

# Your Benefit Summary

## Core Alternatives Plan



| Copay | What You Pay In-Plan | What You Pay Out-of-Plan | Calendar Year Common Coinsurance Maximum (after deductible) | Calendar Year Common Deductible                       |
|-------|----------------------|--------------------------|---|---|
| \$25  | 30%                  | 50%                      | \$5,000 per person<br>\$15,000 per family (3 or more)       | \$7,500 per person<br>\$22,500 per family (3 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](http://www.ProvidenceHealthPlan.com/getstarted).

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- A pre-existing condition exclusion applies to this plan. This exclusion does not apply to members who are under the age of 19. See the back for more information.
- Your deductibles, copayments, some services and penalties do not apply to coinsurance maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

| Core Alternatives Plan Benefit Highlights   | After you pay your calendar year deductible, then you pay the following for covered services:  |  |
|---|--|--|
|   | In-Plan Copay or Coinsurance (when you use a participating provider)   | Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)                       |
| ✓ No deductible needs to be met prior to receiving this benefit.  |  |  |
| <b>My Choice Benefits</b><br>Your deductible is waived for the first 6 visits per calendar year for benefits designated My Choice Benefit. You choose the combination of services.  |  |  |
| <b>Physician / Provider Services</b>  |  |  |
| <ul style="list-style-type: none"> <li>• Periodic health exams; well-baby care (from a Personal Physician/Provider only)</li> <li>• Routine immunizations; shots</li> <li>• Office visits to Personal Physician/Provider</li> <li>• Office visits to specialist</li> <li>• Office visits to alternative care providers (any licensed provider; limited to \$500 per calendar year)</li> <li>• Maternity services; pre- and postnatal visits, delivery</li> <li>• Allergy shots; serums; injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul> | Covered in full ✓<br>Covered in full ✓<br><b>My Choice Benefit</b><br>\$25 / visit<br><b>My Choice Benefit</b><br>\$25 / visit<br><b>My Choice Benefit</b><br>\$25 / visit<br>30%<br>30%<br>30%<br>30% | 50% ✓<br>50%<br>50%<br>50%<br><b>My Choice Benefit</b><br>\$25 / visit<br>50%<br>50%<br>50%<br>50% |
| <b>Women's Health Services</b>  |  |  |
| <ul style="list-style-type: none"> <li>• Gynecological exams (calendar year); Pap tests</li> <li>• Mammograms</li> </ul>  | Covered in full ✓<br>Covered in full ✓   | 50% ✓<br>50%   |
| <b>Hospital Services</b>  |  |  |
| <ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Observation care</li> <li>• Maternity care</li> <li>• Routine newborn nursery care</li> <li>• Rehabilitative care (30 days per calendar year)</li> <li>• Skilled nursing facility (60 days per calendar year)</li> </ul>   | 30%<br>30%<br>30%<br>30%<br>30%<br>30%   | 50%<br>50%<br>50%<br>50%<br>50%<br>50%   |
| <b>Outpatient Diagnostic Services</b>   |  |  |
| <ul style="list-style-type: none"> <li>• X-ray; lab services (Deductible is waived for the first \$500 of in-plan services in a calendar year)</li> <li>• Imaging services (such as PET, CT, MRI)</li> </ul>  | 30%<br>30%   | 50%<br>50%   |

| Core Alternatives Plan Benefit Highlights (continued)  | In-Plan Copay or Coinsurance   | Out-of-Plan Copay or Coinsurance  |
|--|--|---|
| <b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices</b><br>(Removable custom shoe orthotics are limited to \$200 per calendar year; deductible waived)  | 30%*   | 50%   |
| <b>Emergency / Urgent Care / Emergency Medical Transportation</b> <ul style="list-style-type: none"> <li>Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)</li> <li>Urgent care services (for non-life threatening illness/minor injury)</li> </ul>   | \$250  | \$250   |
| <ul style="list-style-type: none"> <li>Emergency medical transportation</li> </ul>   | <b>My Choice Benefit</b><br>\$25 / visit<br>30%  | 50%   |
| <b>Other Covered Services</b> <ul style="list-style-type: none"> <li>Outpatient rehabilitative services (30 visits per calendar year)</li> <li>Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>Home health care</li> <li>Hospice care</li> <li>Tobacco use cessation; counseling/classes and deterrent medications</li> <li>Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)               <ul style="list-style-type: none"> <li>-Generic drugs</li> <li>-Formulary brand-name drugs</li> <li>-Non-formulary brand-name drugs</li> </ul> </li> </ul> | 30%<br>30%<br>50%<br>30%<br>Covered in full✓<br>Covered in full✓<br>\$10✓<br>\$50✓<br>\$100✓ | 50%<br>50%<br>Not covered<br>50%<br>Covered in full✓<br>Not covered<br>Not covered<br>Not covered<br>Not covered<br>Not covered |
| <b>Mental Health / Chemical Dependency</b><br>(To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)   |  |   |
| <ul style="list-style-type: none"> <li>Inpatient and day treatment services</li> <li>Residential services (limited to 60 days per calendar year)</li> <li>Outpatient provider visits</li> </ul>  | 30%<br>30%<br>\$25 / visit✓  | 50%<br>50%<br>50%   |

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

## 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.

### Common coinsurance maximum

The limit on the coinsurance you will have to spend for specified covered health services (a combination of both in and out-of-plan services) in a calendar year. Copayments, some services and expenses do not apply to the common coinsurance maximum. See your Member Handbook for details.

### Common deductible

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-plan or out-of-plan providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays or coinsurance for any supplemental benefits provided by your employer, such as prescription drugs, or routine vision care

### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### 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.

### Formulary

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

### 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](http://www.ProvidenceHealthPlan.com/providerdirectory).

### My Choice Benefits

Designated services for which up to 6 visits can be received prior to meeting your deductible. Services may be received in any combination. For Alternative Care, once the benefit dollar limit is reached, no additional alternative care visits are available for coverage.

### 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.

### 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](http://www.ProvidenceHealthPlan.com/providerdirectory).

### 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](http://www.ProvidenceHealthPlan.com/providerdirectory).

### Pre-existing condition exclusion

A pre-existing condition is any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your enrollment date. Coverage for pre-existing conditions is excluded for a period of six months following your enrollment date. This exclusion period can be reduced by qualifying Creditable Coverage. The pre-existing condition exclusion does not apply to members who are under the age of 19. See your Member Handbook for details.

### 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: **503-574-8702 or 888-244-6642**



Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:  
[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)