Your Benefit Summary

Personal Option Plan

PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum
$10	20% coinsurance	$1,200 per person $2,400 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.

- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- View a list of Providence Signature network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Personal Option Plan Benefit Highlights	You pay the following for covered services Copay or Coinsurance (from in-network providers only)
On-Demand Provider Visits	
• 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	$5 / visit
Preventive Care	
• Periodic health exams and well-baby care	Covered in full
• Routine immunizations; shots	Covered in full
• Colonoscopy (age 50 +)	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	$10 / visit
• 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.)	$10 / visit
• Office visits to Specialists/Other Providers	$20 / 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%
• High-tech imaging services (such as PET, CT or 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)	$20 / visit
• 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%
Hospital Services	
• Inpatient/Observation care	20%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Outpatient Services	
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	20%
• Colonoscopy (non-preventive)	20%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%
• Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)	20%
• Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)	20%
• Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%
Maternity Services	
• Prenatal office visits	Covered in full
• Delivery and postnatal services	$100 / delivery
• Inpatient hospital/facility services	20%
• Routine newborn nursery care	20%
Medical Equipment, Supplies and Devices	
• Medical equipment, appliances and supplies	20%
• Diabetes supplies (such as lancets, test strips and needles)	20%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year)	20%
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	20%
• Day treatment, intensive outpatient and partial hospitalization services	20%
• Applied behavior analysis	20%
• Outpatient provider office visits	$10 / visit
Home Health and Hospice	
• Home health care	20%
• Hospice care	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.

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-Pocket Maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the 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, your in-network provider will request prior authorization for these 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.

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.

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