Your Benefit Summary

Open Option Plan

Сорау	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
\$25	20%	40%	\$2,000 per person	\$1,000 per person
	coinsurance	coinsurance	\$4,000 per family	\$2,000 per family
	(after deductible)	(after deductible; UCR applies)	(2 or more)	(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(s) are included in the out-of-pocket maximum amount(s) listed above.

- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- 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 Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Open Option Plan Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
\checkmark No deductible needs to be met prior to receiving this benefit.	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)
Preventive Care • Periodic health exams; well-baby care • Routine immunizations; shots • Colonoscopy (age 50 +) • Gynecological exams (calendar year) and Pap tests • Mammograms	Covered in full Covered in full Covered in full Covered in full Covered in full	40% 40% 40% 40% 40%
 Tobacco cessation, counseling/classes and deterrent medications 	Covered in full	Not covered
 Physician / Provider Services Office visits Office visits to alternative care providers (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.) 	\$25 / visit \$25 / visit	40%* 40%*
 Phone and video visits Allergy shots, serums, infusions and injectable medications Inpatient hospital visits Surgery; anesthesia 	Covered in full 20% 20% 20%	Not covered 40% 40% 40%
Diagnostic Services • X-ray; lab services • High-tech Imaging services (such as PET, CT, MRI) • Sleep studies	20% ⁴ 20% ⁴ 20% ⁴	40% 40% 40%
 Emergency and Urgent Services Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits) 	\$250*	\$2501
 Urgent care services (for non-life threatening illness/minor injury) 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) 	\$25 / visit * 20%	40% √ 20%
Hospital Services • Inpatient/Observation care • Rehabilitative care (limited to 30 days per calendar year) • Skilled nursing facility (limited to 60 days per calendar year)	20% 20% 20%	40% 40% 40%

