at **DeltaDentalOR.com**

Dependent Eligibility

- Dependents are lawful spouse, state registered domestic partners and eligible children to age 26, including children an employee is required to enroll due to a court or administrative order.

Limitations

If a more expensive treatment than is functionally adequate is performed, Delta Dental Plan of Oregon will pay the applicable percentage of the maximum plan allowance for the least costly treatment.

Preventive (Class 1 services)

- **Diagnostic** Routine or comprehensive examinations or consultations covered twice per calendar year. Supplementary bitewing x-rays are covered once in any 12-month period. Complete series x-rays or a panoramic film are covered once in any 5-year period.
- **Preventive** Prophylaxis (cleaning) or periodontal maintenance is covered twice per calendar year. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional periodontal maintenances per year. Topical application of fluoride is covered twice per calendar year for members age 18 and under. For members age 19 and older, topical application of fluoride is covered once twice per calendar year if there is a recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent molars. Benefits will be limited to one sealant, per tooth, during any 5-year period.

Basic (Class 2 services)

- **Oral Surgery** Limited to extractions and other minor surgical procedures.
- **Restorative** Amalgam and composite fillings are covered for all teeth. A separate charge for general anesthesia and/or IV sedation is not covered when used for non-surgical procedures.
- **Periodontic** Scaling and root planing is limited to once per quadrant in any 2-year period.

Major (Class 3 services)

- **Implants** and implant removal are limited to once per lifetime per tooth space. A crown over an implant is covered once per lifetime of the implant.
- **Restorative** Cast restorations (including pontics) are covered once in a 5-year period on any tooth.
- **Prosthodontic** A bridge or denture (full or partial, including alternate benefits) will be covered once in a 5-year period only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 5 years. Specialized or personalized prosthetics are limited to the cost of standard devices.
- **Occlusal Guard** (night guard) covered at 100% once in a 2-year period, up to $200 maximum. Over-the-counter night guards are excluded.
- **Athletic mouthguard** covered at 50%, once in any 1-year period for members age 15 and under and once in any 2-year period for age 16 and over. Over-the-counter athletic mouth guards are excluded.

Exclusions

- Services covered under worker's compensation or employer's liability laws and services covered by any federal, state, county, municipality or other governmental agency, except Medicaid.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or cosmetic reasons; including, but not limited to cleft palate, upper and lower jaw malformations, enamel hypoplasia (lack of development), fluorosis and disturbance of the temporomandibular joint.
- Services for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth except for occlusal guards.
- Services started prior to the date the individual became eligible for services under the program.
- Hypnosis, prescribed drugs, premedications or analgesia (e.g. nitrous oxide) or any other euphoric drugs.
- Hospital costs or any additional fees charged by the dentist because the patient is hospitalized.
- General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office.
- Plaque control and oral hygiene or dietary instructions.
- Experimental procedures.
- Missed or broken appointments.
- Precision attachments.
- Orthodontic services (except when an orthodontia rider is included).
- Services for cosmetic reasons.
- Claims submitted more than 12 months after the date of service are not covered.
- All other services or supplies, not specifically covered.

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Life & AD&D Insurance Lincoln Financial Group

ELIGIBLE CLASS

Class **1** All Full-Time Employees

The amount of an Insured Person's insurance is determined from the following table. The initial amount of coverage is the amount which applies to an Insured Person's Class on the date his or her coverage takes effect. An Insured Person may become eligible for increases in the amount of insurance in accord with the table. Any such increase will take effect on the latest of:

(1) the first day of the Insurance Month coinciding with or next following the date on which the Insured Person becomes eligible for the increase; if Actively at Work on that day;
(2) the day the Insured Person resumes Active Work, if not Actively at Work on the day the increase would otherwise take effect; or
(3) the day any required evidence of insurability is approved by the Company.

Any decrease will take effect on the day of the change; whether or not the Insured Person is Actively at Work.

The amount of an Insured Person's Life Insurance shall be reduced by the amount of any Life Insurance in effect as a result of exercising the rights under the Conversion Privilege section of this Policy.

The following chart applies to the Extension of Death Benefit provision when benefits end upon attainment of the Social Security Normal Retirement Age:

Year of Birth	Normal Retirement Age
1937 and prior	65
1938	65 and 2 months
1939	65 and 4 months
1940	65 and 6 months
1941	65 and 8 months
1942	65 and 10 months
1943 - 54	66
1955	66 and 2 months
1956	66 and 4 months
1957	66 and 6 months
1958	66 and 8 months
1959	66 and 10 months
1960 and later	67

Note: Persons born on January 1 of any year should refer to the Normal Retirement Age for the previous year.

