Your Benefit Summary

Open Option Plan

PROVIDENCE Health Plan

copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
$15	10% coinsurance (after deductible)	20% coinsurance (after deductible; UCR applies)	$2,000 per person $4,000 per family (2 or more)	$250 per person $500 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.

- 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 EPO 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	After you pay your calendar year common deductible, 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)
Preventive Care		
• Periodic health exams; well-baby care	Covered in full✓	20%✓
• Routine immunizations; shots	Covered in full✓	20%✓
• Colonoscopy (age 50 +)	Covered in full✓	20%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	20%✓
• Mammograms	Covered in full✓	20%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits	$15 / visit✓	20%✓
• 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✓	20%✓
• Allergy shots, serums, infusions and injectable medications	10%	20%
• Inpatient hospital visits	10%	20%
• Surgery; anesthesia	10%	20%
Diagnostic Services		
• X-ray; lab services	10%✓	20%
• High-tech Imaging services (such as PET, CT, MRI)	10%✓	20%
• Sleep studies	10%✓	20%
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✓	20%✓
• Emergency medical transportation (air and/or ground)	10%	10%
Hospital Services		
• Inpatient/Observation care	10%	20%
• Rehabilitative care (30 days per calendar year)	10%	20%
• Skilled nursing facility (60 days per calendar year)	10%	20%

Open Option Plan Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Outpatient Services		
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	10%	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)	10%	20%
Maternity Services		
• Prenatal care	Covered in full✓	20%
• Delivery and postnatal services	$150 / delivery✓	20%
• Inpatient hospital/facility services	10%	20%
• Routine newborn nursery care	10%✓	20%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	10%	20%
• Diabetes supplies (lancets, test strips and needles)	10%✓	20%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	10%	20%
Mental Health and Substance Abuse (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)		
• Inpatient and residential services	10%	20%
• Day treatment, intensive outpatient, and partial hospitalization services	10%	20%
• Applied behavior analysis (limited to 25 hours per week)	10%	20%
• Outpatient provider visits	$15 / visit✓	20%✓
Home Health and Hospice		
• Home health care	10%	20%
• 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.

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 list of preferred brand-name and generic drugs that have been evaluated by us for effectiveness and safety.

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.

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.

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.

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.

Contact us

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Your Benefit Summary
Prescription Drug Plan

PROVIDENCE Health Plan

Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at www.myProvidence.com.

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.ProvidenceHealthPlan.com or call us.
- You have broad access to over 25,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	$15	$45	$15
Brand-name drug	$30	$90	$30
Compounded drug	50%	Does not apply	Does not apply

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If you or your physician request a brand-name drug when a generic is available, you will be responsible for paying the cost difference, in addition to your brand-name drug copay. This cost difference does not apply to your medical plan out-of-pocket maximum.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at www.ProvidenceHealthPlan.com.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.ProvidenceHealthPlan.com for answers to frequently asked questions about both generic drugs and the formulary.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.ProvidenceHealthPlan.com.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

What you need to know about limitations and exclusions

The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to: www.ProvidenceHealthPlan.com.

Limitations

- All drugs must be Food and Drug Administration (FDA) approved medically necessary, and require by law, a prescription to dispense. Not all FDA approved drugs are covered by Providence Health Plan. Newly approved drugs will be reviewed for safety and medical necessity within 12 months after the drug becomes available on the market for Formulary consideration.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 30-consecutive-day supply, whichever is less. Other dispensing limits may apply to certain medications requiring limited use and are listed in the formulary.
- Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through our designated Specialty Pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). Specialty drugs are listed in our Formulary.
- Self-injectible drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and referenced in the formulary.
- Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. You or your Qualified Practitioner can contact us directly to request prior authorization.