PROVIDENCE

Health Plan

Open Option Plan Benefit Highlights (continued)		In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Dutpatient Services			
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation	n therapy	20%	40%
Colonoscopy (non-preventive)	.,	20%	40%
• Temporomandibular joint (TMJ) service		50%	Not covered
(limited to \$1,000 per calendar year / \$5,000 per lifetime)			
• Outpatient rehabilitative services: physical, occupational or spe	eech	20%	40%
therapy (limited to 30 visits per calendar year)			
Maternity Services			
Prenatal office visits		Covered in full	40%
 Delivery and postnatal services 		\$250 / delivery	40%
 Inpatient hospital/facility services 		20%	40%
Routine newborn nursery care		20%	40%
Aedical Equipment, Supplies and Devices			
Medical equipment, appliances and supplies		20%	40%
 Diabetes supplies (lancets, test strips and needles) 		20%	40%
 Prosthetic and orthotic devices (removable custom shoe orthotics are line) 	limited to	20%	40%
 Prostrictic and orthotic devices (enlovable custom shoe orthotics are \$200 per calendar year, deductible waived) 	innited to	2078	40 /8
Mental Health / Chemical Dependency			
Fo initiate services, you must call 800-711-4577. All services, except outpatient pr	rovider visits		
nust be prior authorized.)			
 Inpatient and residential services 		20%	40%
• Day treatment, intensive outpatient, and partial hospitalization	n services	20%	40%
Applied behavior analysis		20%	40%
• Outpatient provider office visits		\$25 / visit	40%
Iome Health and Hospice			
Home health care		20%	40%
Hospice care		Covered in full	Covered in full
•			
Your guide to the words or phrases used to explai	-		
Coinsurance he percentage of the cost that you may need to pay for a covered	In-Network	(
	D . f +		
		ervices received from an exten	
ervice.	physicians,	ervices received from an exten health care providers and fac	ilities contracted by Providenc
ervice. common deductible	physicians, Health Plar	ervices received from an exten health care providers and fac n for your specific plan. Gener	ilities contracted by Providenc ally, your out-of-pocket costs
ervice. Common deductible he dollar amount that an individual or family pays for covered services	physicians, Health Plar will be less	ervices received from an exten health care providers and fac	ilities contracted by Providenc ally, your out-of-pocket costs
ervice. Common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The	physicians, Health Plar will be less providers.	ervices received from an exten health care providers and fac n for your specific plan. Gener when you receive covered ser	ilities contracted by Providenc ally, your out-of-pocket costs
ervice. Common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers,	physicians, Health Plar will be less providers. Limitations	ervices received from an exten health care providers and fac n for your specific plan. Gener when you receive covered ser and Exclusions	ilities contracted by Providenc ally, your out-of-pocket costs vices from in-network
ervice. Common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an	physicians, Health Plar will be less providers. Limitations All covered	ervices received from an exten health care providers and fac of for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions
ervice. Common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an adividual or family deductible:	physicians, Health Plar will be less providers. Limitations All covered specified fo	ervices received from an exten health care providers and fac of for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions
ervice. common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an individual or family deductible: • Services not covered by your plan	physicians, Health Plar will be less providers. Limitations All covered specified for a complete	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim pr your plan. Refer to your me e list.	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions
ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an ndividual or family deductible: • Services not covered by your plan • Fees that exceed usual, customary and reasonable (UCR) charges as	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me list. hysician/provider ohysician or practitioner that can p	ilities contracted by Providence ally, your out-of-pocket costs rvices from in-network nitations and exclusions mber handbook or contract for provide most of your care and,
ervice. Common deductible the dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an addividual or family deductible: • Services not covered by your plan • Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified for when neces	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth	ilities contracted by Providence ally, your out-of-pocket costs rvices from in-network nitations and exclusions mber handbook or contract for provide most of your care and,
ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an ndividual or family deductible: • Services not covered by your plan • Fees that exceed usual, customary and reasonable (UCR) charges as	physicians, Health Plar will be less providers. Limitations All covered specified fr a complete Personal pl A qualified p when neces cost-effectiv	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner.	ilities contracted by Providence ally, your out-of-pocket costs rvices from in-network nitations and exclusions mber handbook or contract for provide most of your care and,
ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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	physicians, Health Plar will be less providers. Limitations All covered specified fr a complete Personal pl A qualified j when neces cost-effectiv Out-of-net	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work	ilities contracted by Providence ally, your out-of-pocket costs rvices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, her providers in a convenient and
 ervice. formon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. 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 	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified p when neces cost-effectiv Out-of-net Refers to sei	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered ser and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-net	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ier providers in a convenient and work provider. Your out-of-pocke
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum 	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified y when neces cost-effectiv Out-of-net Refers to sei costs are ge	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth me manner. work rvices you receive from a non-network nerally higher when you receive of	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract f provide most of your care and, er providers in a convenient and work provider. Your out-of-pocket overed services from