West Slope Water District
000940162445
SCHEDULE OF INSURANCE
For
Class 1 - All Full-Time Employees

MINIMUM HOURS: 30 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
None

CONTRIBUTIONS: Insured Persons are not required to make contributions for Personal Life & AD&D Insurance and Dependent Life Insurance.

Basic Annual Earnings means the Insured Person's annual base salary or annualized hourly pay from the Group Policyholder before taxes on the Determination Date. The **"Determination Date"** is the last day worked just prior to the loss.
It also includes:

1. paid commissions averaged over the 12 months just prior to the Determination Date; or over the actual period of employment with the Group Policyholder just prior to that date, if shorter.

It does **not** include bonuses, overtime pay, or any other extra compensation. It does **not** include income from a source other than the Group Policyholder. It will not exceed the amount shown in the Group Policyholder's financial records or the amount for which premium has been paid; whichever is less.

LIFE AND AD&D INSURANCE

	Benefit Amount
Personal Life Insurance	One and one-half times Basic Annual Earnings, rounded to the next higher $1,000; subject to a maximum of $170,000.
AD&D Insurance Principal Sum	One and one-half times Basic Annual Earnings, rounded to the next higher $1,000; subject to a maximum of $170,000.

Personal Life and AD&D Insurance will be reduced as follows:
- At age 65, benefits will reduce by 35% of the original amount;
- At age 70, benefits will reduce an additional 25% of the original amount;
- At age 75, benefits will reduce an additional 15% of the original amount.

Benefits will terminate when the Insured Person retires.

If the Insured Person first enrolls for Personal Life and AD&D Insurance at age 65 or older, the above age reductions will apply to:
- Any Guarantee Issue Amount available without evidence of insurability; and
- The maximum amount of insurance for which he or she is eligible.

Evidence of Insurability must be submitted to and approved by the Company when:

1. Personal Life and AD&D Insurance amounts exceed the guarantee issue amount of $115,000 at initial enrollment;
2. the amount of Personal Life and AD&D Insurance in excess of the guarantee issue amount, increases after the initial enrollment by more than $25,000 due to salary or benefit increases over a 12-month period based on the month of the policy anniversary;
3. an increased amount of Personal Life and AD&D Insurance coverage is requested and any am?unt of coverage has been previously withdrawn or declined or is pending underwriting review; or
4. initial coverage is elected more than 31 days after first becoming eligible.

Refer to the Evidence of Insurability section for any additional requirements.

If any evidence of insurability is required, it will be provided at the Person's own expense.

West Slope Water District
000940162445
SCHEDULE OF INSURANCE
For
Class 1
LIFE AND AD&D INSURANCE (CONTINUED)

DEPENDENTS INSURANCE

Dependent Life Insurance	Benefit Amount
Spouse	$5,000
Dependent Child (age 14 days to 6 months)	$1,000
Dependent Child (age 6 months to 19 years, 23 years if a full-time student)	$2,000

Spouse Life Insurance will terminate when the Spouse attains age 70

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Long Term Disability Insurance
Lincoln Financial Group

West Slope Water District
000940162446
SCHEDULE OF BENEFITS
For
Class 1 - All Full-Time Employees

MINIMUM HOURS: 30 hours per week

WAITING PERIOD: (For date insurance begins, refer to "Effective Date" section)
None

CONTRIBUTIONS: Insured employees are not required to contribute to the cost of the Long-Term Disability coverage.

LONG-TERM DISABILITY BENEFITS

BENEFIT PERCENTAGE: 66 2/3%

MAXIMUM MONTHLY BENEFIT: $5,000

MINIMUM MONTHLY BENEFIT: $100 or 10% of the Insured Employee's Monthly Benefit, whichever is greater

Long-Term Disability Benefits for PRE-EXISTING CONDITIONS will be subject to the Pre-Existing Condition Exclusion on the Exclusion page.

The Maximum Monthly Benefit will not exceed the Benefit Percentage times Basic Monthly Earnings.

ELIMINATION PERIOD: 90 calendar days of Disability caused by the same or a related Sickness or Injury, which must be accumulated within a 180 calendar day period.

MAXIMUM BENEFIT PERIOD: (For Sickness, Injury or Pre-Existing Conditions): The Insured Employee's Social Security Normal Retirement Age, or the Maximum Benefit Period shown below (whichever is later).

Age at Disability	Maximum Benefit Period
Less than Age 60	To Age 65
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

REGULAR OCCUPATION PERIOD means a period beginning at the end of the Elimination Period and ending 36 months later for Insured Employees.

