PROVIDENCE
Health Plan

INDIVIDUALS & FAMILIES

Plan Overview 2014

Providence Health Plan: Your health plan for life

Choosing a health plan is a big decision. It's about much more than simply selecting someone to cover your care when you're sick. It's about picking a partner you trust to walk with you and support your well-being through every step of your life – at least, that's the way we see it. To us, your health isn't just a destination – it's a journey, and wherever you are on that journey, we'll be right there with you.

Why choose Providence?

Quality: Ask around – people like us. According to a recent survey, folks in the Portland area rate Providence Health Plan No. 1 in customer satisfaction. They also say that we're the plan they'd be most likely to recommend to others.

Choice: Want care in your neighborhood, or nationwide? It's up to you. Our new plans offer you a variety of options to fit your lifestyle, from connected care in your neighborhood to a nationwide network of nearly 1 million health care providers you can choose from, whether or not the Providence name is on the door.

Collaboration: Here's something you don't find in a lot of insurance companies: health plans, hospitals, clinics and providers who are all in it together to make life easier – and better – for you. We're consistently rated among the top 10 most integrated health systems in the country.

Prevention: From health assessments to online health trackers and a 24-hour nurse advice line, we put powerful tools in your hands to help you stay on top of your health. We also help you optimize your well-being through exclusive discounts on alternative care, massage therapy, fitness classes, gym memberships, LASIK and more.

Caring: As a not-for-profit organization, we live and breathe our charitable mission to care for the well-being of the people who live alongside us in our communities, and to reach out to those in need. Visit www.providence.org/cares to learn more about how Providence cares.

Stability: No matter how life changes, you can stick with us. You can choose Providence Health Plan as an individual, a family or an employer, either directly, through a producer (aka agent or broker) or through Cover Oregon. No matter how many changes life springs on you – from lost jobs to new jobs to new family members – the one thing that never has to change is your relationship with Providence.

Commitment: No matter what the years bring, we'll stick with you. Insurance companies come and go, but Providence has been serving Oregon and southwest Washington for more than 150 years. We're in it for the long haul, and we'll be here for you – always.

Compare plans. Check rates. Apply online.

This booklet gives you an overview of our individual and family plans and premiums. For details about plan benefits, enrollment requirements, limitations and exclusions, please see our plan contract and benefit summaries, available online or contact our sales department.

Providence Health Plan Sales Department:

503-574-5000 or 800-988-0088, TTY: 711
Monday through Friday, 8 a.m. to 8 p.m.

4400 NE Halsey St., Building 2
Portland, OR 97213

www.ProvidenceHealthPlan.com

Get more support to live your healthiest life

With Providence Health Plan, you get more than health coverage – you get exclusive discounts and innovative health-management tools that you can use every day to help you live your healthiest life.

Enjoy exclusive discounts on these health-enhancing extras:

Gym memberships: Receive exclusive discounts at hundreds of fitness facilities across Oregon such as 24 Hour Fitness, Curves, and Gold's Gym through LifeBalance.

Massage, acupuncture and chiropractic services: Save 25 percent on provider fees with Choose Healthy™.

LASIK vision correction: Get board-certified LASIK vision correction for just $895 per eye, or custom LASIK for $1,295 per eye, through TruVision.

Hearing aids: Save up to 60 percent on hearing aids for yourself, your parents and your grandparents through TruHearing.

Family attractions: Get exclusive discounts at the Oregon Zoo, Wildlife Safari, Disneyland, SeaWorld and other local and national family attractions, plus discounted tickets to local events like the Oregon Shakespeare Festival, savings at hotels all over the country and more through LifeBalance.

For details on these extras, visit www.ProvidenceHealthPlan.com/discounts.

Use these innovative tools to help you manage your health:

FitTogether™: Take advantage of multiple programs and services to help you feel better and find your fit, including:

- ProvRN, our 24/7 registered nurse advice line to answer your health questions, day or night
- Tobacco-cessation programs and support to help you quit for good
- Award-winning care managers who provide support and encouragement to help you take control of asthma, diabetes and other chronic conditions
- Health and wellness classes to help you learn to manage stress, achieve a healthy weight, begin a yoga practice and more
- An award-winning newsletter that delivers health and wellness information and motivation to your email every month

myProvidence: Log on to our secure website to find out about steps you can take to improve your health – and to manage your care – every day. Use myProvidence to:

- Improve your health with personal health trackers and health assessments, a library of health articles and videos, and other great resources.
- Make the most of your benefits by using our online directory to find in-network providers, reviewing your claims history online and calculating how much of your deductible you've met.
- Manage your health costs with our treatment cost estimator and online bill pay options.
- Stay in touch by sending secure email messages to myProvidence customer service and receiving periodic email updates from us.

Our plans are more flexible than ever

Health care reform has required changes of all health plans, and we've made some changes of our own to go the extra mile for you.

More choices to suit your lifestyle

Our selection of health plans offers many more options to fit your preferences. Choose from familiar plan designs with strong benefits and extensive provider choices; an HSA-qualified plan that lets you save tax-free dollars for future medical expenses; and two new plans centered on a medical home concept that let you choose a primary care clinic near you that will include your health care team who coordinates all aspects of your care.

More options for alternative care visits

The new health care reform law requires that any benefit covered by a health plan may not exclude any specific provider type, as long as the provider is licensed to perform the service. This means that medical services received from an alternative care provider, like a naturopath or chiropractor, are now covered, including services such as office visits, labs and X-rays. Spinal manipulation, acupuncture and massage are not covered.

More time to carry over your deductible

To help you preserve some of the investment you make in your annual deductible, most of our plans allow you to carry forward any deductible amounts paid for services received in the last three months of a calendar year and apply them toward the deductible for the following year (does not apply to HSA or Essential).

More flexibility to change plans during the year

We understand that life sometimes throws you a curve ball. Providence gives you the flexibility to switch to a plan with a lower premium one time during the contract year. For members who purchase a Providence plan through Cover Oregon, this benefit does not apply.

Where to buy our plans

Providence Health Plan has a variety of medical plans that you may purchase directly from us or at the statewide health care marketplace, Cover Oregon. We can help you find the plan that is the best fit for you. Benefit summaries and rates for all plans are available at www.ProvidenceHealthPlan.com.

