Your Benefit Summary
Traditional Option Plan

PROVIDENCE Health Plan

What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
20% coinsurance	$2,750 per person $5,500 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.

- 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.
- Some services must be prior authorized by us or a penalty will apply. See your Member Handbook for a list of these services.
- Benefits are provided based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Traditional Option Plan Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services:
✓ No deductible needs to be met prior to receiving this benefit.	Copay or coinsurance
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	15%
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	20%
• 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.)	20%
• Office visits to Specialists/Other Providers	30%
• 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, all services subject to inpatient benefits.)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Emergency medical transportation (air and/or ground)	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%

Traditional 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) services (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	20%
• 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, deductible waived)	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	20%
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.

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-network
Refers to health care professionals who do not participate in Providence Health Plan's network of participating physicians and providers of health care services.

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. You are responsible for obtaining prior authorization.

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.

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