Employee Assistance Program Providence

Providence Health Plan

Providence Employee Assistance Program (EAP) Benefit Overview — for Providence Health Plan members covered by a small group employer plan

Your guide to confidential employee assistance

The Providence Employee Assistance Program (EAP) makes it easy for you to get the help you need to deal with life's challenges. Your employer offers the EAP benefit as a confidential, easy-to-use resource that focuses on your well-being. Professional assistance is available free of charge, 24 hours a day, 365 days a year. The EAP is available to **ALL employees** and their dependents, *regardless of enrollment in medical benefits.*

Here's how to access the following services:

1. Call **1-800-255-5255** and provide the code: PHPSMG
2. Let our intake specialist know which resources you want to access. You can make an appointment with a counselor or ask to have a counselor call you to discuss your concerns.
3. The EAP counselor will assist in evaluating the problem, provide short-term counseling and, as needed, offer referrals for any professional help which is beyond the scope of the EAP.

At your first session, you should be prepared to give the counselor some background information to assist in formulating an action plan. Many people find it helpful to prepare a list of things they wish to discuss at each session.

Face-to-face counseling services and assessments

Need to discuss confidential personal issues? Schedule up to three sessions per issue to address a variety of your concerns. Providence EAP counselors are experienced in helping individuals, couples and families work through everyday challenges. Get help with:

- Personal and work pressures
- Relationship conflicts
- Career changes
- Stress
- Parenting
- Alcohol and drug problems
- Life crises related to death, divorce, illness and other major events

Telephonic services

Your life is busy and in-person counseling sessions don't always meet your needs. That's why we now offer telephonic counseling sessions. This works well for participants who are uncomfortable meeting with an EAP provider face-to-face, or for those with limitations which make in-person counseling inconvenient.

Legal and financial services

As a Providence EAP member, you can receive a free 30-minute consultation with an attorney in your area. Once you've completed your initial consultation, you can receive a 25 percent discount off the attorney's normal rate, should you wish to retain his or her services.

Need financial guidance? As a Providence EAP member, you're eligible for a free phone consultation. Typical matters include credit counseling, debt and budgeting assistance and tax planning. Local referrals are available for more complex financial planning issues. **Please note:** You are responsible for any costs incurred since this is not a covered EAP benefit.

Elder and child care consultation and referral services

Information and referrals are available for a broad range of elder and child care services. Via the web or phone request you can access: exhaustive searches, customized matches, referrals (minimum of three) verified every time, and detailed profiles. Referrals and education packets are emailed within 12 business hours or mailed within 24 hours of request; emergency referrals and education packets are emailed within six business hours or mailed overnight.

Work/Life Resources on the web

Our comprehensive website (also available in Spanish) provides you with interactive tools, calculators and current information about wellness, education, eldercare, and everyday life issues. Each month, the website's main pages are updated with feature articles that follow a topical theme. New articles and resource links are added every month. Go to **ProvidenceHealthPlan.com/EAP** and click on the Work/Life Resources link.

Privacy is a priority

Providence EAP upholds strict confidentiality standards. Your personal information is kept confidential in accordance with federal and state laws. No one will be provided any information about you without your written consent.

Learn more

Visit us on the web at **ProvidenceHealthPlan.com/EAP** or call **1-800-255-5255** and provide the code: PHPSMG