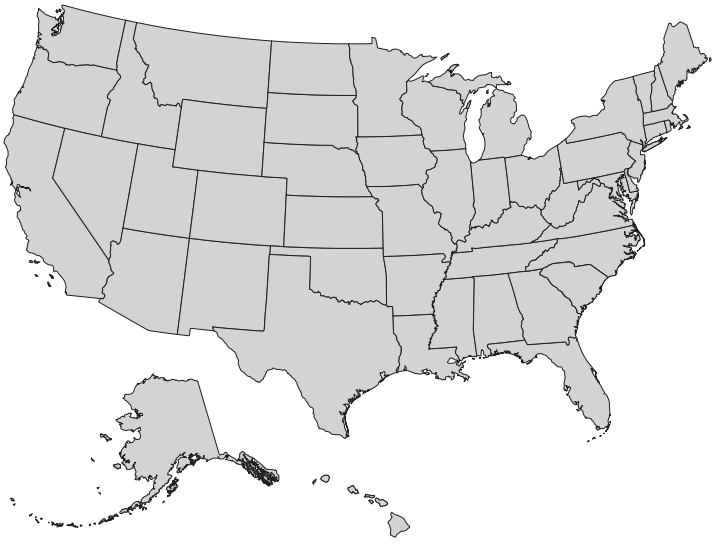
Plan	Network	Number of plans available directly from Providence	Number of plans available directly from Cover Oregon
Balance	EPO	1	1
Value	EPO	1	1
HSA	EPO	2	0
Choice	Choice	3	2
Connect	Neighborhood	3	2
Standard	EPO	2	3
Essential	EPO	0	1

Our network

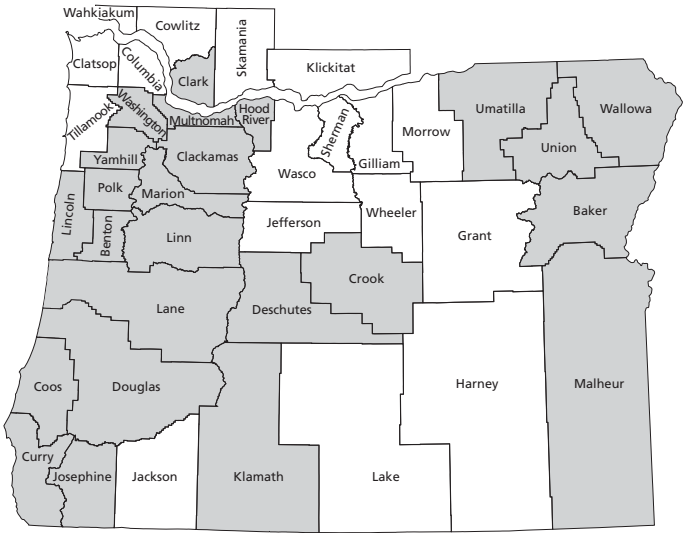
Choose your network: from your neighborhood to nationwide

See our online provider directory at www.ProvidenceHealthPlan.com/providerdirectory for a complete listing of providers and facilities by network.

Please note that the selling area for each plan may be different from the network area. See page 15.



Providence EPO Network: This robust national network gives you the broadest selection of nearly 1 million health care providers, both in Providence facilities and in other locations. Our Balance, Value and HSA plans all give you the freedom to choose providers from our national EPO network.



Providence Choice Network: This statewide network allows you to choose a primary care clinic from more than 180 clinics located throughout much of Oregon and southwest Washington as your medical home. When you select our Choice plan, you receive the support of your medical home health care team from the Choice network. With a referral from your health care team you have access to a vast range of clinical and facility specialists.

Providence Neighborhood Network: This Portland-area network lets you choose a medical home from more than 25 primary care clinics in Multnomah, Washington and Clackamas counties. When you select our Connect plan, your medical home care team from the Neighborhood network will support all of your health needs. You can connect with your team in whatever way is most convenient for you, including e-visits, phone visits or personal visits to your clinic.

Which plan works best for you?

Our plans offer you a variety of options, from basic to comprehensive coverage, and neighborhood to national networks. Out-of-network benefits are available for all plans.

Balance

This plan offers a balance of cost-saving features and coverage for the services you use most. With excellent benefits at an affordable premium, it's the most traditional of our health plans.

- Deductible is waived for primary care, generic prescription drugs, lab and X-ray
- Freedom to choose providers from the national Providence EPO Network
- Deductible amounts paid for services received in the last three months of the previous year carry forward to the next year

Value

With a lower premium and simplified benefits, this plan offers great value and strong financial protection in the event of a major medical problem. Most out-of-pocket costs go toward your deductible and coinsurance.

- Affordable major-medical coverage with lower premiums
- Freedom to choose providers from the national Providence EPO Network
- Deductible amounts paid for services received in the last three months of the previous year carry forward to the next year

HSA

Paired with a tax-exempt savings account, HSA health plans combine health coverage with the ability to save pre-tax dollars to pay for future health care expenses.

- Affordable coverage and low premium
- Use tax-free savings to pay for future health needs
- Freedom to choose providers from the national Providence EPO Network
- Get a preferred rate with U.S. Bank

Connect

Our lowest-premium option, Connect lets you choose a medical home near you for all of your care. Choose from more than 25 primary care clinics within our Portland metro-area Neighborhood network. Your health will be supported by a team of expert health professionals who collaborate with you to address all aspects of your health, from preventive care to health management. With this plan, you can connect with your team in both traditional and innovative ways, including visits by email and phone, or in-person at your medical home clinic. The Connect plan is a great choice for personalized, convenient and efficient care.

- Lowest premium cost
- A medical home team coordinates all of your care
- Choice of more than 25 primary care clinics as your medical home
- Medical visits by e-mail, phone and in-person
- Deductible amounts paid for services received in the last three months of the previous year carry forward to the next year
- Additional charges apply for certain elective procedures

Choice

Choice puts you at the center of your care. First, you select a medical home from the Providence Choice Network of more than 180 primary care clinics in Oregon and southwest Washington. From then on, your health will be supported by a team of health professionals within your medical home. Your care team will work collaboratively to support all aspects of your health, from wellness and prevention to active management of chronic conditions. Your team also may refer you to a broad network of specialists for covered services, if needed. Choice is a great option if you're interested in lower premium costs and a connected care experience that takes a holistic approach to supporting your long-term health.

- Comprehensive coverage with lower premiums than broader network plans
- Deductible is waived for primary care, generic prescription drugs, lab and X-ray
- A medical home with a team to coordinate your care
- More than 180 primary care clinics to choose from as your medical home
- Referrals from your care team to specialists when needed
- Deductible amounts paid for services received in the last three months of the previous year carry forward to the next year
- Additional charges apply for certain elective procedures

Standard Plans

Defined by the state of Oregon, the Standard Plans offer greater choice between coverage levels and affordable premiums. The Providence Oregon Standard Gold Plan provides the highest level of coverage and is available only through Cover Oregon. The Providence Oregon Standard Silver Plan strikes a greater balance between cost and coverage. The Providence Oregon Standard Bronze Plan emphasizes premium savings while still maintaining a high level of coverage. All of the Standard Plans include the following:

- Freedom to choose providers from the national Providence EPO network
- Deductible amounts paid for services received in the last three months of the previous year carry forward to the next year
- Standard Silver and Bronze plans can be purchased either direct through Providence or at Cover Oregon

Essential

The Providence Essential plan provides protection against unforeseen major medical expenses. It is a catastrophic plan available only to individuals under the age of 30 at Cover Oregon, www.coveroregon.com.

- Affordable coverage with lower premiums
- Up to 3 office visits per calendar year before the deductible is met
- Prescription drug coverage included

Some benefit limitations and exclusions apply to our plans.

Under the new health care reform law, pediatric dental coverage is required as an essential health benefit with all health plans. Since Providence Health Plan does not include pediatric dental coverage, you will be required to purchase that coverage separately. An exception is made for Providence plans purchased through the public health insurance exchange, called Cover Oregon – those plans do not require pediatric dental coverage.

