Your Benefit Summary

Choice Plan



Copay

\$20

What You Pay In-Network

30% coinsurance (after deductible) What You Pay Out-of-Network

50% coinsurance (after deductible; UCR applies) Calendar Year In-Network Out-of-Pocket Maximum

\$7,350 per person \$14,700 per family (2 or more) Calendar Year Out-of-Network Out-of-Pocket Maximum

\$14,700 per person \$29,400 per family (2 or more) Calendar Year In-Network Deductible

\$1,500 per person \$3,000 per family (2 or more) Calendar Year Out-of-Network Deductible

\$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	After you pay your calendar year deductible(s), then you pay the following for covered services	
✓ No deductible needs to be met prior to receiving this service	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)
 On-Demand Provider Visits Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits Providence ExpressCare Retail Health Clinic 	Covered in full	Not covered Not applicable
Virtual visits to a Specialist by phone & video	\$25 / visit	Not covered
 Preventive Care Periodic health exams and well-baby care Routine immunizations; shots Colonoscopy (age 50+) Gynecological exams (calendar year) and Pap tests Mammograms Tobacco cessation, counseling/classes and deterrent medications 	Covered in full	50% 50% 50% 50% 50% Not covered
 Physician / Provider Services Office visits to Primary Care Provider 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.) Office visits to Specialists/Other Providers Allergy shots and serums Infusions and injectable medications Surgery; anesthesia in an office or facility Inpatient hospital visits 	\$20 / visit*/ \$20 / visit*/ \$40 / visit*/ 30%*/ 30% 30% 30%	50% 50% 50% 50% 50% 50%
Diagnostic Services X-ray and lab services High-tech imaging services (such as PET, CT or MRI) Sleep studies	30%' 30%' 30%'	50% 50% 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 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.

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. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

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.

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.

Virtual visit

Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

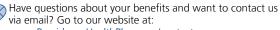
Web-direct Visit

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: 711



www.ProvidenceHealthPlan.com/contactus