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Providence Extras

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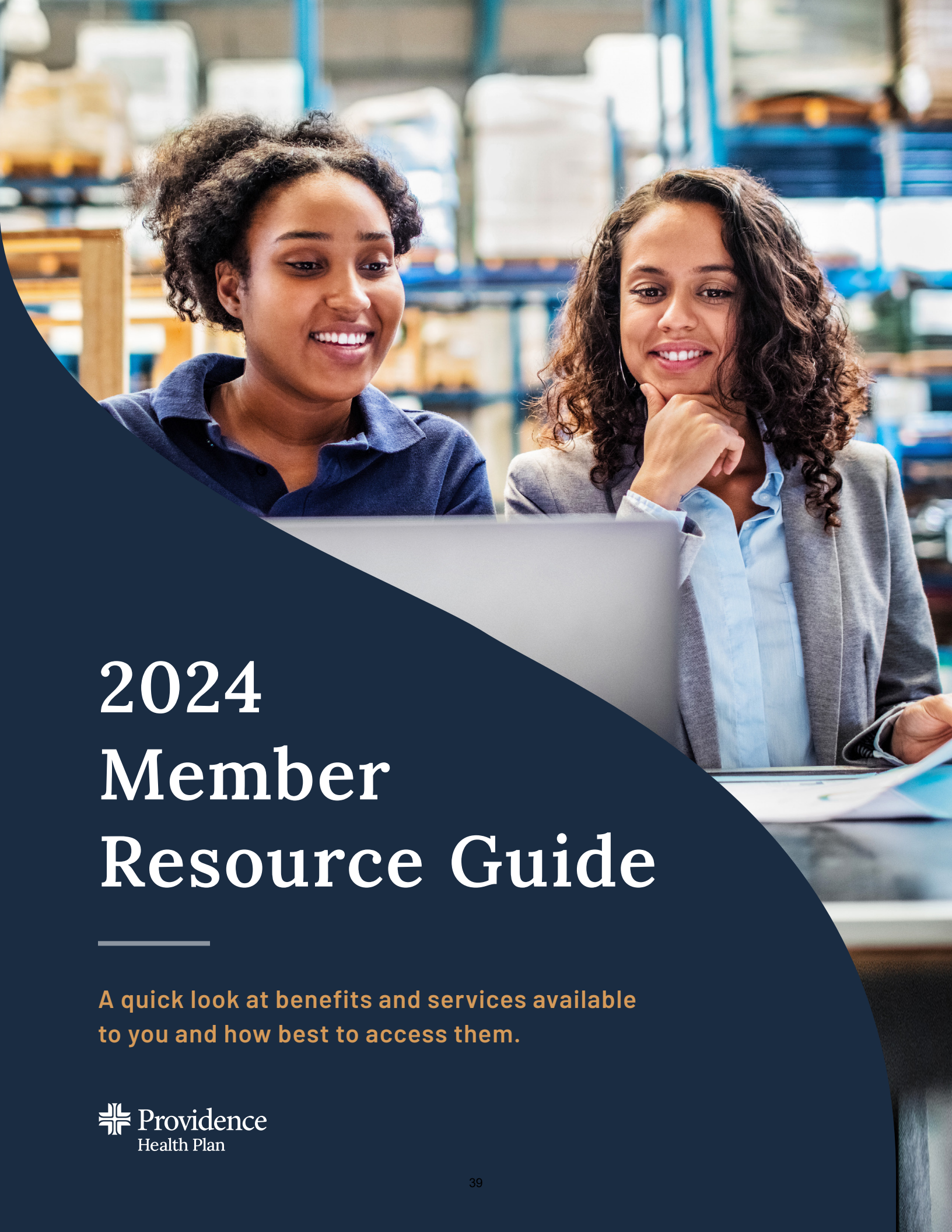

2024 Member Resource Guide

A quick look at benefits and services available to you and how best to access them.

Providence Health Plan

myProvidence.com

First things first...

Sign up for a **myProvidence.com** account to access your member portal. Register today to securely access and manage your health benefits right from our website on any smart device.

- Find in-network providers
- Print a replacement member ID card
- Estimate costs for services
- View claims and explanations of benefits
- View progress towards your deductible and out-of-pocket maximum
- Take a health assessment to better understand your current health status
- Communicate with Customer Service via secure email and chat
- Access exclusive member discounts on fitness memberships, travel, and more

Tips to ease registration

- Your 11-digit Member ID (this includes a 2-digit suffix to indicate subscriber and other members on the plan) and 6-digit Group ID can be found on your Providence Health Plan ID card
- ZIP code must match the current ZIP code on file with Providence
- To help ensure the activation link is received, use a personal email rather than a work email
- Email address entered must be unique to the user. If a family email address is being used for more than one myProvidence account – see example below:
- Include a plus sign with numbers to allow for multiple instances of the email address:
  firstnamelastname@gmail.com
  firstnamelastname+1@gmail.com

To register:

Visit **myProvidence.com** or call the myProvidence help desk at **877-569-7768** 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday.

Provider Directory

The provider directory with you in mind. The many search options help you find the right fit.

Important identifiers include:

- Race and ethnicity
- Personal identity
- Cultural competency
- LGBTQ+
- Location
- Provider type
- Specialty
- Languages spoken
- Gender affirming care

Finding a provider is easy

01 Log in to **myProvidence.com** and select Find a Provider
Or, visit **ProvidenceHealthPlan.com/FindAProvider** and search using your ID number from your member ID card

02 Choose "Find a Provider" then select which type of provider you're looking for

03 Adjust filters to find the right provider: ZIP code, specialty, language, gender, race and ethnicity, personal identity, and more

Check out the provider directory today

ProvidenceHealthPlan.com/FindAProvider

Care Options

Knowing your options for care helps you get the care you need when you need it.