Visit www.ProvidenceHealthPlan.com for details on these and other benefit limitations and exclusions.

	Connect 6200		Connect 3000		Connect 2700	
Network	**Providence Neighborhood Network**					
	in-network	out-of-network	in-network	out-of-network	in-network	out-of-network
Deductible (Individual/Family)	$6,200/$12,400	$12,400/$24,800	$3,000/$6,000	$6,000/$12,000	$2,700/$5,400	$5,400/$10,800
Out-of-Pocket Maximum (Individual/Family) Includes deductible	$6,200/$12,400	$12,400/$24,800	$5,000/$10,000	$10,000/$20,000	$5,000/$10,000	$10,000/$20,000
Accidental Injury Benefit	The deductible is waived for all covered services required to treat an accidental injury within 90 days of injury.					
	After meeting your deductible, you pay the following amounts for covered services. The deductible is waived for some covered services. These are marked with ✓					
Preventive Care						
Periodic health exams and well-baby care (from a Personal Physician/Provider only)	Covered in full✓	Covered in full	Covered in full✓	50%	Covered in full✓	50%
Routine immunizations and shots	Covered in full✓	Covered in full	Covered in full✓	50%	Covered in full✓	50%
Mammograms, gynecological exams and Pap tests	Covered in full✓	Covered in full	Covered in full✓	50%	Covered in full✓	50%
Colorectal cancer screenings (age 50 and over)	Covered in full✓	Covered in full	Covered in full✓	50%	Covered in full✓	50%
Office Visits for Medical Services						
Personal Physician/Provider	$40✓	Covered in full	$35✓	50%	$25✓	50%
Specialist	$90✓	Covered in full	$70✓	50%	$50✓	50%
Alternative Care Provider*	Covered in full	Covered in full	30%	50%	30%	50%
Hospital Services						
Inpatient care	Covered in full	Covered in full	30%	50%	30%	50%
Maternity care	Covered in full	Covered in full	30%	50%	30%	50%
Routine newborn nursery care	Covered in full	Covered in full	30%	50%	30%	50%
Rehabilitative care**	Covered in full	Covered in full	30%	50%	30%	50%
Emergency/Urgent Care						
Emergency services	Covered in full	Covered in full	$250 then 30%	$250 then 30%	$250 then 30%	$250 then 30%
Urgent care visits	$90✓	Covered in full	$70✓	50%	$50✓	50%
Outpatient Diagnostic Services						
X-ray and lab services	50%✓	Covered in full	30%✓	50%	30%✓	50%
High tech imaging services (such as PET, CT, MRI)	Covered in full	Covered in full	30%	50%	30%	50%
Other Covered Services						
Outpatient surgery at an ambulatory surgery center	Covered in full	Covered in full	$250	50%	$250	50%
Outpatient surgery at a hospital-based facility	Covered in full	Covered in full	30%	50%	30%	50%
Outpatient dialysis, infusion, chemotherapy, radiation therapy	Covered in full	Covered in full	30%	50%	30%	50%
Prescription Drugs						
Generic drugs	$25✓	Not covered	$15✓	Not covered	$15✓	Not covered
Preferred brand name drugs	Covered in full	Not covered	$45	Not covered	$45	Not covered
Non-preferred brand name and specialty drugs	Covered in full	Not covered	50%	Not covered	50%	Not covered
Pediatric Vision Services						
Routine eye exams (limited to one exam per calendar year)	Covered in full✓	Covered✓	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Covered in full✓	Covered✓	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Adult Vision Services						
Routine eye exams (limited to one exam per calendar year)	$25✓	Covered✓	$25✓	Covered✓	$25✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Not covered	Not covered	Not covered	Not covered	Not covered	Not covered

*Spinal manipulation and acupuncture are not covered **30 days per calendar year, 60 days for head/spinal injuries

	HSA 6200		HSA 2800	
Network	**Providence EPO Network**			
	in-network	out-of-network	in-network	out-of-network
Deductible (Individual/Family)	$6,200/$12,400		$2,800/$5,600	
Out-of-Pocket Maximum (Individual/Family) Includes deductible	$6,200/$12,400		$6,200/$12,400	
Accidental Injury Benefit	Not covered		Not covered	
	After meeting your deductible, you pay the following amounts for covered services. The deductible is waived for some covered services. These are marked with✓			
Preventive Care				
Periodic health exams and well-baby care (from a Personal Physician/Provider only)	Covered in full✓	Covered in full	Covered in full✓	50%
Routine immunizations and shots	Covered in full✓	Covered in full	Covered in full✓	50%
Mammograms, gynecological exams and Pap tests	Covered in full✓	Covered in full	Covered in full✓	50%
Colorectal cancer screenings (age 50 and over)	Covered in full✓	Covered in full	Covered in full✓	50%
Office Visits for Medical Services				
Personal Physician/Provider	Covered in full	Covered in full	50%	50%
Specialist	Covered in full	Covered in full	50%	50%
Alternative Care Provider*	Covered in full	Covered in full	50%	50%
Hospital Services				
Inpatient care	Covered in full	Covered in full	50%	50%
Maternity care	Covered in full	Covered in full	50%	50%
Routine newborn nursery care	Covered in full	Covered in full	50%	50%
Rehabilitative care**	Covered in full	Covered in full	50%	50%
Emergency/Urgent Care				
Emergency services	Covered in full	Covered in full	50%	50%
Urgent care visits	Covered in full	Covered in full	50%	50%
Outpatient Diagnostic Services				
X-ray and lab services	Covered in full	Covered in full	50%	50%
High tech imaging services (such as PET, CT, MRI)	Covered in full	Covered in full	50%	50%
Other Covered Services				
Outpatient surgery at an ambulatory surgery center	Covered in full	Covered in full	50%	50%
Outpatient surgery at a hospital-based facility	Covered in full	Covered in full	50%	50%
Outpatient dialysis, infusion, chemotherapy, radiation therapy	Covered in full	Covered in full	50%	50%
Prescription Drugs				
Generic drugs	Covered in full	Not covered	50%	Not covered
Preferred brand name drugs	Covered in full	Not covered	50%	Not covered
Non-preferred brand name and specialty drugs	Covered in full	Not covered	50%	Not covered
Pediatric Vision Services				
Routine eye exams (limited to one exam per calendar year)	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Adult Vision Services				
Routine eye exams (limited to one exam per calendar year)	$25✓	Covered✓	$25✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Not covered	Not covered	Not covered	Not covered

*Spinal manipulation and acupuncture are not covered **30 days per calendar year, 60 days for head/spinal injuries

