Your Benefit Summary
Open Option Plan

<table>
<thead>
<tr>
<th>Copay</th>
<th>What You Pay In-Network</th>
<th>What You Pay Out-of-Network</th>
<th>Calendar Year Common Out-of-Pocket Maximum</th>
<th>Calendar Year Common Deductible</th>
</tr>
</thead>
<tbody>
<tr>
<td>$15</td>
<td>20% coinsurance (after deductible)</td>
<td>40% coinsurance (after deductible; UCR applies)</td>
<td>$4,000 per person</td>
<td>$2,000 per person</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>$8,000 per family (2 or more)</td>
<td>$4,000 per family (2 or more)</td>
</tr>
</tbody>
</table>

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

No deductible needs to be met prior to receiving this benefit.

Preventive Care
- Periodic health exams; well-baby care
- Routine immunizations; shots
- Colonoscopy (age 50+)
- Gynecological exams (calendar year) and Pap tests
- Mammograms
- Tobacco cessation, counseling/classes and deterrent medications

Physician / Provider Services
- Office visits
  - $15 / visit
  - 40%
- 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.)
  - $15 / visit
  - 40%
- Phone and video visits
  - (including Providence Health eXpress®)
  - $5 / 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; lab services
  - 20%
  - 40%
- High-tech Imaging services (such as PET, CT, MRI)
  - 20%
  - 40%
- Sleep studies
  - 20%
  - 40%

Emergency and Urgent Services
- Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)
  - $250
  - $250
- Urgent care services (for non-life threatening illness/minor injury)
  - $15 / visit
  - 40%
- Emergency medical transportation (air and/or ground)
  - 20%
  - 20%

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%
### Open Option Plan Benefit Highlights (continued)

<table>
<thead>
<tr>
<th>Service Type</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Colonoscopy (non-preventive)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Temporomandibular joint (TMJ) service</td>
<td>50%</td>
<td>Not covered</td>
</tr>
<tr>
<td>(limited to $1,000 per calendar year / $5,000 per lifetime)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)</td>
<td>20%</td>
<td>40%</td>
</tr>
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<tr>
<td><strong>Maternity Services</strong></td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td>• Prenatal office visits</td>
<td>$150 / delivery</td>
<td>40%</td>
</tr>
<tr>
<td>• Delivery and postnatal services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Inpatient hospital/facility services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Routine newborn nursery care</td>
<td></td>
<td></td>
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<tr>
<td><strong>Medical Equipment, Supplies and Devices</strong></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Medical equipment, appliances and supplies</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Diabetes supplies (lancets, test strips and needles)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)</td>
<td>20%</td>
<td>40%</td>
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<tr>
<td><strong>Mental Health / Chemical Dependency</strong></td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>(To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Inpatient and residential services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Day treatment, intensive outpatient, and partial hospitalization services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Applied behavior analysis</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Outpatient provider office visits</td>
<td>$15 / visit</td>
<td>40%</td>
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<tr>
<td><strong>Home Health and Hospice</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Home health care</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td>• Hospice care</td>
<td>Covered in full</td>
<td>Covered in full</td>
</tr>
</tbody>
</table>

### 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.

**Common deductible**
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or 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**
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-network services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

**Copay**
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

**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.

**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.

**Out-of-network**
Refers to services you receive from a non-network provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

**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. These amounts do not apply to your out-of-pocket maximums.