## 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>30% coinsurance (after deductible)</td>
<td>50% coinsurance (after deductible; UCR applies)</td>
<td>$5,000 per person</td>
<td>$10,000 per person (2 or more)</td>
<td>$3,000 per person</td>
<td>$6,000 per person (2 or more)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10,000 per family (2 or more)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$20,000 per family (2 or more)</td>
<td></td>
<td></td>
<td></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](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

#### In-Network Copay or Coinsurance

- **Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct visits**
  - Covered in full
- **Providence ExpressCare Retail Health Clinic**
  - Covered in full
- **Virtual visits to a Specialist by phone & video**
  - $20 / visit

#### Out-of-Network Copay or Coinsurance

- **Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct visits**
  - Not covered
- **Providence ExpressCare Retail Health Clinic**
  - Not applicable
- **Virtual visits to a Specialist by phone & video**
  - Not covered

#### Preventive Care

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

#### 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**
  - 30%
- **Infusions and injectable medications**
  - 30%
- **Surgery; anesthesia in an office or facility**
  - 30%
- **Inpatient hospital visits**
  - 30%

#### Diagnostic Services

- **X-ray and lab services**
  - 30%
- **Imaging services (such as PET, CT, MRI)**
  - 30%
- **Sleep studies**
  - 30%

#### Emergency and Urgent Services

- **Emergency services**
  - $250
- **Urgent care services**
  - $35 / visit
- **Emergency medical transportation (air and/or ground)**
  - 30%
<table>
<thead>
<tr>
<th>Hospital Services</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>● Inpatient/Observation care</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Skilled nursing facility (Limited to 60 days per calendar year)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Temporomandibular joint (TMJ) services (inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)</td>
<td>50%</td>
<td>Not covered</td>
</tr>
<tr>
<td>Outpatient Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)</td>
<td>50%</td>
<td>Not covered</td>
</tr>
<tr>
<td>● Colonoscopy (non-preventive)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Maternity Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Prenatal office visits</td>
<td>Covered in full✓</td>
<td>50%</td>
</tr>
<tr>
<td>● Delivery and postnatal services</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Inpatient hospital/facility services</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Routine newborn nursery care</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Medical Equipment, Supplies and Devices</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Medical equipment, appliances and supplies</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Diabetes supplies (such as lancets, test strips and needles)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>Mental Health / Chemical Dependency</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Inpatient and residential services</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Day treatment, intensive outpatient and partial hospitalization services</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Applied behavior analysis</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Outpatient provider office visits</td>
<td>$25 / visit✓</td>
<td>50%</td>
</tr>
<tr>
<td>Home Health and Hospice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>● Home health care</td>
<td>30%</td>
<td>50%</td>
</tr>
<tr>
<td>● Hospice care</td>
<td>Covered in full✓</td>
<td>Covered in full✓</td>
</tr>
</tbody>
</table>
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.