Exclusions

- Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of the common cold.
- Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment.
- Drugs or medications delivered, injected or administered for you by a physician, other provider or another trained person.
- Amphetamines and amphetamine derivatives, except when used in the treatment of narcolepsy or hyperactivity in children and adults.
- Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra® or drugs required for, or as a result of, sexual transformation.
- Drugs used for the treatment of fertility or infertility.
- Fluoride, for members over the age of 10 years old.
- Replacement of lost or stolen medication.
- Drugs used for weight loss or cosmetic purposes.
- Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Over-the-counter (OTC) drugs, medications or vitamins that may be purchased without a provider's written prescription and prescription drugs that are available in an OTC therapeutically similar form.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Drugs dispensed from pharmacies outside the United States, except for urgent and emergency medical conditions.
- Drugs or prescribed medications that are not medically necessary or are not provided according to our medical policy.
- Drugs to stimulate hair growth, including, but not limited to, Rogaine® (i.e., topical minoxidil) or other similar drug preparations.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Drugs that are not FDA approved or designated as "less than effective" by the FDA, also known as a "DESI" drug.
- Drugs placed on prescription-only status as required by state or local law.
- Compounded drugs from bulk powders that are not a component of an FDA-approved drug.
- Vaccines, immunizations and preventative medications solely for the purpose of travel.

Your guide to the words or phrases used to explain your benefits

Brand-name drug
Brand name drugs are protected by U.S. patent laws for up to 17 years, so only the pharmaceutical company that holds the patent has exclusive rights to produce and sell them.

Coinsurance
The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

Compounded drug
The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

Copay
The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

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.

Generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs. Generic drugs are only usually available after the brand-name patent expires. Some generic drugs are marketed before a patent expires. These generics may not be on the formulary or may be available at the brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

Maintenance drug
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future.

Participating pharmacies
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Prior authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information.

Self-administered chemotherapy
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Contact us

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Your Benefit Summary

Chiropractic Manipulation and Acupuncture

PROVIDENCE Health Plan

Copay
$15

Maximum Calendar Year Benefit
$1,500 per member

Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at www.myProvidence.com.

- With this benefit you have access to in-network qualified practitioners, including chiropractors and acupuncturists, for spinal manipulations and acupuncture.
- For members enrolled in a Health Savings Account (HSA) plan, your deductible applies to these benefits and your copayment or coinsurance applies to your plan out-of-pocket maximum. For members on all other plans, your medical plan deductible does not apply to these benefits, and copayment or coinsurance does not apply to your medical plan out-of-pocket maximum.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your chiropractic and acupuncture benefits

This plan covers chiropractic manipulations and acupuncture when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physicians or acupuncturists, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to www.ProvidenceHealthPlan.com/providerdirectory or call us.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.
- Routine preventive care in the absence of an illness, injury, or disease is not covered.

Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

Acupuncture covered services

- Acupuncture
- Adjunctive therapy which may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture. All adjunctive therapy must be medically necessary for the treatment of neuromusculoskeletal disorders, nausea or pain and provided together with acupuncture services.
- Services may require review for medical necessity.

Your guide to the words or phrases used to explain your benefits

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

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.

Maximum calendar year benefit
The total dollar amount of benefits that you can receive, per calendar year.

Medical Necessity Review
A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

Out-of-Network
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

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Your Benefit Summary
Men's Elective Sterilization

PROVIDENCE Health Plan

Covered Services

Covered services under this supplemental benefit endorsement include a male Member's elective sterilization (vasectomy). Prior authorization is not required and Members may receive covered services from the provider and/or facility of their choice.

Please review your medical Benefit Summary for your Copayment or Coinsurance amounts. For Members enrolled on a medical plan with In-Plan and Out-of-Plan benefits, elective sterilization Services are covered at the Outpatient Surgery In-Plan Copayment or Coinsurance amount.

For Members enrolled in a Health Savings Account (HSA) plan, your Deductible DOES apply to this benefit.

For Members on all other plans, the medical Deductible, if any, DOES NOT apply to this benefit.

Copayments and coinsurance apply to your medical plan Out-of-Pocket Maximum.

All Covered Services are subject to the specific conditions, duration limitations and all applicable maximums of the Group Contract on a Usual, Customary and Reasonable (UCR) cost basis.

Please note:

Providence Health Plan is a Catholic-sponsored health plan and as a matter of conscience does not offer these services at Providence Health & Services facilities. Services are available at other Participating facilities.

Contact us

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