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	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$4,000 per person $8,000 per family (2 or more)	$8,000 per person $16,000 per family (2 or more)	$1,500 per person $3,000 per family (2 or more)	$3,000 per person $6,000 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.

- 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.
- 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

✓ No deductible needs to be met prior to receiving this service	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)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%
• Routine immunizations and shots	Covered in full✓	40%
• Colonoscopy (age 50+)	Covered in full✓	40%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	40%
• Mammograms	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Personal Physician/Provider	$25 / visit✓	40%
• Office visits to specialist	$50 / visit✓	40%
• 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.)	$25 / visit✓	40%
• Phone and video visits to Personal Physician/Provider	Covered in full✓	Not covered
• Phone and video visits to specialists	$35 / visit✓	Not covered
• Allergy shots, serums, infusions, and injectable medications	20%	40%
• Inpatient hospital visits	20%	40%
• Surgery; anesthesia	20%	40%
Diagnostic Services		
• X-ray and lab services	20%✓	40%
• High-tech imaging services (such as PET, CT or MRI)	20%	40%
Emergency and Urgent Services		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	$250	$250
• Urgent care services (for non-life threatening illness/minor injury)	$50 / visit✓	40%
• 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)	20%	20%

Choice Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (limited to 30 days per calendar year)	20%	40%
• Skilled nursing facility (limited to 60 days per calendar year)	20%	40%
Outpatient Services		
• Outpatient surgery, dialysis, chemotherapy, radiation therapy	20%	40%
• Colonoscopy (non-preventive)	20%	40%
• 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)	20%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	20%	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%	40%
Medical 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 limited to $200 per calendar year, deductible waived)	20%	40%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	40%
• Outpatient provider office visits	$25 / visit✓	40%
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full✓	Covered in full✓
Additional Cost Tier (Inpatient or Outpatient) (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 20%	$500 then 40%
• Knee, hip replacement	$500 then 20%	$500 then 40%
• Knee, hip resurfacing	$500 then 20%	$500 then 40%
• Shoulder arthroscopy	$500 then 20%	$500 then 40%
• Sinus surgery	$100 then 20%	$100 then 40%
• Sleep studies	$100 then 20%	$100 then 40%
• Spinal injections for pain	$100 then 20%	$100 then 40%
• Spine procedures	$500 then 20%	$500 then 40%
• Upper GI endoscopy	$100 then 20%	$100 then 40%

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 you 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.

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