Your Benefit Summary

Value 6200

Passport Plan

PROVIDENCE Health Plan

What You Pay In-Plan	What You Pay Out-of-Plan	Calendar Year In-Plan Out-of-Pocket Maximum	Calendar Year Out-of-Plan Out-of-Pocket Maximum	Calendar Year In-Plan Deductible	Calendar Year Out-of-Plan Deductible
Covered in full (after deductible)	Covered in full (after deductible; UCR applies)	$6,200 per person $12,400 per family (2 or more)	$6,200 per person $12,400 per family (2 or more)	$6,200 per person $12,400 per family (2 or more)	$6,200 per person $12,400 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for myProvidence at www.ProvidenceHealthPlan.com/getstarted.

- Not sure what a word or phrase means? See the last page of this summary for definitions.
- The per person deductible and out-of-pocket maximums apply when only the employee is enrolled. The family deductible and out-of-pocket maximum apply when an employee and dependent(s) are enrolled.
- In-Plan and Out-of-Plan deductibles, as well as In-Plan and Out-of-Plan out-of-pocket maximums, accumulate separately and are not combined.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online or call us.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Value Benefit Highlights

✓ No deductible needs to be met prior to receiving this service	After you pay your calendar year deductible, then you pay the following for covered services: In-Plan Copay or Coinsurance (after deductible, when you use a participating provider)	Out-of-Plan Copay or Coinsurance (after deductible, when you use a non-participating provider)
Physician / Provider Services		
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	Covered in full
• Office visits to Personal Physician/Provider	Covered in full	Covered in full
• Office visits to alternative care providers	Covered in full	Covered in full
• Office visits to all other physicians/providers	Covered in full	Covered in full
• Maternity services: prenatal	Covered in full✓	Covered in full
• Maternity services: delivery and postnatal	Covered in full	Covered in full
• Routine immunizations; shots	Covered in full✓	Covered in full
• Allergy shots; serums; injectable medications	Covered in full	Covered in full
• Inpatient hospital visits	Covered in full	Covered in full
• Surgery; anesthesia	Covered in full	Covered in full
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	Covered in full
• Mammograms	Covered in full✓	Covered in full
Hospital Services		
• Inpatient care	Covered in full	Covered in full
• Observation care	Covered in full	Covered in full
• Rehabilitative care (limited to 30 days per calendar year, 60 days for head/spinal injuries)	Covered in full	Covered in full
• Habilitative Care (limited to 30 days per calendar year, 60 days for head/spinal injuries)	Covered in full	Covered in full
• Maternity care	Covered in full	Covered in full
• Routine newborn nursery care	Covered in full	Covered in full
• Skilled nursing facility (limited to 60 days per calendar year)	Covered in full	Covered in full

Value Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Outpatient Diagnostic Services		
• X-ray; lab services	Covered in full	Covered in full
• High-tech imaging services (such as PET, CT, MRI)	Covered in full	Covered in full
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year; deductible waived)	Covered in full*	Covered in full
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits)	Covered in full	Covered in full
• Urgent care services (for non-life threatening illness/minor injury)	Covered in full	Covered in full
• Emergency medical transportation	Covered in full	Covered in full
Other Covered Services		
• Outpatient surgery at an ambulatory surgery center	Covered in full	Covered in full
• Outpatient surgery at a hospital-based facility	Covered in full	Covered in full
• Outpatient dialysis, infusion, chemotherapy, radiation therapy	Covered in full	Covered in full
• Outpatient rehabilitative services (limited to 30 visits per calendar year; up to 30 additional visits per specified condition)	Covered in full	Covered in full
• Outpatient habilitative services (limited to 30 visits per calendar year; up to 30 additional visits per specified condition)	Covered in full	Covered in full
• Home health care	Covered in full	Covered in full
• Hospice care	Covered in full✓	Covered in full✓
• Respite care (limited to members receiving Hospice care; limited to 5 days, up to 30 days per lifetime)	Covered in full	Covered in full
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓	Not covered
• Spinal manipulations and acupuncture (limited to 5 visits combined per calendar year)	Covered in full	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
• Generic drugs	Covered in full	Not covered
• Preferred brand-name drugs	Covered in full	Not covered
• Non-preferred brand-name and specialty drugs	Covered in full	Not covered
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All inpatient, residential, and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	Covered in full	Covered in full
• Residential services	Covered in full	Covered in full
• Outpatient provider visits	Covered in full	Covered in full
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
• Generic	$20✓	Not covered
• Preferred brand name	Covered in full	Not covered
• Non-preferred brand name	Covered in full	Not covered
• Specialty	Covered in full	Not covered
Pediatric Vision Services To find a VSP Choice participating provider, go to www.vsp.com or contact VSP Member Services at 800-877-7195.		
• Routine eye exam (limited to one exam per calendar year)	Covered in full✓	Covered up to $45✓
• Lenses (limited to one 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✓
• Frames (limited to one pair per calendar year)	Covered in full✓	Covered up to $70✓
• Contact lens services and materials (in place of glasses. Annual limits apply; limited to the following):	Covered in full✓	Covered up to $105✓
-Standard (one pair annually) - 1 lens per eye (total 2 lenses)		
-Monthly (six month supply) - 6 lenses per eye (total 12 lenses)		
-Bi-weekly (three month supply) - 6 lenses per eye (total 12 lenses)		
-Dailies (one month supply) - 30 lenses per eye (total 60 lenses)		

Value Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Supplemental Benefit - Adult Vision Services To find a VSP Choice participating provider, go to www.vsp.com or contact VSP Member Services at 800-877-7195. (Your deductible does not apply to vision services. Copayments do not apply to your Out-of-Pocket maximums.)		
• Routine eye exam (limited to one exam per calendar year)	$30✓	Covered up to $45✓
• Lenses (limited to one pair every two calendar years)		
-Single vision	Covered in full✓	Covered up to $30✓
-Bifocal	Covered in full✓	Covered up to $50✓
-Trifocal	Covered in full✓	Covered up to $70✓
• Frames (limited to one pair every two calendar years)	Covered up to $120 retail✓	Covered up to $70✓
• Contact lens services and materials (in place of glasses) (limited to every two calendar years)	Covered up to $120 retail✓	Covered up to $105✓

* Your deductible(s) do not apply to purchases of diabetes supplies

Pediatric and Supplemental Adult Vision Exclusions

The following items are excluded under this plan:

- Two pairs of glasses instead of bifocals
- Replacement of lenses, frames or contacts
- Medical or surgical treatment
- Orthoptics, vision training or supplemental testing

Items not covered under the contact lens benefit:

- Insurance policies or service agreements
- Artistically painted or non-prescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing or cleaning

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.

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

Deductible carryover
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

Exclusion Period
A period of time during which all specified treatments or services are excluded from coverage. If treatment was covered under a previous plan, then the exclusion period is reduced by each day of continuous prior creditable coverage.

Formulary
A list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the preferred brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

In-plan benefit
The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Non-preferred brand drug
A brand name drug that is included on the formulary at a higher cost share.

Out-of-plan
Refers to services you receive from a non-participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

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.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

Preferred brand drug
A brand name drug that is included on the formulary.

Prescription drug prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. 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.

Prior authorization
Some services must be pre-approved. In-Plan, your provider will request prior authorization. Out-of-Plan, you are responsible for obtaining prior authorization.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-plan provider. When the cost of out-of-plan 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.

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

Have questions about your benefits and want to contact us via email? Go to our website at:
www.ProvidenceHealthPlan.com/contactus