	Value 5000		Balance 2000	
Network	**Providence EPO Network**			
	in-network	out-of-network	in-network	out-of-network
Deductible (Individual/Family)	$5,000/$10,000	$5,000/$10,000	$2,000/$4,000	$2,000/$4,000
Out-of-Pocket Maximum (Individual/Family) Includes deductible	$6,200/$12,400	$6,200/$12,400	$6,000/$12,000	$6,000/$12,000
Accidental Injury Benefit	The deductible is waived for all covered services required to treat an accidental injury within 90 days of injury.			
	After meeting your deductible, you pay the following amounts for covered services. The deductible is waived for some covered services. These are marked with✓			
Preventive Care				
Periodic health exams and well-baby care (from a Personal Physician/Provider only)	Covered in full✓	50%	Covered in full✓	50%
Routine immunizations and shots	Covered in full✓	50%	Covered in full✓	50%
Mammograms, gynecological exams and Pap tests	Covered in full✓	50%	Covered in full✓	50%
Colorectal cancer screenings (age 50 and over)	Covered in full✓	50%	Covered in full✓	50%
Office Visits for Medical Services				
Personal Physician/Provider	30%	50%	$30/visit✓	50%
Specialist	30%	50%	$90/visit✓	50%
Alternative Care Provider*	30%	50%	30%	50%
Hospital Services				
Inpatient care	30%	50%	30%	50%
Maternity care	30%	50%	30%	50%
Routine newborn nursery care	30%	50%	30%	50%
Rehabilitative care**	30%	50%	30%	50%
Emergency/Urgent Care				
Emergency services	$250 then 30%	$250 then 30%	$250 then 30%	$250 then 30%
Urgent care visits	30%	50%	$90✓	50%
Outpatient Diagnostic Services				
X-ray and lab services	30%	50%	30%✓	50%
High tech imaging services (such as PET, CT, MRI)	30%	50%	30%	50%
Other Covered Services				
Outpatient surgery at an ambulatory surgery center	$300	50%	$300	50%
Outpatient surgery at a hospital-based facility	30%	50%	30%	50%
Outpatient dialysis, infusion, chemotherapy, radiation therapy	30%	50%	30%	50%
Prescription Drugs				
Generic drugs	$20✓	Not covered	$15✓	Not covered
Preferred brand name drugs	$60	Not covered	$45	Not covered
Non-preferred brand name and specialty drugs	50%	Not covered	50%	Not covered
Pediatric Vision Services				
Routine eye exams (limited to one exam per calendar year)	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Adult Vision Services				
Routine eye exams (limited to one exam per calendar year)	$30✓	Covered✓	$30✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Covered✓	Covered✓	Covered✓	Covered✓

*Spinal manipulation and acupuncture are not covered **30 days per calendar year, 60 days for head/spinal injuries

	Choice 6200		Choice 2500		Choice 1750	
Network	**Providence Choice Network**					
	in-network	out-of-network	in-network	out-of-network	in-network	out-of-network
Deductible (Individual/Family)	$6,200/$12,400	$12,400/$24,800	$2,500/$5,000	$5,000/$10,000	$1,750/$3,500	$3,500/$7,000
Out-of-Pocket Maximum (Individual/Family) Includes deductible	$6,200/$12,400	$12,400/$24,800	$6,000/$12,000	$12,000/$24,000	$6,000/$12,000	$12,000/$24,000
Accidental Injury Benefit	The deductible is waived for all covered services required to treat an accidental injury within 90 days of injury.					
	After meeting your deductible, you pay the following amounts for covered services. The deductible is waived for some covered services. These are marked with✓					
Preventive Care						
Periodic health exams and well-baby care (from a Personal Physician/Provider only)	Covered in full✓	Covered in full	Covered in full✓	40%	Covered in full✓	50%
Routine immunizations and shots	Covered in full✓	Covered in full	Covered in full✓	40%	Covered in full✓	50%
Mammograms, gynecological exams and Pap tests	Covered in full✓	Covered in full	Covered in full✓	40%	Covered in full✓	50%
Colorectal cancer screenings (age 50 and over)	Covered in full✓	Covered in full	Covered in full✓	40%	Covered in full✓	50%
Office Visits for Medical Services						
Personal Physician/Provider	$50✓	Covered in full	$30✓	40%	$30✓	50%
Specialist	$90✓	Covered in full	$60✓	40%	$60✓	40%
Alternative Care Provider*	Covered in full	Covered in full	30%	40%	30%	50%
Hospital Services						
Inpatient care	Covered in full	Covered in full	30%	40%	30%	50%
Maternity care	Covered in full	Covered in full	30%	40%	30%	50%
Routine newborn nursery care	Covered in full	Covered in full	30%	40%	30%	50%
Rehabilitative care**	Covered in full	Covered in full	30%	40%	30%	50%
Emergency/Urgent Care						
Emergency services	Covered in full	Covered in full	$250 then 30%	$250 then 30%	$250 then 30%	$250 then 50%
Urgent care visits	$90✓	Covered in full	$60✓	40%	$60✓	50%
Outpatient Diagnostic Services						
X-ray and lab services	50%✓	Covered in full	30%✓	40%	30%✓	50%
High tech imaging services (such as PET, CT, MRI)	Covered in full	Covered in full	30%	40%	30%	50%
Other Covered Services						
Outpatient surgery at an ambulatory surgery center	Covered in full	Covered in full	$300	40%	$300	50%
Outpatient surgery at a hospital-based facility	Covered in full	Covered in full	30%	40%	30%	50%
Outpatient dialysis, infusion, chemotherapy, radiation therapy	Covered in full	Covered in full	30%	40%	30%	50%
Prescription Drugs						
Generic drugs	$30✓	Not covered	$15✓	Not covered	$15✓	Not covered
Preferred brand name drugs	Covered in full	Not covered	$45	Not covered	$60	Not covered
Non-preferred brand name and specialty drugs	Covered in full	Not covered	50%	Not covered	50%	Not covered
Pediatric Vision Services						
Routine eye exams (limited to one exam per calendar year)	Covered in full✓	Covered✓	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Covered in full✓	Covered✓	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Adult Vision Services						
Routine eye exams (limited to one exam per calendar year)	$30✓	Covered✓	$30✓	Covered✓	$30✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Covered✓	Covered✓	Covered✓	Covered✓	Covered✓	Covered✓

*Spinal manipulation and acupuncture are not covered **30 days per calendar year, 60 days for head/spinal injuries