 ervice. ommon deductible ne dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an dividual 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 ommon out-of-pocket maximum ne limit on the dollar amount you will have to spend for specified	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified y when neces cost-effectiv Out-of-net Refers to sei costs are ge non-particip	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive co tating providers. To find a particip.	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract f provide most of your care and, er providers in a convenient and work provider. Your out-of-pocket overed services from ating provider, go to
 ervice. ommon deductible ne dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an dividual 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 ommon out-of-pocket maximum ne limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network 	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified y when neces cost-effectiv Out-of-net Refers to sei costs are ge non-particip	ervices received from an exten health care providers and fac on for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive co tating providers. To find a particip lenceHealthPlan.com/providerdire	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract f provide most of your care and, er providers in a convenient and work provider. Your out-of-pocket overed services from ating provider, go to
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to 	physicians, Health Plar will be less providers. Limitations All covered specified fa a complete Personal pl A qualified y when neces cost-effectiv Out-of-net Refers to see costs are ge non-particip www.Provic Prior autho	ervices received from an exten health care providers and fac on for your specific plan. Gener when you receive covered set and Exclusions diservices are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive of bating providers. To find a particip lenceHealthPlan.com/providerdire orization ces must be pre-approved. In-	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ier providers in a convenient and work provider. Your out-of-pocket overed services from ating provider, go to ctory. network, your provider will
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to be common out-of-pocket maximum. See your Member Handbook for 	physicians, Health Plar will be less providers. Limitations All covered specified fa a complete Personal pl A qualified y when neces cost-effectiv Out-of-net Refers to sei costs are ge non-particip www.Provic Prior autho Some servi request pri	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive of bating providers. To find a particip lenceHealthPlan.com/providerdire orization ces must be pre-approved. In- or authorization. Out-of-netwo	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ier providers in a convenient and work provider. Your out-of-pocket overed services from ating provider, go to ctory. network, your provider will
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to he common out-of-pocket maximum. See your Member Handbook for etails. 	physicians, Health Plar will be less providers. Limitations All covered specified fa a complete Personal pl A qualified p when neces cost-effectiv Out-of-net Refers to set costs are ge non-particip www.Provic Prior autho Some servir request prio obtaining	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive of bating providers. To find a particip lenceHealthPlan.com/providerdire- orization ces must be pre-approved. In- or authorization. Out-of-netwo prior authorization.	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, er providers in a convenient and work provider. Your out-of-pocke overed services from ating provider, go to ctory. network, your provider will
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for etails. 	physicians, Health Plar will be less providers. Limitations All covered specified fa a complete Personal pl A qualified y when neces cost-effectiv Out-of-net Refers to sel costs are ge non-particip www.Provic Prior autho Some servi request prio obtaining J Usual, Cus	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive of bating providers. To find a particip, lenceHealthPlan.com/providerdire- orization ces must be pre-approved. In- or authorization. Out-of-netwo prior authorization.	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, er providers in a convenient and work provider. Your out-of-pocke overed services from ating provider, go to ctory. network, your provider will ork, you are responsible for
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to be common out-of-pocket maximum. See your Member Handbook for etails. opay he fixed dollar amount you pay to a health care provider for a covered 	physicians, Health Plar will be less providers. Limitations All covered specified fa a complete Personal pl A qualified when neces cost-effectiv Out-of-net Refers to sel costs are ge non-particip www.Provic Prior autho Some servi request prio obtaining p Usual, Cus	ervices received from an exten health care providers and fac for your specific plan. Gener when you receive covered set and Exclusions d services are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive of bating providers. To find a particip, lenceHealthPlan.com/providerdire- orization ces must be pre-approved. In- or authorization. Out-of-netwo prior authorization. tomary & Reasonable (UCR) your plan's allowed charges fo	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ler providers in a convenient and work provider. Your out-of-pocke overed services from ating provider, go to ctory. network, your provider will ork, you are responsible for r services that you receive fro
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to be common out-of-pocket maximum. See your Member Handbook for etails. opay he fixed dollar amount you pay to a health care provider for a covered ervice at the time care is provided. 	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified J when neces cost-effectiv Out-of-net Refers to sel costs are ge non-particip www.Provic Prior autho Some servi request pri obtaining J Usual, Cus Describes y an out-of-I	ervices received from an exten health care providers and fac on for your specific plan. Gener when you receive covered set and Exclusions diservices are subject to the lim or your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work rvices you receive from a non-network nerally higher when you receive of the manner. work	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ler providers in a convenient and work provider. Your out-of-pocket overed services from ating provider, go to ctory. network, your provider will ork, you are responsible for r services that you receive fro ost of out-of-network services
