Your Benefit Summary

Option Advantage A

<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</td>
<td>50% coinsurance (after deductible; UCR applies)</td>
<td>$5,000 per person</td>
<td>$10,000 per person</td>
<td>$500 per person</td>
<td>$1,000 per person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$10,000 per family (2 or more)</td>
<td>$20,000 per family (2 or more)</td>
<td>$1,000 per family</td>
<td>$2,000 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

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

- **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
  - **In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)**
    - Covered in full
  - **Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)**
    - Not covered

- **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
  - **In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)**
    - Covered in full
    - $20 / visit
  - **Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)**
    - 50%
    - Not applicable

- **Physician / Provider Services**
  - Office visits to Primary Care Provider
  - Office visits to Alternative Care Provider
  - Office visits to Specialists/Other Providers
  - Allergy shots and serums
  - Surgery; anesthesia in an office or facility
  - Inpatient hospital visits
  - **In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)**
    - $25 / visit
    - $35 / visit
  - **Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)**
    - 50%
    - 30%

- **Diagnostic Services**
  - X-ray and lab services
  - Imaging services (such as PET, CT, MRI)
  - **In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)**
    - $250
    - 30%
  - **Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)**
    - $250
    - 50%

- **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)
  - **In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)**
    - $250
    - $35 / visit
    - 30%
  - **Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)**
    - $250
    - 50%

PDC-OR 0118 LG OP ADV SD
Oregon - Large Group
ADV-986
OP ADV A 25/30/50/5000/500sd
### Hospital Services

<table>
<thead>
<tr>
<th>Service Description</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><strong>Hospital Services (continued)</strong></td>
<td></td>
<td></td>
</tr>
<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>
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</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>
</tbody>
</table>

### Outpatient Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<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 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>
</tbody>
</table>

### Maternity Services

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

### Medical Equipment, Supplies and Devices

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<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>30%</td>
</tr>
</tbody>
</table>

### Mental Health / Chemical Dependency

(All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<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>
</tbody>
</table>

### Home Health and Hospice

<table>
<thead>
<tr>
<th>Service Description</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<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.
**Non-discrimination Statement**

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:
- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW - Room 509F HHH Building  
Washington, DC 20201  
1-800-368-1019, 1-800-537-7697 (TTY)

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCION: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).


注意：如果您使用繁體中文，您也可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телефейн: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви говорите українською мовою, ви маєте доступ до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телефейн: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

MLHOVOZHA: Ėka kënt ëdëkhto ndërgu ë, ën hëkk ëm ëtëtë ëmldë ë nlëdë ëtòfr lk ëkm ëjmañ. ëttso 1-800-878-4445 (TTY: 711).

ATENTIE: Dacă vorbiți limba română, vă stau la dispoziție serviciile de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).


ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).