### Your Benefit Summary
#### Personal Option Plan

<table>
<thead>
<tr>
<th>Copay</th>
<th>What You Pay</th>
<th>Calendar Year Out-of-Pocket Maximum</th>
<th>Calendar Year Deductible</th>
</tr>
</thead>
</table>
| $10   | 10% coinsurance (after deductible) | $1,950 per person  
$3,900 per family (2 or more) | $250 per person  
$500 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 is included in the out-of-pocket maximum amount listed above.
- 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](http://www.ProvidenceHealthPlan.com/providerdirectory).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

### Personal Option Plan Benefit Highlights

<table>
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<tr>
<th>Benefit Category</th>
<th>Description</th>
<th>Copay or Coinsurance</th>
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| 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 | Covered in full
$5 / visit

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<thead>
<tr>
<th>Preventive Care</th>
<th>Description</th>
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| ● Periodic health exams and well-baby care  
● Routine immunizations; shots  
● Colonoscopy (age 50 +)  
● Gynecological exams (calendar year) and Pap tests  
● Mammograms  
● Tobacco cessation, counseling/classes and deterrent medications | Covered in full

<table>
<thead>
<tr>
<th>Physician / Provider Services</th>
<th>Description</th>
<th>Copay or Coinsurance</th>
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| ● 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 | $10 / visit
$10 / visit
$20 / visit
10%
10%
10%
10%

<table>
<thead>
<tr>
<th>Diagnostic Services</th>
<th>Description</th>
<th>Copay or Coinsurance</th>
</tr>
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</table>
| ● X-ray and lab services  
● High-tech imaging services (such as PET, CT or MRI)  
● Sleep studies | 10%
10%
10%

<table>
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<tr>
<th>Emergency and Urgent Services</th>
<th>Description</th>
<th>Copay or Coinsurance</th>
</tr>
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</table>
| ● 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) | $250
$20 / visit
10%
### Hospital Services
- **Inpatient/Observation care**
- **Rehabilitative care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
- **Habilitation 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)
- **Skilled nursing facility**

### Outpatient Services
- **Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy** (Prior authorization required for outpatient hospital-based infusions)
- **Colonoscopy** (non-preventive)
- **Temporomandibular joint (TMJ) service**
- **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**

### 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)

### 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**
- **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.

**Copay**
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

**Deductible**
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. 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.

**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.

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**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)