# 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>
<tbody>
<tr>
<td>$10</td>
<td>20% coinsurance (after deductible)</td>
<td>$2,000 per person $4,000 per family (2 or more)</td>
<td>$250 per person $500 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](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>
<thead>
<tr>
<th>Service Type</th>
<th>Coverage Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>On-Demand Provider Visits</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Preventive Care</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Physician / Provider Services</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Diagnostic Services</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Emergency and Urgent Services</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

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**Important Points**

- No deductible needs to be met prior to receiving this service.
- Copays and coinsurances vary depending on the type of service and whether the provider is in-network.
- Out-of-network services may have additional costs.
- Benefits and limitations apply to covered services.

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**For more details, please refer to the [Member Handbook](http://www.myProvidence.com) and visit [www.myProvidence.com/providerdirectory](http://www.myProvidence.com/providerdirectory).**
### Hospital Services

- **Inpatient/Observation care**
  - Copay or Coinsurance: 20%

- **Rehabilitative care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
  - Copay or Coinsurance: 20%

- **Habilitative care** (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
  - Copay or Coinsurance: 20%

- **Skilled nursing facility** (Limited to 60 days per calendar year)
  - Copay or Coinsurance: 20%

- **Temporomandibular joint (TMJ) services** (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)
  - Copay or Coinsurance: 50%

### Outpatient Services

- **Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy** (Prior authorization required for outpatient hospital-based infusions)
  - Copay or Coinsurance: 20%

- **Colonoscopy** (non-preventive)
  - Copay or Coinsurance: 20%

- **Temporomandibular joint (TMJ) service**
  - Copay or Coinsurance: 50%

- **Outpatient rehabilitative physical therapy**
  - Copay or Coinsurance: 20%

- **Outpatient rehabilitative occupational and speech therapy**
  - Copay or Coinsurance: 20%

- **Outpatient habilitative services: physical, occupational or speech therapy**
  - Copay or Coinsurance: 20%

### Maternity Services

- **Prenatal office visits**
  - Covered in full

- **Delivery and postnatal services**
  - Copay or Coinsurance: $100 / visit

- **Inpatient hospital/facility services**
  - Copay or Coinsurance: 20%

- **Routine newborn nursery care**
  - Copay or Coinsurance: 20%

### Medical Equipment, Supplies and Devices

- **Medical equipment, appliances and supplies**
  - Copay or Coinsurance: 20%

- **Diabetes supplies** (such as lancets, test strips and needles)
  - Copay or Coinsurance: 20%

- **Prosthetic and orthotic devices** (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)
  - Copay or Coinsurance: 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**
  - Copay or Coinsurance: 20%

- **Day treatment, intensive outpatient and partial hospitalization services**
  - Copay or Coinsurance: 20%

- **Applied behavior analysis**
  - Copay or Coinsurance: 20%

- **Outpatient provider office visits**
  - Copay or Coinsurance: $10 / visit

### Home Health and Hospice

- **Home health care**
  - Copay or Coinsurance: 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.

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.