Primary Care

Visit your Primary Care Provider (PCP) to build a relationship and establish a personalized health history. If you need a primary care provider, visit **myProvidence.com** and select "Find a Provider" after logging in. Then choose Primary Care Providers.

Telehealth (Phone or Video Appointment)*

Arrange a phone appointment to talk with your provider from wherever you are. Schedule a visit with your PCP or specialist using a video conferencing platform such as Zoom.

24/7 Nurse Advice Line (ProvRN)

Speak with a registered nurse anytime, any day. Call when you have a health concern and are looking for advice. Have your member number available and call **800-700-0481**.

ExpressCare Virtual

On-demand virtual care with Providence ExpressCare Virtual. Connect to care in minutes from anywhere using your tablet, smartphone, or computer. Conditions treated by this service include things like common colds, fever, heartburn, sore throat, pink eye, UTIs, allergies, dry skin, and more.

To get started, visit **Providence.org/Services/ExpressCare-Virtual**.

ExpressCare Clinics

Find a same-day in-person appointment or walk-in where available. Treat common conditions like a cold, sore throat, or allergies. Most clinics are open from either 7 a.m. to 7 p.m. or 8 a.m. to 8 p.m. To find a location and schedule an appointment, visit **Providence.org/ExpressCare**.

Urgent Care

Urgent care is where you turn when you can't wait for a primary care appointment for minor injuries like cuts, burns, and pains. To find an urgent care clinic, login to **myProvidence.com** and select "Find a Provider." Then choose "Find a Service or Place; Urgent Care Clinic."

Emergency Care

Call 911 or go to the nearest emergency room if you think your life is in danger. Use for symptoms like suspected heart attack, severe abdominal pain, poisoning, or loss of consciousness.

For more information, visit

ProvidenceHealthPlan.com/Care-Options

*Subject to availability, call your provider's office to ask if this is an option.

Pharmacy Resources

Understand your benefits and save money on prescriptions.

Formulary – Your List of Covered Medications

A formulary is just a list of generic and brand name prescription drugs that are covered under your health plan. The medications listed on your formulary have been approved based on their safety, quality, effectiveness, and affordability. Providence provides this comprehensive list to all members with pharmacy benefits.

To access your formulary, visit
ProvidenceHealthPlan.com/FindMyFormulary

A Specialty Team for Specialty Pharmacies

Specialty drugs require careful handling or administration (like refrigeration or complex injection instructions). To make sure you have the information you need, you'll have access to a dedicated, specialty care team. They'll provide you with extra support, including where to find your nearest specialty pharmacy, and how to get financial assistance when available.

Find a Preferred Pharmacy

Our network of preferred pharmacies includes those affiliated with Providence along with major retailers like Rite Aid, CVS, Costco, Walmart, and many more. To get the best experience using our directory, search using your ID number from your member ID card.

To search for in-network pharmacies, visit
ProvidenceHealthPlan.com/FindAProvider

Enjoy Access to a Nationwide Network

There are thousands of participating pharmacies you can choose from to get the medication you need. Retail and preferred retail pharmacies offer a 30-day supply, or up to 90 days for maintenance medication. Also, when you fill a prescription at a preferred retail pharmacy, you may save money.

Save a Trip to the Pharmacy – Have Your Medication Delivered

When you switch to mail order you can get what you need delivered directly to your home.[1]
Just have your provider send your prescriptions to one of our preferred mail order pharmacies: Costco Mail Order or Postal Prescription Services.[2]

Questions about pharmacy benefits?

Visit **ProvidenceHealthPlan.com/Pharmacy** or call **877-216-3644 (TTY: 711)**
Monday – Friday between 8 a.m. and 5 p.m. (Pacific Time).

[1] Excludes specialty and compounded medications
[2] Your network provisions may require the use of just one of these mail-order pharmacies for coverage

Care Management

Care Management services are open to all Providence Health Plan members and available at no cost.

The registered nurses, social workers, clinical support coordinators, and technicians who make up the Providence Care Management team will help you better understand your health so you can take an active role in improving it. Whether you need help understanding a new diagnosis or assistance navigating options for a diagnosis that has been affecting one's life for a long time, Providence Care Management is here to help.

Care managers help you better understand your condition and support you on your journey so you can take a more active role in meeting your health goals.