 ervice. Common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. 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 Common out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to ne common out-of-pocket maximum. See your Member Handbook for etails. Copay he fixed dollar amount you pay to a health care provider for a covered ervice at the time care is provided. 	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified J when neces cost-effectiv Out-of-net Refers to sel costs are ge non-particip www.Provic Prior autho Some servi request pri obtaining J Usual, Cus Describes y an out-of-f	ervices received from an exten health care providers and fac on for your specific plan. Gener when you receive covered set and Exclusions diservices are subject to the lim for your plan. Refer to your me e list. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth re manner. work rvices you receive from a non-network nerally higher when you receive of taing providers. To find a particip, lenceHealthPlan.com/providerdire- orization ces must be pre-approved. In- or authorization. Out-of-network prior authorization. tomary & Reasonable (UCR) your plan's allowed charges for network provider. When the c CR amounts, you are responsil	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ler providers in a convenient and work provider. Your out-of-pocke overed services from ating provider, go to ctory. network, your provider will ork, you are responsible for r services that you receive fro ost of out-of-network services ole for paying the provider and
 ervice. Common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. 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 Common out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to ne common out-of-pocket maximum. See your Member Handbook for etails. Copay he fixed dollar amount you pay to a health care provider for a covered ervice at the time care is provided. ormulary formulary is a list of FDA-approved prescription drugs developed by 	physicians, Health Plar will be less providers. Limitations All covered specified fr a complete Personal pl A qualified J when neces cost-effectiv Out-of-net Refers to set costs are ge non-particip www.Provid Prior autho Some servi request pri obtaining J Usual, Cus Describes y an out-of-fer exceeds UC difference.	ervices received from an exten health care providers and fac of for your specific plan. Gener when you receive covered services and Exclusions diservices are subject to the lim for your plan. Refer to your me elist. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth remanner. work rvices you receive from a non-network nerally higher when you receive co taing providers. To find a particip. lenceHealthPlan.com/providerdirecor prization ces must be pre-approved. In- or authorization. Out-of-network prior authorization. tomary & Reasonable (UCR) your plan's allowed charges for network provider. When the c CR amounts, you are responsil These amounts do not apply	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ler providers in a convenient and work provider. Your out-of-pocke overed services from ating provider, go to ctory. network, your provider will ork, you are responsible for r services that you receive from ost of out-of-network services one for paying the provider any
 ervice. Common deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. 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 Common out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to be common out-of-pocket maximum. See your Member Handbook for etails. Copay he fixed dollar amount you pay to a health care provider for a covered ervice at the time care is provided. ormulary formulary is a list of FDA-approved prescription drugs developed by hysicians and pharmacists, designed to offer drug treatment choices 	physicians, Health Plar will be less providers. Limitations All covered specified for a complete Personal pl A qualified J when neces cost-effectiv Out-of-net Refers to sel costs are ge non-particip www.Provic Prior autho Some servi request pri obtaining J Usual, Cus Describes y an out-of-f	ervices received from an exten health care providers and fac of for your specific plan. Gener when you receive covered services and Exclusions diservices are subject to the lim for your plan. Refer to your me elist. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth remanner. work rvices you receive from a non-network nerally higher when you receive co taing providers. To find a particip. lenceHealthPlan.com/providerdirecor prization ces must be pre-approved. In- or authorization. Out-of-network prior authorization. tomary & Reasonable (UCR) your plan's allowed charges for network provider. When the c CR amounts, you are responsil These amounts do not apply	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ler providers in a convenient and work provider. Your out-of-pocket overed services from ating provider, go to ctory. network, your provider will ork, you are responsible for r services that you receive from ost of out-of-network services ple for paying the provider any
 ervice. ommon deductible he dollar amount that an individual or family pays for covered services efore your plan pays any benefits within a calendar year. The eductible can be met by using in-network or out-of-network providers, r the combination of both. The following expenses do not apply to an idividual 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 ommon out-of-pocket maximum he limit on the dollar amount you will have to spend for specified overed health services (a combination of both in- and out-of-network ervices) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for etails. opay he fixed dollar amount you pay to a health care provider for a covered ervice at the time care is provided. ormulary formulary is a list of FDA-approved prescription drugs developed by 	physicians, Health Plar will be less providers. Limitations All covered specified fr a complete Personal pl A qualified J when neces cost-effectiv Out-of-net Refers to set costs are ge non-particip www.Provid Prior autho Some servi request pri obtaining J Usual, Cus Describes y an out-of-fer exceeds UC difference.	ervices received from an exten health care providers and fac of for your specific plan. Gener when you receive covered services and Exclusions diservices are subject to the lim for your plan. Refer to your me elist. hysician/provider ohysician or practitioner that can p sary, will coordinate care with oth remanner. work rvices you receive from a non-network nerally higher when you receive co taing providers. To find a particip. lenceHealthPlan.com/providerdirecor prization ces must be pre-approved. In- or authorization. Out-of-network prior authorization. tomary & Reasonable (UCR) your plan's allowed charges for network provider. When the c CR amounts, you are responsil These amounts do not apply	ilities contracted by Providence ally, your out-of-pocket costs vices from in-network nitations and exclusions mber handbook or contract for provide most of your care and, ler providers in a convenient and work provider. Your out-of-pocke overed services from ating provider, go to ctory. network, your provider will ork, you are responsible for r services that you receive from ost of out-of-network services one for paying the provider any

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: <u>www.ProvidenceHealthPlan.com/contactus</u>