## Your Benefit Summary

### Option Advantage

<table>
<thead>
<tr>
<th>Copay</th>
<th>What You Pay In-Network</th>
<th>What You Pay Out-of-Network</th>
<th>Calendar Year In-Network Out-of-Pocket Maximum</th>
<th>Calendar Year Out-of-Network Out-of-Pocket Maximum</th>
<th>Calendar Year In-Network Deductible</th>
<th>Calendar Year Out-of-Network Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$25/$35</td>
<td>20% coinsurance (after deductible)</td>
<td>40% coinsurance (after deductible; UCR applies)</td>
<td>$4,000 per person</td>
<td>$8,000 per family (2 or more)</td>
<td>$1,000 per person</td>
<td>$2,000 per family (2 or more)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$8,000 per person</td>
<td>$16,000 per family (2 or more)</td>
<td>$1,000 per person</td>
<td>$4,000 per family (2 or more)</td>
</tr>
</tbody>
</table>

### 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 services 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.

### Option Advantage Benefit Highlights

<table>
<thead>
<tr>
<th>Benefit</th>
<th>In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)</th>
<th>Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-Demand Provider Visits</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
<tr>
<td>Virtual visits to a Primary Care Provider by phone &amp; video (ExpressCare Virtual) or by Web-direct Visits</td>
<td>Covered in full</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Providence ExpressCare Retail Health Clinic</td>
<td>Covered in full</td>
<td>Not applicable</td>
</tr>
<tr>
<td>Virtual visits to a Specialist by phone &amp; video</td>
<td>$20 / visit</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

### Preventive Care

- Periodic health exams and well-baby care: Covered in full
- Colonoscopy (age 50+)
- Routine immunizations; shots
- Gynecological exams (calendar year) and Pap tests
- Mammograms
- Tobacco cessation, counseling/classes and deterrent medications

### Physician / Provider Services

- Office visits to Primary Care Provider: $25 / visit
- Office visits to Alternative Care Provider: $25 / visit
- Office visits to Specialists/Other Providers: $35 / visit
- Allergy shots and serums: 20%
- Infusions and injectable medications: 20%
- Surgery; anesthesia in an office or facility: 20%
- Inpatient hospital visits: 20%

### Diagnostic Services

- X-ray and lab services: 20%
- Imaging services (such as PET, CT, MRI): 20%
- Sleep studies: 20%

### Emergency and Urgent Services

- Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.): $250
- Urgent care services (for non-life threatening illness/minor injury): $35 / visit
- Emergency medical transportation (air and/or ground): 20%
### Hospital Services
- **Inpatient/Observation care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Rehabilitative care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Habilitation care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Skilled nursing facility** (Limited to 60 days per calendar year)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Temporomandibular joint (TMJ) services** (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)
  - In-Network: 50%
  - Out-of-Network: Not covered

### Outpatient Services
- **Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy** (Prior authorization required for outpatient hospital-based infusions)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Temporomandibular joint (TMJ) service** (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)
  - In-Network: 50%
  - Out-of-Network: Not covered
- **Colonoscopy** (non-preventive)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Outpatient rehabilitative physical therapy** (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Outpatient rehabilitative occupational and speech therapy** (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Outpatient habilitative services: physical, occupational or speech therapy** (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)
  - In-Network: 20%
  - Out-of-Network: 40%

### Maternity Services
- **Prenatal office visits**
  - In-Network: Covered in full
  - Out-of-Network: 40%
- **Delivery and postnatal services**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Inpatient hospital/facility services**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Routine newborn nursery care**
  - In-Network: 20%
  - Out-of-Network: 40%

### Medical Equipment, Supplies and Devices
- **Medical equipment, appliances and supplies**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Diabetes supplies** (such as lancets, test strips and needles)
  - In-Network: 20%
  - Out-of-Network: 40%
- **Prosthetic and orthotic devices** (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)
  - In-Network: 20%
  - Out-of-Network: 40%

### Mental Health / Chemical Dependency
(All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)
- **Inpatient and residential services**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Day treatment, intensive outpatient and partial hospitalization services**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Applied behavior analysis**
  - In-Network: 20%
  - Out-of-Network: 40%
- **Outpatient provider office visits**
  - In-Network: $25 / visit
  - Out-of-Network: 40%

### Home Health and Hospice
- **Home health care**
  - In-Network: 20%
  - Out-of-Network: Covered in full
- **Hospice care**
  - In-Network: 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.

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

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 plan 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.

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

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

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.

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

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.