

# Your Benefit Summary

## Choice Plan



Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
\$25	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	\$7,150 per person \$14,300 per family (2 or more)	\$14,300 per person \$28,600 per family (2 or more)	\$3,000 per person \$6,000 per family (2 or more)	\$6,000 per person \$12,000 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).

- Once you have registered, you can select your medical home online or by calling customer service.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network deductibles and out-of-pocket maximums accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Choice network and obtain referrals from your medical home. View a list of in-network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- If you choose to go outside the Choice network or do not obtain a referral, use providers who have contracted rates with Providence Health Plan. This ensures that you will not be subject to billing for charges that are above contracted rates. When seeing providers who are not contracted with Providence Health Plan, benefits for out-of-network services are based on Usual, Customary and Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Choice Benefit Highlights	After you pay your calendar year deductible(s), then you pay the following for covered services	
	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
<ul style="list-style-type: none"> <li>✓ No deductible needs to be met prior to receiving this service</li> </ul>		
<b>Preventive Care</b>		
<ul style="list-style-type: none"> <li>• Periodic health exams and well-baby care</li> <li>• Routine immunizations and 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>	Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓	50% 50% 50% 50% 50% Not covered
<b>Physician / Provider Services</b>		
<ul style="list-style-type: none"> <li>• Office visits to Personal Physician/Provider</li> <li>• Office visits to specialist</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>• Phone and video visits to Personal Physician/Provider</li> <li>• Phone and video visits to specialists</li> <li>• Allergy shots, serums, infusions, and injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul>	\$25/visit ✓ \$50/visit ✓ \$25/visit ✓ Covered in full ✓ \$35/visit ✓ 30% 30% 30%	50% 50% 50% Not covered Not covered 50% 50% 50%
<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> </ul>	30% ✓ 30%	50% 50%
<b>Emergency and Urgent Services</b>		
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only. If admitted to hospital, 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>	\$250 \$50/visit ✓ 30%	\$250 50% 30%

Choice Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
<b>Hospital Services</b>		
• Inpatient/Observation care	30%	50%
• Rehabilitative care (limited to 30 days per calendar year)	30%	50%
• Skilled nursing facility (limited to 60 days per calendar year)	30%	50%
<b>Outpatient Services</b>		
• Outpatient surgery, dialysis, chemotherapy, radiation therapy	30%	50%
• Colonoscopy (non-preventive)	30%	50%
• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services; physical, occupational or speech therapy (limited to 30 visits per calendar year)	30%	50%
<b>Maternity Services</b>		
• Prenatal office visits	Covered in full✓	50%
• Delivery and postnatal services	30%	50%
• Inpatient hospital/facility services	30%	50%
• Routine newborn nursery care	30%	50%
<b>Medical Equipment, Supplies and Devices</b>		
• Medical equipment, appliances and supplies	30%	50%
• Diabetes supplies (lancets, test strips and needles)	30%✓	50%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)	30%	50%
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	30%	50%
• Day treatment, intensive outpatient, and partial hospitalization services	30%	50%
• Applied behavior analysis	30%	50%
• Outpatient provider office visits	\$25/visit✓	50%
<b>Home Health and Hospice</b>		
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓
<b>Additional Cost Tier (Inpatient or Outpatient)</b> (Additional cost tier does not apply to services related to cancer diagnosis/treatment or tissue injuries resulting from an external force which require immediate repair. Prior authorization is required. These copayments/coinsurance apply to provider services only. Your Out-of-Network copayment does not apply to your Out-of-Network Out-of-Pocket Maximum.)		
• Knee arthroscopy	\$500 then 30%	\$500 then 50%
• Knee, hip replacement	\$500 then 30%	\$500 then 50%
• Knee, hip resurfacing	\$500 then 30%	\$500 then 50%
• Shoulder arthroscopy	\$500 then 30%	\$500 then 50%
• Sinus surgery	\$100 then 30%	\$100 then 50%
• Sleep studies	\$100 then 30%	\$100 then 50%
• Spinal injections for pain	\$100 then 30%	\$100 then 50%
• Spine procedures	\$500 then 30%	\$500 then 50%
• Upper GI endoscopy	\$100 then 30%	\$100 then 50%

## 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.

### **Medical Home**

A full service health care clinic which has been designated as a Medical Home providing and coordinating members' medical care.

### **Medical Home referral**

A referral from your Medical Home to receive services from an in-network provider that is not part of your medical home.

### **Out-of-network**

Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### **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.

### **Personal physician/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. In-network, your provider will request prior authorization. Out-of-network, 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.

### **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)

## 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>, 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)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Information

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 розмовляєте 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 اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711).

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

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់ប្រើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

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

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

دیوری بگ. شما یرا گان یرا بصورت یر زبان لات یر تسه، دی کن یم گفتگ و یر فارس زبان به اگر: توجه  
ف یم باشد. یا (TTY: 711) 1-800-878-4445 تماس

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

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)