Care Management includes:

- Support for conditions like asthma, heart failure, diabetes, and more
- Assistance finding health care services in your area
- Personalized health education about your medical concern, including new innovations, medication therapy, and symptom management
- Coordination with your provider and other members of your care team, as needed
- Ongoing one-on-one telephone support
- An individualized plan developed with you to help you reach your health goals
- Advice on general health and lifestyle choices to help reduce risks, including nutrition and exercise
- Encouragement and support to help through the easy, and not so easy, times
- Support with prior authorizations or provider referrals

To get started or for more information, visit
ProvidenceHealthPlan.com/CareManagement

Alternative Care

We want to help you be your best and achieve both physical and mental well-being. That's why we offer coverage for alternative care therapies that can help alleviate pain and positively impact your overall health.

Chiropractic care

Chiropractic care promotes health through improving your quality of life and alleviating pain. Chiropractors use clinical expertise and the best available evidence to diagnose and treat conditions that affect your body's movement without medication or surgery. Some of the most common reasons for getting chiropractic care are:

- Back pain
- Neck pain
- Headaches
- Allergy relief
- Numbness, tingling, or weakness

Acupuncture

Acupuncture therapy involves a licensed professional inserting small needles to stimulate specific parts of the body and its neural network. Studies show acupuncture may help manage the following conditions with little risk of side effects:

- Arthritis
- Low back pain
- Neck pain
- Migraines
- Anxiety, depression, or insomnia

Massage therapy*

Massage therapy is performed by a trained massage therapist, who will apply gentle or strong pressure to the muscles and joints of the body to ease pain and tension. Important reasons for getting massage therapy can include:

- Relief from pain
- Diminish stress/better mood
- Relaxation
- Increase mobility
- Reduce injury or improve already injured parts of the body

*Massage therapy isn't covered for all members. Check your benefit summary for coverage details.

Behavioral Health Suite of Services

Giving you more choice in how you want and need to access services and care.

Talkspace

80%

found Talkspace to be as effective or more effective than traditional therapy

Behavioral Health Concierge

42%

of members would not ask for help without this service

Learn to Live

44%

improvement in psychometric outcomes, when working with a Learn to Live coach

Equip

81%

of patients are seeing improvement in eating disorder symptoms

Charlie Health

91%

attended a scheduled session

What is behavioral health?

Behavioral health includes the emotions and behaviors affecting your overall well-being and is treated by caring for your mental health or challenges with substance use. Covered services include things like counseling, addiction support programs, and psychotherapy treatment.

For more information, visit

ProvidenceHealthPlan.com/BehavioralHealth or call Providence Customer Service at 800-878-4445

Behavioral Health isn't a one-size-fits-all solution. Each person is unique, so we work to offer a mix of services and solutions. Here is a quick look at our suite of offerings:

Resources for Improved Well-Being

Resources to Relax & Recharge

- Savings on massage therapy, yoga, meditation, and more

LifeBalance

- ProvidenceHealthPlan.com/LifeBalance

Self-Management and Mindfulness Tools

Stress Management Health Coaching

- ProvidenceHealthPlan.com/HealthCoaching
- One-on-one health coaching sessions
- Personalized goal setting with manageable steps
- A program designed to empower members to achieve their health goals

Learn to Live

- LearnToLive.com/Welcome/ProvidenceHealthPlan
- Self-directed virtual therapy to manage mental well-being
- One-on-one coaching, mindfulness exercises, and live and on-demand webinars
- Available at any time within the app

Telehealth/Virtual

Behavioral Health Concierge

- Providence.org/BHC
- Quick access to direct care with Providence providers
- Extended hours 7 a.m. - 8 p.m., seven days week
- Help with life stressors, mental health, and addiction issues

Talkspace

- Talkspace.com/ProvidenceHealthPlan
- Telehealth provider of virtual psychotherapy for teens (13+) and adults
- Be matched to a provider within 48 hours
- Connect through text, call, or live video
- Access to therapy, psychiatry,* or both

Equip

- Virtual, eating disorder treatment
- Kids and young adults ages 6-24
- Family-Based Treatment (FBT) matched with a multi-disciplinary team

Charlie Health

- Virtual Intensive Outpatient Program (vIOP)
- Teens and young adults ages 11-30
- Personalized treatment plans, including group and family / individual therapy

Broad Clinical Support

Behavioral Health Network

- Local and nationwide access
- In-person and virtual services
- Age-specific care (kids, teens, adults)
- Access to specialty behavioral health network

Provider Directory

- ProvidenceHealthPlan.com/FindAProvider
- Go to the Provider Directory and search using your Member ID
- Select "Find a care provider"
- Select "Mental Health/Substance Use Disorder"

Crisis Care

24/7 Crisis Line (HUB)

- Immediate access 24/7
- Team trained in crisis triage care
- Real time referrals
- Call customer service at 503-574-7500 or 800-878-4445 and they will help connect you directly to our clinical department

Urgent Care

- Inpatient and residential care
- Partial hospital care

*Psychiatrists have the ability to prescribe medication

Health Coaching

Reach your goals with support from a Providence Health Coach.