	Providence Oregon Standard Silver Plan		Providence Oregon Standard Bronze Plan	
Network	**Providence EPO Network**			
	in-network	out-of-network	in-network	out-of-network
Deductible (Individual/Family)	$2,500/$5,000	$5,000/$10,000	$5,000/$10,000	$10,000/$20,000
Out-of-Pocket Maximum (Individual/Family) Includes deductible	$6,350/$12,700	$12,700/$25,400	$6,350/$12,700	$12,700/$25,400
Accidental Injury Benefit	The deductible is waived for all covered services required to treat an accidental injury within 90 days of injury.			
	After meeting your deductible, you pay the following amounts for covered services. The deductible is waived for some covered services. These are marked with✓			
Preventive Care				
Periodic health exams and well-baby care (from a Personal Physician/ Provider only)	Covered in full✓	50%	Covered in full✓	50%
Routine immunizations and shots	Covered in full✓	50%	Covered in full✓	50%
Mammograms, gynecological exams and Pap tests	Covered in full✓	50%	Covered in full✓	50%
Colorectal cancer screenings (age 50 and over)	Covered in full✓	50%	Covered in full✓	50%
Office Visits for Medical Services				
Personal Physician/Provider	$35/visit✓	50%	$60/visit	50%
Specialist	$70/visit✓	50%	$100	50%
Alternative Care Provider*	$70/visit✓	50%	$100	50%
Hospital Services				
Inpatient care	30%	50%	50%	50%
Maternity care	30%	50%	50%	50%
Routine newborn nursery care	30%	50%	50%	50%
Rehabilitative care**	30%✓	50%	50%	50%
Emergency/Urgent Care				
Emergency services	30%	30%	50%	50%
Urgent care visits	$90✓	50%	$120	50%
Outpatient Diagnostic Services				
X-ray and lab services	30%	50%	50%	50%
High tech imaging services (such as PET, CT, MRI)	30%	50%	50%	50%
Other Covered Services				
Outpatient surgery at an ambulatory surgery center	30%	50%	50%	50%
Outpatient surgery at a hospital-based facility	30%	50%	50%	50%
Outpatient dialysis, infusion, chemotherapy, radiation therapy	30%	50%	50%	50%
Prescription Drugs				
Generic drugs	$15✓	Not covered	$20	Not covered
Preferred brand name drugs	$50✓	Not covered	$80	Not covered
Non-preferred brand name and specialty drugs	50%✓	Not covered	50%	Not covered
Pediatric Vision Services				
Routine eye exams (limited to one exam per calendar year)	Covered in full✓	Covered✓	Covered in full✓	Covered✓
Vision hardware (frames, lenses, contact lenses) Limits apply	Covered in full✓	Covered✓	Coveredin full✓	Covered✓
Adult Vision Services				
Routine eye exams (limited to one exam per calendar year)	Not covered	Not covered	Not covered	Not covered
Vision hardware (frames, lenses, contact lenses) Limits apply	Not covered	Not covered	Not covered	Not covered

*Spinal manipulation and acupuncture are not covered **30 days per calendar year, 60 days for head/spinal injuries

Your decision-making guide

With so many changes taking place under the new health care law, choosing a new health plan could be challenging, to say the least. Here is a step-by-step guide to help you make the right decision for yourself and your family.

Step 1: Review your current plan. What do you like about it? What aspects of your current plan do you definitely want to keep in your new plan? Make a list to refer to as you review your new plan options.

Step 2: Think about your health care needs for 2014. How many doctor visits, aside from preventive care, do you anticipate needing? Do you want to keep your current providers? Are you planning any surgeries? Do you need new eyeglasses?

Step 3: Decide what type of provider network you prefer.

- Do you want the freedom to choose from nearly 1 million providers nationwide? If so, consider a Providence Balance, Value or HSA plan.
- Would you prefer to work closely with a care team from one medical home, with the flexibility for specialist referrals? If so, consider the Providence Choice plan.
- Would you rather have a dedicated care team from one medical home in the Portland area to support every aspect of your health and wellness, with the convenience of e-visits, phone visits and in-person clinic visits? If so, consider the Providence Connect plan.

Step 4: Determine your budget. What can your budget handle for monthly premiums and out-of-pocket costs? Review the benefit summary and rate charts to compare benefits and premiums. Shop now at www.ProvidenceHealthPlan.com to review side-by-side comparisons of benefits, rates and networks.

Step 5: Find out if you are eligible for financial assistance. Use the calculator at www.coveroregon.com to determine the exact amount of any tax credit or cost-sharing subsidy you may be eligible for. If you are eligible, you must complete the steps on the Cover Oregon website to receive your tax credit.

Step 6: Choose your new plan. Be sure to specify which Providence plan you've chosen if you shop on the Cover Oregon website.

Step 7: Complete the application or visit the website to enroll online at www.ProvidenceHealthPlan.com.

Notes:

Decision worksheet

Use this worksheet to compare plans and determine your monthly premium. There is no additional cost for more than three children.

Plan name	Plan name	Plan name
Pros	**Pros**	**Pros**
Cons	**Cons**	**Cons**

	Monthly premium		Monthly premium		Monthly premium
Subscriber		Subscriber		Subscriber	
Spouse		Spouse		Spouse	
Child #1		Child #1		Child #1	
Child #2		Child #2		Child #2	
Child #3		Child #3		Child #3	
Total premium		Total premium		Total premium	

Individual and Family Plan

To apply for a Providence Individual and Family plan, you must reside in our selling area for each plan type (counties highlighted in gray).

Please note that the selling area for each plan may be different from the network area. See page 5.

Value, Balance, HSA and Standard

Selling area ZIP codes: All ZIP codes in Benton, Clackamas, Clatsop, Columbia, Crook, Deschutes, Douglas, Gilliam, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Linn, Marion, Multnomah, Polk, Sherman, Tillamook, Wasco, Washington, Wheeler and Yamhill counties.

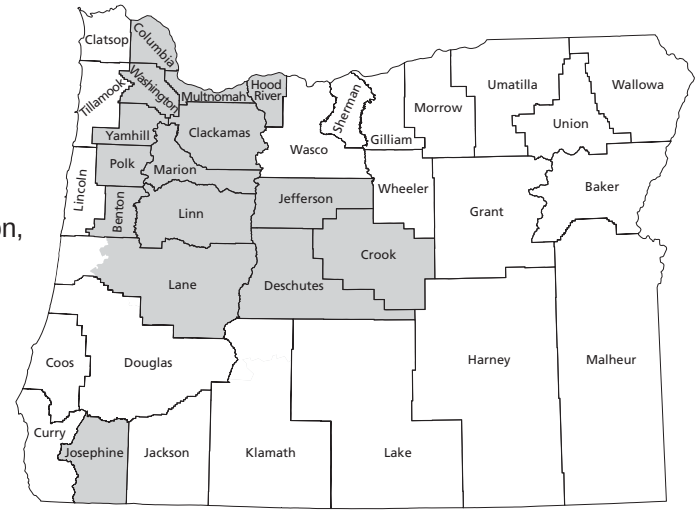
Select ZIP codes in Lane County:
97401, 97402, 97403, 97404, 97405, 97408, 97409, 97412, 97413, 97419, 97424, 97426, 97427, 97431, 97434, 97437, 97438, 97440, 97448, 97451, 97452, 97454, 97455, 97461, 97463, 97472, 97477, 97478, 97482, 97487, 97488, 97489, 97490, 97492

Select ZIP codes in Klamath County:
97425, 97733, 97737

Choice

Selling area ZIP codes:
All ZIP codes in Benton, Clackamas, Columbia, Crook, Deschutes, Hood River, Jefferson, Josephine, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties.

Select ZIP codes in Lane County:
97401, 97402, 97403, 97404, 97405, 97408, 97409, 97412, 97413, 97419, 97424, 97426, 97427, 97431, 97434, 97437, 97438, 97440, 97448, 97451, 97452, 97454, 97455, 97461, 97463, 97472, 97477, 97478, 97482, 97487, 97488, 97489, 97490, 97492



Connect

Selling area ZIP codes:
All ZIP codes in Clackamas, Multnomah and Washington counties.

