

# Your Benefit Summary

## Option Advantage B



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
\$15	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	\$3,500 per person \$7,000 per family (2 or more)	\$7,000 per person \$14,000 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](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

After you pay your calendar year deductible(s), then you pay the following for covered services:

	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)
✓ No deductible needs to be met prior to receiving this benefit.		
<b>On-Demand Provider Visits</b>		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	\$5 / visit✓	Not covered
<b>Preventive Care</b>		
• Periodic health exams and well-baby care	Covered in full✓	40%✓
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%✓
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	40%✓
• Mammograms	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
<b>Physician / Provider Services</b>		
• Office visits to Primary Care Provider	\$15 / visit✓	40%✓
• 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.)	\$15 / visit✓	40%✓
• Office visits to Specialists/Other Providers	\$15 / visit✓	40%✓
• Allergy shots and serums	20%✓	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%
<b>Diagnostic Services</b>		
• X-ray and lab services	20%✓	40%
• Imaging services (such as PET, CT, MRI)	20%✓	40%
• Sleep studies	20%✓	40%
<b>Emergency and Urgent Services</b>		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	\$250✓	\$250✓
• Urgent care services (for non-life threatening illness/minor injury)	\$15 / visit✓	40%✓
• 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)	20%	20%

Option Advantage Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
<b>Hospital Services</b>		
<ul style="list-style-type: none"> <li>Inpatient/Observation care</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Skilled nursing facility (Limited to 60 days per calendar year)</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> </ul>	50%	Not covered
<b>Outpatient Services</b>		
<ul style="list-style-type: none"> <li>Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> </ul>	50%	Not covered
<ul style="list-style-type: none"> <li>Colonoscopy (non-preventive)</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)</li> </ul>	20%✓	40%
<ul style="list-style-type: none"> <li>Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</li> </ul>	20%	40%
<b>Maternity Services</b>		
<ul style="list-style-type: none"> <li>Prenatal office visits</li> </ul>	Covered in full✓	40%
<ul style="list-style-type: none"> <li>Delivery and postnatal services</li> </ul>	\$150 / delivery✓	40%
<ul style="list-style-type: none"> <li>Inpatient hospital/facility services</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Routine newborn nursery care</li> </ul>	20%✓	40%
<b>Medical Equipment, Supplies and Devices</b>		
<ul style="list-style-type: none"> <li>Medical equipment, appliances and supplies</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Diabetes supplies (such as lancets, test strips and needles)</li> </ul>	20%✓	40%
<ul style="list-style-type: none"> <li>Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)</li> </ul>	20%	40%
<b>Mental Health / Chemical Dependency</b>		
(All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
<ul style="list-style-type: none"> <li>Inpatient and residential services</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Day treatment, intensive outpatient and partial hospitalization services</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Applied behavior analysis</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Outpatient provider office visits</li> </ul>	\$15 / visit✓	40%✓
<b>Home Health and Hospice</b>		
<ul style="list-style-type: none"> <li>Home health care</li> </ul>	20%	40%
<ul style="list-style-type: none"> <li>Hospice care</li> </ul>	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

### **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](http://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.

### **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](http://www.ProvidenceHealthPlan.com/contactus)