Your Benefit Summary

Option Advantage Base

Bend Chamber of Commerce - Base 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 Common Deductible
$25/$50	20% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$6,000 per person $12,000 per family (2 or more)	$6,000 per person $12,000 per family (2 or more)	$1,000 per person $2,000 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 myprovidence.com.

- The individual deductible applies if there are no dependents enrolled. If two or more members are enrolled, the individual deductible applies for each member only until the family deductible is met.
- The individual out-of-pocket maximum applies if there are no dependents enrolled. If two or more members are enrolled, the individual out-of-pocket applies for each member only until the family out-of-pocket is met.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Accident Benefit: The first $1,000 of covered services within 90 days of an accident is covered up to the maximum benefit available and not subject to the deductible. The date of injury must occur after the member is enrolled in this plan. If date of injury occurred prior to being enrolled on this plan, the benefit will not apply. The balance is covered as shown below. See your member handbook for further details.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network plus OHSU. View a list of In-Network Providers and pharmacies at ProvidenceHealthPlan.com/findaprovider
- 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.
- Learn more about covered preventive services rated "A" or "B" by the U.S. Preventive Services Task Force at ProvidenceHealthPlan.com/PreventiveCare .

Option Advantage Base Benefit Highlights ✓ No deductible needs to be met prior to receiving this benefit.	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)
On-Demand Provider Visits		
• Providence ExpressCare Virtual	Covered in full ✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full ✓	Not applicable
Preventive Care		
• Periodic health exams and well-baby care	Covered in full ✓	50%
• Routine immunizations; shots	Covered in full ✓	50%
• Colonoscopy (Age 45+)	Covered in full ✓	50%
• Gynecological exam (calendar year) and PAP test	Covered in full ✓	50%
• Mammograms	Covered in full ✓	50%
• Nutritional counseling	Covered in full ✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not covered
• Diabetes self management education	Covered in full ✓	Covered in full ✓

Option Advantage Base Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Physician / Provider Services		
• Office visits to Primary Care Provider or Naturopath (In-person) (First 3 in-network in-person and virtual visits: covered in full, deductible waived, then copay.)	$25 / visit ✓	50%
• Office visits to Primary Care Provider or Naturopath (Virtually) (First 3 in-network in-person and virtual visits: covered in full, deductible waived.)	Covered in full ✓	50%
• Office visits to Specialists/other providers (In-person & Virtually)	$50 / visit	50%
• Office visits to an Alternative Care provider (In-person and Virtually)	$25 / visit ✓	50%
• Chiropractic Manipulations (limited to 20 visits per calendar year)	$25 / visit	$25 / visit
• Acupuncture (limited to 12 visits per calendar year)	$25 / visit	$25 / visit
• Allergy shots and serums	$5	50%
• Infusions and injectable medications	20%	50%
• Surgery; anesthesia in an office or facility	20%	50%
• Inpatient hospital visits	20%	50%
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	20%	50%
• High-tech Imaging services (such as PET, CT, MRI)	20%	50%
• Diagnostic and supplemental breast exam	Covered in full ✓	50%
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 + 20%	$250 + 20%
• 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)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	50%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health or Substance Use Disorder Services.)	20%	50%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health or Substance Use Disorder Services.)	20%	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	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, osteopathic manipulation, pain management (multi-disciplinary) program	20%	50%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	10%	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
• Colonoscopy (Non-preventive) at a Hospital-based facility	20%	50%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	10%	50%
• Outpatient rehabilitative physical therapy, occupational, and speech therapy. (Limited to 30 visits per calendar year. Limits do not apply to Mental Health/Substance Use Disorder Services.)	20%	50%
• Outpatient habilitative physical therapy, occupational, and speech therapy. (Limited to 30 visits per calendar year. Limits do not apply to Mental Health/Substance Use Disorder Services.)	20%	50%
• Cardiac rehabilitation (In-network, first 16 visits covered in full, deductible waived, then deductible and coinsurance)	20%	50%
• Biofeedback for specified diagnosis (limited to 10 visits per lifetime, limits do not apply to Mental Health/Substance Use Disorder Services)	20%	50%
• Vision therapy (convergence insufficiency) (Limited to 12 visits per lifetime)	20%	50%
Maternity Services		
• Prenatal office visits	Covered in full ✓	50%
• Delivery and postnatal services	20%	50%
• Inpatient hospital/facility services	20%	50%
• Routine newborn nursery care	20%	50%

Option Advantage Base Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies	20%	50%
• Hearing aids (One per ear per every three calendar years)	20%✓	50%
• Diabetes supplies (Such as lancets, test strips, needles, blood and continuous glucose monitors)	20%✓	50%
• Removable custom shoe orthotics	20%✓	50%✓
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	20%	50%
Mental Health / Substance Use Disorder		
Services except outpatient provider office visits may require prior authorization.		
• Inpatient and residential services	20%	50%
• Day treatment, intensive outpatient and partial hospitalization services	20%	50%
• Applied behavior analysis	20%	50%
• Outpatient provider office visits (In-person) (First 3 in-network virtual and in-person visits: covered in full, deductible waived, then copay.)	$25 / visit✓	50%
• Outpatient provider office visits (Virtually) (First 3 in-network virtual and in-person visits: covered in full, deductible waived.)	Covered in full✓	50%
Home Health and Hospice		
• Home health care	20%	50%
• Hospice care	Covered in full✓	Covered in full✓
• Respite Care (Limited to 5 consecutive days; 30 days per lifetime)	20%	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 ervices 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.

Office Visits Virtually
Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom.

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 ProvidenceHealthPlan.com/findaprovider.

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a plan year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family 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.

Providence ExpressCare 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.

Providence ExpressCare Virtual
Sevices for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-based platform through a tablet, smartphone, or computer for same day appointments.

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.

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: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY:711) for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).