Individual and Family Plan rates for non-tobacco users

Purchase these plans directly from Providence or your producer
Effective Jan. 1, 2014 - Dec. 31, 2014

To determine the premium for an individual, use your age and find the plan that fits your needs. To determine the premium for your family, find the plan that fits your needs and then use the ages for each person who will be covered and add up the premium amounts. If you are covering more than three children (younger than 20 years of age), you only need to add the premiums for your first three children; there will be no premium charged for additional children.

Age	Purchase these plans directly from Providence or your producer						
	Connect 6200	Connect 3000	Connect 2700	HSA 6200	HSA 2800	Value 5000	Balance 2000
20 or younger	$103.76	$116.39	$118.23	$108.12	$119.87	$123.63	$143.36
21	$163.41	$183.30	$186.18	$170.28	$188.77	$194.70	$225.76
22	$163.41	$183.30	$186.18	$170.28	$188.77	$194.70	$225.76
23	$163.41	$183.30	$186.18	$170.28	$188.77	$194.70	$225.76
24	$163.41	$183.30	$186.18	$170.28	$188.77	$194.70	$225.76
25	$164.06	$184.03	$186.93	$170.96	$189.52	$195.48	$226.66
26	$167.33	$187.70	$190.65	$174.36	$193.30	$199.37	$231.18
27	$171.25	$192.09	$195.12	$178.45	$197.83	$204.04	$236.60
28	$177.62	$199.24	$202.38	$185.09	$205.19	$211.64	$245.40
29	$182.85	$205.11	$208.34	$190.54	$211.23	$217.87	$252.63
30	$185.47	$208.04	$211.32	$193.26	$214.25	$220.98	$256.24
31	$189.39	$212.44	$215.79	$197.35	$218.78	$225.66	$261.66
32	$193.31	$216.84	$220.26	$201.44	$223.31	$230.33	$267.08
33	$195.76	$219.59	$223.05	$203.99	$226.14	$233.25	$270.46
34	$198.38	$222.52	$226.03	$206.71	$229.17	$236.36	$274.07
35	$199.68	$223.99	$227.52	$208.08	$230.68	$237.92	$275.88
36	$200.99	$225.45	$229.01	$209.44	$232.19	$239.48	$277.69
37	$202.30	$226.92	$230.50	$210.80	$233.70	$241.04	$279.49
38	$203.60	$228.39	$231.99	$212.16	$235.21	$242.60	$281.30
39	$206.22	$231.32	$234.96	$214.89	$238.23	$245.71	$284.91
40	$208.83	$234.25	$237.94	$217.61	$241.25	$248.83	$288.52
41	$212.76	$238.65	$242.41	$221.70	$245.78	$253.50	$293.94
42	$216.51	$242.87	$246.69	$225.62	$250.12	$257.98	$299.13
43	$221.74	$248.73	$252.65	$231.06	$256.16	$264.21	$306.36
44	$228.28	$256.07	$260.10	$237.87	$263.71	$271.99	$315.39
45	$235.96	$264.68	$268.85	$245.88	$272.58	$281.15	$326.00
46	$245.11	$274.95	$279.28	$255.41	$283.15	$292.05	$338.64
47	$255.40	$286.49	$291.01	$266.14	$295.05	$304.31	$352.86
48	$267.17	$299.69	$304.41	$278.40	$308.64	$318.33	$369.12
49	$278.77	$312.70	$317.63	$290.49	$322.04	$332.16	$385.15
50	$291.84	$327.37	$332.52	$304.11	$337.14	$347.73	$403.21
51	$304.75	$341.85	$347.23	$317.56	$352.05	$363.11	$421.04
52	$318.97	$357.80	$363.43	$332.38	$368.48	$380.05	$440.69
53	$333.35	$373.93	$379.82	$347.36	$385.09	$397.19	$460.55
54	$348.87	$391.34	$397.50	$363.54	$403.02	$415.68	$482.00
55	$364.40	$408.75	$415.19	$379.71	$420.95	$434.18	$503.45
56	$381.23	$427.63	$434.37	$397.25	$440.40	$454.23	$526.70
57	$398.22	$446.69	$453.73	$414.96	$460.03	$474.48	$550.18
58	$416.36	$467.04	$474.40	$433.86	$480.98	$496.09	$575.24
59	$425.35	$477.12	$484.64	$443.23	$491.36	$506.80	$587.66
60	$443.48	$497.47	$505.30	$462.13	$512.32	$528.41	$612.72
61	$459.17	$515.06	$523.18	$478.47	$530.44	$547.10	$634.39
62	$469.47	$526.61	$534.91	$489.20	$542.33	$559.37	$648.61
63	$482.38	$541.09	$549.61	$502.65	$557.25	$574.75	$666.45
64	$490.23	$549.90	$558.54	$510.84	$566.31	$584.10	$677.28

Individual and Family Plan rates for non-tobacco users

Purchase these plans directly from Providence or your producer
Effective Jan. 1, 2014 - Dec. 31, 2014

To determine the premium for an individual, use your age and find the plan that fits your needs. To determine the premium for your family, find the plan that fits your needs and then use the ages for each person who will be covered and add up the premium amounts. If you are covering more than three children (younger than 20 years of age), you only need to add the premiums for your first three children; there will be no premium charged for additional children.

Age	Purchase these plans directly from Providence or your Producer			Purchase these plans directly from Providence, your producer or Cover Oregon	
	Choice 6200	Choice 2500	Choice 1750	Providence Oregon Standard Silver	Providence Oregon Standard Bronze
20 or younger	$117.93	$131.85	$135.70	$135.23	$114.81
21	$185.72	$207.63	$213.70	$212.95	$180.81
22	$185.72	$207.63	$213.70	$212.95	$180.81
23	$185.72	$207.63	$213.70	$212.95	$180.81
24	$185.72	$207.63	$213.70	$212.95	$180.81
25	$186.46	$208.46	$214.56	$213.81	$181.53
26	$190.17	$212.61	$218.83	$218.06	$185.15
27	$194.63	$217.60	$223.96	$223.18	$189.49
28	$201.87	$225.69	$232.29	$231.48	$196.54
29	$207.82	$232.34	$239.13	$238.30	$202.32
30	$210.79	$235.66	$242.55	$241.70	$205.22
31	$215.25	$240.64	$247.68	$246.81	$209.56
32	$219.70	$245.63	$252.81	$251.92	$213.89
33	$222.49	$248.74	$256.01	$255.12	$216.61
34	$225.46	$252.06	$259.43	$258.53	$219.50
35	$226.95	$253.73	$261.14	$260.23	$220.95
36	$228.43	$255.39	$262.85	$261.93	$222.39
37	$229.92	$257.05	$264.56	$263.64	$223.84
38	$231.40	$258.71	$266.27	$265.34	$225.29
39	$234.37	$262.03	$269.69	$268.75	$228.18
40	$237.35	$265.35	$273.11	$272.15	$231.07
41	$241.80	$270.34	$278.24	$277.27	$235.41
42	$246.07	$275.11	$283.15	$282.16	$239.57
43	$252.02	$281.76	$289.99	$288.98	$245.35
44	$259.45	$290.06	$298.54	$297.50	$252.59
45	$268.17	$299.82	$308.59	$307.51	$261.08
46	$278.57	$311.45	$320.55	$319.43	$271.21
47	$290.27	$324.53	$334.02	$332.85	$282.60
48	$303.65	$339.48	$349.40	$348.18	$295.62
49	$316.83	$354.22	$364.57	$363.30	$308.46
50	$331.69	$370.83	$381.67	$380.34	$322.92
51	$346.36	$387.23	$398.55	$397.16	$337.20
52	$362.52	$405.30	$417.15	$415.69	$352.93
53	$378.86	$423.57	$435.95	$434.43	$368.85
54	$396.50	$443.29	$456.25	$454.66	$386.02
55	$414.15	$463.02	$476.55	$474.89	$403.20
56	$433.28	$484.40	$498.57	$496.82	$421.82
57	$452.59	$506.00	$520.79	$518.97	$440.63
58	$473.21	$529.04	$544.51	$542.61	$460.70
59	$483.42	$540.46	$556.27	$554.32	$470.64
60	$504.03	$563.51	$579.99	$577.96	$490.71
61	$521.86	$583.44	$600.50	$598.40	$508.07
62	$533.56	$596.52	$613.96	$611.82	$519.46
63	$548.23	$612.93	$630.85	$628.64	$533.74
64	$557.16	$622.89	$641.10	$638.85	$542.43

