Your Benefit Summary

Option Advantage Premium

Bend Chamber of Commerce - Premier 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
$10/$25	10% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$3,500 per person $7,000 per family (2 or more)	$3,500 per person $7,000 per family (2 or more)	$500 per person $1,000 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 Premium 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 benefit.	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
Physician / Provider Services		
• Office visits to Primary Care Provider (In-person)	$10 / visit✓	50%
• Office visits to Primary Care Provider or Alternative Care Provider (Virtually)	Covered in full✓	50%
• Office visits to Specialists/Other Providers (In-person & Virtually)	$25 / visit✓	50%
• Office visits to Alternative Care Provider (such as Naturopath)	$10 / visit✓	50%
• Chiropractic Manipulations (limited to 20 visits per calendar year)	$10 / visit✓	$10 / visit✓
• Acupuncture (limited to 12 visits per calendar year)	$10 / visit✓	$10 / visit✓
• Allergy shots and serums	$5✓	50%
• Infusions and injectable medications	10%	50%
• Surgery; anesthesia in an office or facility	10%	50%
• Inpatient hospital visits	10%	50%

Option Advantage Premium Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Diagnostic Services		
• X-ray, lab services, and testing services (includes ultrasound)	10%✓	50%
• High-tech imaging services (such as PET, CT or MRI)	10%	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 + 10%✓	$250 + 10%✓
• Urgent care services (for non-life threatening illness/minor injury)	$25 / 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)	10%	10%
Hospital Services		
• Inpatient/Observation care	10%	50%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	10%	50%
• Habilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	10%	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	10%	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	10%	50%
• Outpatient Surgery at an Ambulatory Surgical Center (ASC)	5%	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	10%	50%
• Colonoscopy (Non-preventive) at an Ambulatory Surgical Center (ASC)	5%	50%
• Outpatient rehabilitative services: physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services)	10%✓	50%
• Outpatient habilitative services: physical, occupational and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	10%✓	50%
• Cardiac rehabilitation (In-network, first 16 visits covered in full, deductible waived, then deductible and coinsurance)	10%	50%
• Biofeedback for specified diagnosis (limited to 10 vists per lifetime, limits do not apply to Mental Health Services)	10%	50%
• Vision therapy (convergence insufficiency) (Limited to 12 visits per lifetime)	10%✓	50%
Maternity Services		
• Prenatal office visits	Covered in full✓	50%
• Delivery and postnatal services	10%	50%
• Inpatient hospital/facility services	10%	50%
• Routine newborn nursery care	10%✓	50%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances, prosthetics/orthotics and supplies (Hearing aids limited to 1 per ear every 3 calendar years)	10%	50%
• Diabetes supplies (Such as lancets, test strips, needles, blood and continuous glucose monitors)	10%✓	50%
• Removable custom shoe orthotics (Limited to $200 per calendar year)	10%✓	50%✓
• Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	10%	50%
Mental Health / Chemical Dependency Services except outpatient provider office visits may require prior authorization.		
• Inpatient and residential services	10%	50%
• Day treatment, intensive outpatient and partial hospitalization services	10%	50%
• Applied behavior analysis	10%	50%
• Outpatient provider office visits (In-person)	$10 / visit✓	50%
• Outpatient provider office visits (Virtually)	Covered in full✓	50%
Home Health and Hospice		
• Home health care	10%	50%
• Hospice care	Covered in full✓	Covered in full✓

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.

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