## 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>$35/$45</td>
<td>30% coinsurance (after deductible)</td>
<td>50% coinsurance (after deductible; UCR applies)</td>
<td>$4,000 per person $8,000 per family (2 or more)</td>
<td>$8,000 per person $16,000 per family (2 or more)</td>
<td>$750 per person $1,500 per family (2 or more)</td>
<td>$1,500 per person $3,000 per family (2 or more)</td>
</tr>
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### 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](http://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](http://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

- No deductible needs to be met prior to receiving this benefit.

#### On-Demand Provider Visits

- Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits
- Providence ExpressCare Retail Health Clinic
- Virtual visits to a Specialist by phone & video

#### Preventive Care

- Periodic health exams and well-baby care
- 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
- 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.)
- Office visits to Specialists/Other Providers
- Allergy shots and serums
- Infusions and injectable medications
- Surgery; anesthesia in an office or facility
- Inpatient hospital visits

#### Diagnostic Services

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

#### 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.)
- Urgent care services (for non-life threatening illness/minor injury)
- 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)
### Hospital Services
- Inpatient/Observation care
- Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
- Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
- Skilled nursing facility (Limited to 60 days per calendar year)
- Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)

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

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### Maternity Services
- Prenatal office visits
- Delivery and postnatal services
- Inpatient hospital/facility services
- Routine newborn nursery care

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

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### Mental Health / Chemical Dependency
- Inpatient and residential services
- Day treatment, intensive outpatient and partial hospitalization services
- Applied behavior analysis
- Outpatient provider office visits

### Home Health and Hospice
- Home health care
- Hospice care

### 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.

### 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:

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.