Whether you'd like to increase your activity level, reduce stress, improve your eating habits, lose weight, quit tobacco, or just feel better, a Providence Health Coach can help. We're here to remove barriers, motivate you when you need a nudge, and be a resource on your journey.

The Providence Health Coaching program offers telephonic or virtual sessions at no cost to members[1], along with:

- One-on-one health coaching sessions
- Personalized goal setting with manageable steps
- A program designed to empower you to achieve health goals
- Guidance to help you take action toward healthier lifestyle

Your road to better health

- Weight management
- Nutrition
- Physical activity
- Stress
- Sleep
- Social support
- Digital wellbeing

Talk to a Health Coach today
ProvidenceHealthPlan.com/HealthCoach

[1] Eligibility and participation criteria apply. Health Coaching services are not available for all members. To determine program eligibility, please contact the health coaching program.

Help to quit smoking

Connect with a coach over the phone or use live chat to create a personalized plan and get support every step of the way. You'll also get access to resources to help you manage your triggers and overcome your cravings. All Providence members are eligible.

Call Quit for Life at **866-QUIT-4-LIFE (866-784-8454)** to opt in or out of the program.

Member Perks

Explore additional benefits and programs available to cover every aspect of your life.

One Pass Select™

Discover whole body health in one affordable program. Choose a membership tier that fits your lifestyle and access digital fitness apps, gym memberships, and home grocery delivery services. Start your journey for less than $1 a day.

LifeBalance

LifeBalance gives you and your family discounts on the things you love to do, like seeing a movie or taking a vacation. Stay active, reduce stress, and save on thousands of recreational, cultural, well-being, and travel related purchases.

Travel Assistance®

We've partnered with Assist America Travel Assistance® to provide logistical support for your emergency medical needs when you're hundreds of miles or more from your home. Get help with prompt admission to a qualified hospital or replacing prescriptions that have been left behind, and much more.

ID Protection

Assist America protects you from the theft of your personal data, and helps restore its integrity if it is used fraudulently. Store important information in a safe location, and if it's lost or stolen, take advantage of a fast and simple resolution process.

To access these services and for more information, visit
ProvidenceHealthPlan.com/Member-Perks

Providence
Health Plan

Health For All

We believe everyone should have access to quality healthcare. Healthcare is a human right. And we're dedicated to the health and care of every member of the community because everyone's well-being matters.

Have questions?

We're here to help

Customer Service is available 8 a.m. to 5 p.m. (Pacific Time), Monday through Friday.

Give us a call at **503-574-7500** or **800-878-4445 (TTY: 711)**.

ProvidenceHealthPlan.com

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Resources

HEALTH INSURANCE TERMS YOU NEED TO KNOW

ACA – Affordable Care Act

Ambulatory Care – Health care services that do not require a hospital stay, such as those delivered in a doctor's office, clinic or day surgery center.

Assignment of Benefits – This means signing a document that allows your hospital or doctor to collect your health insurance benefits directly from your health carrier. Otherwise, you pay for treatment and the insurance company reimburses you.

Benefits – The amount of money payable by an insurance company to a claimant under the insurance policy.

Case Management – A technique that insurance companies use to ensure that individuals receive appropriate, timely and reasonable health care services.

Claim – A request by an individual (or his or her provider) for the insurance company to pay for services obtained.

Coinsurance – The money that an individual is required to pay for services, after a deductible has been paid. It is often a specified percentage of the charges. For example, the employee pays 20 percent of the charges while the health plan pays 80 percent.

Copayment – An arrangement where an individual pays a specified amount for various health care services and the health plan or insurance company pays the remainder. The individual must usually pay his or her share when services are rendered. The concept is similar to coinsurance, except that copayments are usually a set dollar amount (such as $20 per office visit), rather than a percentage of the charges.

Deductible – A set dollar amount that a person must pay before insurance coverage for medical expenses can begin. They are usually charged on an annual basis.

Denial of claim – Refusal by an insurance company to pay a submitted request for health care services obtained.

Employee Assistance Program (EAP) – Mental health counseling services that are sometimes offered by insurance companies or employers. Typically, individuals or employers do not have to pay directly for EAP services provided.