Individual and Family Plan rates for tobacco users

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Effective Jan. 1, 2014 - Dec. 31, 2014

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Age	Purchase these plans directly from Providence or your producer						
	Connect 6200	Connect 3000	Connect 2700	HSA 6200	HSA 2800	Value 5000	Balance 2000
20 or younger	$103.76	$116.39	$118.23	$108.12	$119.87	$123.63	$143.36
21	$171.58	$192.47	$195.49	$178.79	$198.21	$204.44	$237.05
22	$171.58	$192.47	$195.49	$178.79	$198.21	$204.44	$237.05
23	$171.58	$192.47	$195.49	$178.79	$198.21	$204.44	$237.05
24	$171.58	$192.47	$195.49	$178.79	$198.21	$204.44	$237.05
25	$172.26	$193.23	$196.28	$179.51	$199.00	$205.25	$237.99
26	$175.70	$197.09	$200.18	$183.08	$202.97	$209.34	$242.74
27	$179.81	$201.69	$204.88	$187.37	$207.72	$214.24	$248.43
28	$186.50	$209.20	$212.50	$194.34	$215.45	$222.22	$257.67
29	$191.99	$215.37	$218.76	$200.07	$221.79	$228.76	$265.26
30	$194.74	$218.44	$221.89	$202.92	$224.96	$232.03	$269.05
31	$198.86	$223.06	$226.58	$207.22	$229.72	$236.94	$274.74
32	$202.98	$227.68	$231.27	$211.51	$234.48	$241.85	$280.43
33	$205.55	$230.57	$234.20	$214.19	$237.45	$244.91	$283.98
34	$208.30	$233.65	$237.33	$217.05	$240.63	$248.18	$287.77
35	$209.66	$235.19	$238.90	$218.48	$242.21	$249.82	$289.67
36	$211.04	$236.72	$240.46	$219.91	$243.80	$251.45	$291.57
37	$212.42	$238.27	$242.03	$221.34	$245.39	$253.09	$293.46
38	$213.78	$239.81	$243.59	$222.77	$246.97	$254.73	$295.37
39	$216.53	$242.89	$246.71	$225.63	$250.14	$258.00	$299.16
40	$219.27	$245.96	$249.84	$228.49	$253.31	$261.27	$302.95
41	$223.40	$250.58	$254.53	$232.79	$258.07	$266.18	$308.64
42	$227.34	$255.01	$259.02	$236.90	$262.63	$270.88	$314.09
43	$232.83	$261.17	$265.28	$242.61	$268.97	$277.42	$321.68
44	$239.69	$268.87	$273.11	$249.76	$276.90	$285.59	$331.16
45	$247.76	$277.91	$282.29	$258.17	$286.21	$295.21	$342.30
46	$257.37	$288.70	$293.24	$268.18	$297.31	$306.65	$355.57
47	$268.17	$300.81	$305.56	$279.45	$309.80	$319.53	$370.50
48	$280.53	$314.67	$319.63	$292.32	$324.07	$334.25	$387.58
49	$292.71	$328.34	$333.51	$305.01	$338.14	$348.77	$404.41
50	$306.43	$343.74	$349.15	$319.32	$354.00	$365.12	$423.37
51	$319.99	$358.94	$364.59	$333.44	$369.65	$381.27	$442.09
52	$334.92	$375.69	$381.60	$349.00	$386.90	$399.05	$462.72
53	$350.02	$392.63	$398.81	$364.73	$404.34	$417.05	$483.58
54	$366.31	$410.91	$417.38	$381.72	$423.17	$436.46	$506.10
55	$382.62	$429.19	$435.95	$398.70	$442.00	$455.89	$528.62
56	$400.29	$449.01	$456.09	$417.11	$462.42	$476.94	$553.04
57	$418.13	$469.02	$476.42	$435.71	$483.03	$498.20	$577.69
58	$437.18	$490.39	$498.12	$455.55	$505.03	$520.89	$604.00
59	$446.62	$500.98	$508.87	$465.39	$515.93	$532.14	$617.04
60	$465.65	$522.34	$530.57	$485.24	$537.94	$554.83	$643.36
61	$482.13	$540.81	$549.34	$502.39	$556.96	$574.46	$666.11
62	$492.94	$552.94	$561.66	$513.66	$569.45	$587.34	$681.04
63	$506.50	$568.14	$577.09	$527.78	$585.11	$603.49	$699.77
64	$514.74	$577.40	$586.47	$536.37	$594.63	$613.31	$711.14

Individual and Family Plan rates for tobacco users

Purchase these plans directly from Providence or your producer
Effective Jan. 1, 2014 - Dec. 31, 2014

