Your Benefit Summary

Choice Plan

PROVIDENCE Health 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)	$7,350 per person $14,700 per family (2 or more)	$14,700 per person $29,400 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.

- 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	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	$35 / visit✓	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	50%
• Routine immunizations; shots	Covered in full✓	50%
• Colonoscopy (age 50+)	Covered in full✓	50%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	50%
• Mammograms	Covered in full✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	$25 / visit✓	50%
• 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✓	50%
• Office visits to Specialists/Other Providers	$50 / visit✓	50%
• Allergy shots and serums	30%✓	50%
• Infusions and injectable medications	30%	50%
• Surgery; anesthesia in an office or facility	30%	50%
• Inpatient hospital visits	30%	50%
Diagnostic Services		
• X-ray and lab services	30%✓	50%
• High-tech imaging services (such as PET, CT or MRI)	30%	50%
• Sleep studies	30%✓	50%

Choice Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$250	$250
• Urgent care services (for non-life threatening illness/minor injury)	$50 / visit✓	50%
• 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)	30%	30%
Hospital Services		
• Inpatient/Observation care	30%	50%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	30%	50%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	30%	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	30%	50%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	30%	50%
• Colonoscopy (non-preventive)	30%	50%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)	30%✓	50%
• Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)	30%	50%
• Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	30%	50%
Maternity Services		
• 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%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	30%	50%
• Diabetes supplies (such as 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%	30%
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	30%	50%
• Day treatment, intensive outpatient and partial hospitalization services	30%✓	50%
• Applied behavior analysis	30%✓	50%
• Outpatient provider office visits	$25 / visit✓	50%
Home Health and Hospice		
• Home health care	30%	50%
• 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 calendar year 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%
• 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 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

Have questions about your benefits and want to contact us via email? Go to our website at:
www.ProvidenceHealthPlan.com/contactus