EOB (Explanation of Benefits) – is a statement sent by a health insurance company to covered individuals explaining what medical treatments and/or services were paid for on their behalf. The EOB should provide the date of service, total charges of the claim, non-covered charges, deductible, provider discounts, remaining covered charges, your copay, patient responsibility, total benefit paid by the carrier, and any comments.

Exclusions and Limitations – Specific conditions or circumstances for which an insurance policy or plan will not provide coverage (exclusions), or for which coverage is specifically limited (limitations).

HRA (Health Reimbursement Arrangement – is an employer-funded spending account that can be used to pay for qualified medical expenses. The HRA is 100% funded by your employer. The terms of these arrangements can provide first dollar medical coverage until the funds are exhausted or insurance coverage kicks in.

In-Network –Typically refers to physicians, hospitals or other health care providers who contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Coverage for services received from in-network providers will typically be greater than for services received from out-of-network providers, depending on the plan.

Long-Term Care Insurance – Insurance policies that cover the costs of providing nursing care, home health care services, and custodial care for the aged and infirm.

Maximum Benefit – The maximum dollar amount that an insurance company will pay for claims, either for a specific service or procedure, or during a specified period of time.

Medically Necessary – A term used to describe the supplies and services needed to diagnose and treat a medical condition in accordance with the standards of good medical practice. Many health plans will only pay for treatment deemed medically necessary. For example, most plans will not cover elective cosmetic surgery.

MERP – MERP stands for Medical Expense Reimbursement Plan and is any plan or arrangement under which an employer reimburses an employee for out-of-pocket medical expenses incurred by employees and/or their dependents. Redmond Fire & Rescue currently reimburses their employees a portion of their deductible and out-of-pocket maximum that they incur during the plan year.

Out-of-Network – Typically refers to physicians, hospitals or other health care providers who do not contract with the insurance plan (usually an HMO or PPO) to provide services to its members. Depending upon the insurance plan, expenses incurred for services provided by out-of-network providers might not be covered, or coverage may be less than for in-network providers.

Out-of-Pocket Maximum – The total amount paid each year by the member for the deductible and coinsurance. After reaching the out-of-pocket maximum, the plan pays 100 percent of the allowable charges for covered services the rest of that calendar year.

Pre-Admission Certification – Also called "precertification" or "pre-admission review." Approval granted by a case manager or insurance company representative (usually a nurse) for a person to be admitted to a hospital or inpatient facility before admittance. The goal is to ensure that individuals are not exposed to inappropriate health care services, or services that are not medically necessary.

Pre-Existing Condition –Any medical condition that was diagnosed or treated within a specified period immediately before a health insurance policy became effective. These conditions may not be covered for a specified period of time under the new policy.

Preferred Provider Organization (PPO) – A type of managed care plan in which doctors and hospitals agree to provide discounted rates to plan members. Patients are typically reimbursed 80 to 100 percent for treatment received within the network, versus 50 to 70 percent outside the network.

Primary Care Physician (PCP) – A health care professional who is responsible for monitoring an individual's overall health care needs. Typically, a PCP serves as a gatekeeper for an individual's medical care, referring him or her to specialists and admitting him or her to hospitals when needed.

Reasonable and Customary Charges – The commonly charged or prevailing fees for health services within a geographic area. If charges are higher than what an insurance carrier considers reasonable and customary, the carrier will not pay the full amount and instead will pay what is deemed appropriate for the particular service. The remaining charges then are the responsibility of the patient.

Self-Insured – A health benefits plan in which the employer is responsible for the cost of its employees' health care. Typically, a third party provides administrative services for the plan to the employer group.

VEBA – "VEBA" stands for voluntary employees' beneficiary association. VEBAs are a type of trust instrument used to hold plan assets for the purpose of providing employee benefits. VEBAs are authorized by Internal Revenue Code § 501(c)(9). VEBA Trust offers a health reimbursement arrangement commonly known as the VEBA Plan

Waiting Period – A period of time in which your health plan does not provide coverage for a particular pre-existing condition.

Waiver – A rider or amendment to a policy that restricts benefits by excluding certain medical conditions from coverage.

Notes

Notes

The information in this Benefits Resource Guide is presented for illustrative purposes and is based on information provided by the employer. The text contained in this Guide was taken from various summary plan descriptions and benefit information. While every effort was taken to accurately report your benefits, discrepancies or errors are always possible. In case of discrepancy between the Benefits Resource Guide and the actual plan documents, the actual plan documents will prevail. All information is confidential, pursuant to the Health Insurance Portability and Accountability Act of 1996. If you have any questions about this summary, contact Human Resources.