## Personal Option Plan Benefit Highlights

### On-Demand Provider Visits
- Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits (where available)
- Providence ExpressCare Retail Health Clinic
- Virtual visits to a Specialist by phone & video

### Preventive Care
- Periodic health exams and well-baby care
- Routine immunizations; shots
- Colonoscopy (age 50+)
- Gynecological exams (calendar year) and Pap tests
- Mammograms
- Nutritional counseling
- Tobacco cessation, counseling/classes and deterrent medications

### Physician / Provider Services
- Office visits to Primary Care Provider
- Office visits to Alternative Care Provider (such as Naturopath)
- Office visits to Specialists/Other Providers
- Allergy shots and serums
- Infusions and injectable medications
- Surgery; anesthesia in an office or facility
- Inpatient hospital visits

### Diagnostic Services
- X-ray, lab services, and testing services (includes ultrasound)
- High-tech imaging services (such as PET, CT or MRI)

### 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)

### Hospital Services
- Inpatient/Observation care
- Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)
- Habilitative 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)
### Personal Option Plan Benefit Highlights (continued)

#### Outpatient Services

<table>
<thead>
<tr>
<th>Service</th>
<th>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>20%</td>
</tr>
<tr>
<td>Outpatient Surgery at an Ambulatory Surgical Center (ASC)</td>
<td>10%</td>
</tr>
<tr>
<td>Colonoscopy (Non-preventive) at a Hospital-based facility</td>
<td>20%</td>
</tr>
<tr>
<td>Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Temporomandibular joint (TMJ) service</td>
<td>50%</td>
</tr>
<tr>
<td>(Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)</td>
<td></td>
</tr>
<tr>
<td>Outpatient rehabilitative services: physical, occupational, and speech therapy</td>
<td>20%</td>
</tr>
<tr>
<td>(Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)</td>
<td></td>
</tr>
<tr>
<td>Outpatient habilitative services: physical, occupational and speech therapy</td>
<td>20%</td>
</tr>
<tr>
<td>(Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)</td>
<td></td>
</tr>
<tr>
<td>Cardiac rehabilitation</td>
<td>20%</td>
</tr>
<tr>
<td>(First 16 visits covered in full, then coinsurance)</td>
<td></td>
</tr>
</tbody>
</table>

#### Maternity Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prenatal office visits</td>
<td>Covered in full</td>
</tr>
<tr>
<td>Delivery and postnatal services</td>
<td>$100 / delivery</td>
</tr>
<tr>
<td>Inpatient hospital/facility services</td>
<td>20%</td>
</tr>
<tr>
<td>Routine newborn nursery care</td>
<td></td>
</tr>
</tbody>
</table>

#### Medical Equipment, Supplies and Devices

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical equipment, appliances, prosthetics/orthotics and supplies</td>
<td>20%</td>
</tr>
<tr>
<td>(Hearing aids limited to 1 per ear every 3 calendar years)</td>
<td></td>
</tr>
<tr>
<td>Diabetes supplies (such as lancets, test strips and needles)</td>
<td>20%</td>
</tr>
<tr>
<td>Removable custom shoe orthotics (Limited to $200 per calendar year)</td>
<td>20%</td>
</tr>
<tr>
<td>Oral Sleep Apnea Appliance</td>
<td>20%</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</th>
<th>Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Inpatient and residential services</td>
<td>20%</td>
</tr>
<tr>
<td>Day treatment, intensive outpatient and partial hospitalization services</td>
<td>20%</td>
</tr>
<tr>
<td>Applied behavior analysis</td>
<td>20%</td>
</tr>
<tr>
<td>Outpatient provider office visits</td>
<td>$10 / visit</td>
</tr>
</tbody>
</table>

#### Home Health and Hospice

<table>
<thead>
<tr>
<th>Service</th>
<th>Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td>20%</td>
</tr>
<tr>
<td>Hospice care</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

#### Routine Vision Exam

Provided by VSP

VSP Choice Network (for Customer Service call 800-877-7195)

Your copays do not apply to your plan’s medical out-of-pocket maximums

- Pediatric WellVision Exam® (under age 19) - Every 12 months
- Adult WellVision Exam® - Every 12 months

- In-Network: Covered in full
- Out-of-Network: Covered up to $45
- In-Network: $10
- Out-of-Network: Covered up to $45

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PGC-OR 0120 LG PE
Oregon - Large Group

PER-921
PE 10/20/600/20/250/2X/SIG
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: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: www.ProvidenceHealthPlan.com/contactus
**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](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)

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

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您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 (телетайп: 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 можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 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。

ملحوظة: إذا كنت تتحدث اللغة، فإن خدمات المساعدة اللغوية تتوفر لك بالمجان. اتصل برقم 4445-800-1-878 (TTY: 711).

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

XIYYEEFFANNA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).


دویریجک: شما ییبرای داگاره بیصورت وزبان لاتیتسی نیییدیکن می گنگوی یفارس زبان یهاگر تویچ

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