Your Benefit Summary

Core Advantages Plan

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$35/$45	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$7,150 per person $14,300 per family (2 or more)	$14,300 per person $28,600 per family (2 or more)	$1,500 per person $3,000 per family (2 or more)	$3,000 per person $6,000 per family (2 or more)

Important information about your plan

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

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network deductibles and out-of-pocket maximums accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Core Advantages Plan Benefit Highlights	After you pay your calendar year deductible(s), then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	50%✓
• Routine immunizations; shots	Covered in full✓	50%
• Colonoscopy (age 50+)	Covered in full✓	50%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Personal Physician/Provider	$35 / visit✓	50%✓
• Office visits to specialist	$45 / visit✓	50%✓
• Office visits to alternative care provider (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)	$35 / visit✓	50%✓
• Phone and video visits to Personal Physician/Provider	Covered in full✓	Not covered
• Phone and video visits to specialists	$30/ visit✓	Not covered
• Allergy shots; serums; infusions and injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Diagnostic Services		
• X-ray; lab services (Covered in full for the first $500 of in-network services in a calendar year)	30%	50%
• High-tech imaging services (such as PET, CT or MRI)	30%	50%
• Sleep studies	30%	50%
Emergency and Urgent Services		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	$250	$250
• Urgent care services (for non-life threatening illness/minor injury)	$45 / visit✓	50%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	30%	30%

Core Advantages Plan Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Hospital Services		
• Inpatient/Observation care	30%	50%
• Rehabilitative care (limited 30 days per calendar year)	30%	50%
• Skilled nursing facility (limited to 60 days per calendar year)	30%	50%
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	30%	50%
• Colonoscopy (non-preventive)	30%	50%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational, or speech therapy (30 visits per calendar year)	30%	50%
Maternity Services		
• Prenatal office visits	Covered in full✓	50%
• Delivery and postnatal services	30%	50%
• Inpatient hospital/facility services	30%	50%
• Routine newborn nursery care	30%	50%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	30%	50%
• Diabetes supplies (lancets, test strips and needles)	30%✓	50%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	30%	50%
Mental Health / Chemical Dependency		
• Inpatient and residential treatment services	30%	50%
• Day treatment, intensive outpatient and partial hospitalization services	30%	50%
• Applied behavior analysis	30%	50%
• Outpatient provider office visits	$35 / visit✓	50%✓
Home Health and Hospice		
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓

Your guide to the words or phrases used to explain your benefits

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

Deductible
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. The following expenses 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

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

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a calendar year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

Personal physician/provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

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

Usual, Customary & Reasonable (UCR)
Describes predefined charges established by your plan for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

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