

# Your Benefit Summary

## Personal Option Plan



<b>Copay</b>	<b>What You Pay</b>	<b>Calendar Year Out-of-Pocket Maximum</b>
<b>\$15</b>	<b>20%</b> coinsurance	<b>\$2,000</b> per person <b>\$4,000</b> 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).

- 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	You pay the following for covered services
	Copay or Coinsurance (from in-network providers only)
<b>On-Demand Provider Visits</b>	
<ul style="list-style-type: none"> <li>• Virtual visits to a Primary Care Provider by phone &amp; video (ExpressCare Virtual) or by Web-direct Visits</li> <li>• Providence ExpressCare Retail Health Clinic</li> <li>• Virtual visits to a Specialist by phone &amp; video</li> </ul>	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full \$10 / visit</p>
<b>Preventive Care</b>	
<ul style="list-style-type: none"> <li>• Periodic health exams and well-baby care</li> <li>• Routine immunizations; shots</li> <li>• Colonoscopy (age 50 +)</li> <li>• Gynecological exams (calendar year) and Pap tests</li> <li>• Mammograms</li> <li>• Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	<p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p> <p style="text-align: center;">Covered in full</p>
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits to Primary Care Provider</li> <li>• Office visits to Alternative Care Provider (Chiropractic manipulation &amp; acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)</li> <li>• Office visits to Specialists/Other Providers</li> <li>• Allergy shots and serums</li> <li>• Infusions and injectable medications</li> <li>• Surgery; anesthesia in an office or facility</li> <li>• Inpatient hospital visits</li> </ul>	<p style="text-align: center;">\$15 / visit</p> <p style="text-align: center;">\$15 / visit</p> <p style="text-align: center;">\$25 / visit</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p>
<b>Diagnostic Services</b>	
<ul style="list-style-type: none"> <li>• X-ray and lab services</li> <li>• High-tech imaging services (such as PET, CT or MRI)</li> <li>• Sleep studies</li> </ul>	<p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p>
<b>Emergency and Urgent Services</b>	
<ul style="list-style-type: none"> <li>• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• 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)</li> </ul>	<p style="text-align: center;">\$250</p> <p style="text-align: center;">\$25 / visit</p> <p style="text-align: center;">20%</p>
<b>Hospital Services</b>	
<ul style="list-style-type: none"> <li>• Inpatient/Observation care</li> <li>• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</li> <li>• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)</li> <li>• Skilled nursing facility (Limited to 60 days per calendar year)</li> <li>• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> </ul>	<p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">20%</p> <p style="text-align: center;">50%</p>

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
<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> <li>● Colonoscopy (non-preventive)</li> <li>● Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of \$1,000 per calendar year/\$5,000 per lifetime)</li> <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> <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> <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% 20% 50% 20% 20% 20%
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>● Prenatal office visits</li> <li>● Delivery and postnatal services</li> <li>● Inpatient hospital/facility services</li> <li>● Routine newborn nursery care</li> </ul>	Covered in full \$150 / delivery 20% 20%
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>● Medical equipment, appliances and supplies</li> <li>● Diabetes supplies (such as lancets, test strips and needles)</li> <li>● Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year)</li> </ul>	20% 20% 20%
<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> <li>● Day treatment, intensive outpatient and partial hospitalization services</li> <li>● Applied behavior analysis</li> <li>● Outpatient provider office visits</li> </ul>	20% 20% 20% \$15 / visit
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>● Home health care</li> <li>● Hospice care</li> </ul>	20% 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](http://www.ProvidenceHealthPlan.com/contactus)