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Age	Purchase these plans directly from Providence or your producer			Purchase these plans directly from Providence, your producer or Cover Oregon	
	Choice 6200	Choice 2500	Choice 1750	Providence Oregon Standard Silver	Providence Oregon Standard Bronze
20 or younger	$117.93	$131.85	$135.70	$135.23	$114.81
21	$195.01	$218.01	$224.39	$223.60	$189.85
22	$195.01	$218.01	$224.39	$223.60	$189.85
23	$195.01	$218.01	$224.39	$223.60	$189.85
24	$195.01	$218.01	$224.39	$223.60	$189.85
25	$195.78	$218.88	$225.29	$224.50	$190.61
26	$199.68	$223.24	$229.77	$228.96	$194.41
27	$204.36	$228.48	$235.16	$234.34	$198.96
28	$211.96	$236.97	$243.90	$243.05	$206.37
29	$218.21	$243.96	$251.09	$250.22	$212.44
30	$221.33	$247.44	$254.68	$253.79	$215.48
31	$226.01	$252.67	$260.06	$259.15	$220.04
32	$230.69	$257.91	$265.45	$264.52	$224.58
33	$233.61	$261.18	$268.81	$267.88	$227.44
34	$236.73	$264.66	$272.40	$271.46	$230.48
35	$238.30	$266.42	$274.20	$273.24	$232.00
36	$239.85	$268.16	$275.99	$275.03	$233.51
37	$241.42	$269.90	$277.79	$276.82	$235.03
38	$242.97	$271.65	$279.58	$278.61	$236.55
39	$246.09	$275.13	$283.17	$282.19	$239.59
40	$249.22	$278.62	$286.77	$285.76	$242.62
41	$253.89	$283.86	$292.15	$291.13	$247.18
42	$258.37	$288.87	$297.31	$296.27	$251.55
43	$264.62	$295.85	$304.49	$303.43	$257.62
44	$272.42	$304.56	$313.47	$312.38	$265.22
45	$281.58	$314.81	$324.02	$322.89	$274.13
46	$292.50	$327.02	$336.58	$335.40	$284.77
47	$304.78	$340.76	$350.72	$349.49	$296.73
48	$318.83	$356.45	$366.87	$365.59	$310.40
49	$332.67	$371.93	$382.80	$381.47	$323.88
50	$348.27	$389.37	$400.75	$399.36	$339.07
51	$363.68	$406.59	$418.48	$417.02	$354.06
52	$380.65	$425.57	$438.01	$436.47	$370.58
53	$397.80	$444.75	$457.75	$456.15	$387.29
54	$416.33	$465.45	$479.06	$477.39	$405.32
55	$434.86	$486.17	$500.38	$498.63	$423.36
56	$454.94	$508.62	$523.50	$521.66	$442.91
57	$475.22	$531.30	$546.83	$544.92	$462.66
58	$496.87	$555.49	$571.74	$569.74	$483.74
59	$507.59	$567.48	$584.08	$582.04	$494.17
60	$529.23	$591.69	$608.99	$606.86	$515.25
61	$547.95	$612.61	$630.53	$628.32	$533.47
62	$560.24	$626.35	$644.66	$642.41	$545.43
63	$575.64	$643.58	$662.39	$660.07	$560.43
64	$585.02	$654.03	$673.16	$670.79	$569.55

Our Mission

As people of Providence,
we reveal God's love for all,
especially the poor and vulnerable,
through our compassionate service.

Our Core Values

Respect, Compassion, Justice,
Excellence, Stewardship

Portland metro area

503-574-5000

All other areas

800-988-0088

www.ProvidenceHealthPlan.com

PROVIDENCE
Health Plan

IND-016L_13-01675

Your Benefit Summary

Connect 2700

Medical Neighborhood 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)	$5,000 per person $10,000 per family (2 or more)	$10,000 per person $20,000 per family (2 or more)	$2,700 per person $5,400 per family (2 or more)	$5,400 per person $10,800 per family (2 or more)

Important information about your plan

This plan is a Medical Neighborhood plan. You choose a Medical Neighborhood clinic staffed by a team of health care professionals, led by your Medical Neighborhood Personal Physician/Provider, who work together with you to support your health care needs. This team coordinates your care, including referrals when needed. Your out-of-pocket costs are generally higher if you use services not coordinated through your Medical Neighborhood clinic.

This summary provides only highlights of your benefits. To view all your plan details, including your Individual & Family Plan Contract and Plan Guide, register for myProvidence at **www.ProvidenceHealthPlan.com/getstarted.**

- Not sure what a word or phrase means? See the last page of this summary for definitions.
- Your deductible does not apply to covered services required to treat an accidental injury within 90 days following the injury.
- The per person deductible and out-of-pocket maximums apply when only the individual is enrolled. The family deductible and out-of-pocket maximum apply when an individual and dependent(s) are enrolled.
- In-network and out-of-network deductibles, as well as in-network and out-of-network out-of-pocket maximums, accumulate separately and are not combined.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- View a list of participating pharmacies, including specialty pharmacies, at www.ProvidenceHealthPlan.com or call us.
- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online or call us.
- Some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Individual & Family Plan Contract for details.

Connect Benefit Highlights	After you pay your calendar year deductible, 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, from your Medical Neighborhood or with a Medical Neighborhood referral)	**Out-of-Network Copay or Coinsurance** (after deductible, from a Non-Network provider or without a Medical Neighborhood referral)
Physician / Provider Services		
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	50%
• Office visits to Personal Physician/Provider	$25✓	50%
• Office visits to alternative care providers	30%	50%
• Office visits to all other physicians/providers	$50✓	50%
• E-visits	$10✓	Not covered
• Telephone consults	$10✓	50%
• Providence Retail Health	$10✓	Not applicable
• Routine immunizations; shots	Covered in full✓	50%
• Allergy shots; serums; injectable medications	30%	50%
• Inpatient hospital visits	30%	50%
• Surgery; anesthesia	30%	50%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	50%
• Mammograms	Covered in full✓	50%

Connect Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Maternity Services		
• Prenatal care	Covered in full✓	50%
• Delivery; postnatal care		
• Certified nurse midwife	20%	50%
• Personal Physician/Provider	20%	50%
• OB/GYN Physician/Provider	30%	50%
Hospital Services		
• Inpatient care	30%	50%
• Observation care	30%	50%
• Rehabilitative care (limited to 30 days per calendar year, 60 days for head/spinal injuries)	30%	50%
• Habilitative Care (limited to 30 days per calendar year, 60 days for head/spinal injuries)	30%	50%
• Maternity care	30%	50%
• Routine newborn nursery care	30%	50%
• Skilled nursing facility (limited to 60 days per calendar year)	30%	50%
Outpatient Diagnostic Services		
• X-ray; lab services	30%✓	50%
• High-tech imaging services (such as PET, CT, MRI)	30%	50%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year; deductible waived)	30%*	50%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	$250 then 30%	$250 then 30%
• Urgent care services (for non-life threatening illness/minor injury)	$50✓	50%
• Emergency medical transportation	30%	30%
Other Covered Services		
• Outpatient surgery at an ambulatory surgery center	$250	50%
• Outpatient surgery at a hospital-based facility	30%	50%
• Outpatient dialysis, infusion, chemotherapy, radiation therapy	30%	50%
• Outpatient rehabilitative services (limited to 30 visits per calendar year; up to 30 additional visits per specified condition)	30%	50%
• Outpatient habilitative services (limited to 30 visits per calendar year; up to 30 additional visits per specified condition)	30%	50%
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓
• Respite care (limited to members receiving Hospice care; limited to 5 days, up to 30 days per lifetime)	30%	50%
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓	Not covered
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy; generic, preferred brand-name or non-preferred brand-name drugs)		
• Generic drugs	30%	Not covered
• Preferred brand-name drugs	30%	Not covered
• Non-preferred brand-name and specialty drugs	30%	Not covered
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-Plan copayment does not apply to your Out-of-Plan Out-of-Pocket Maximum.)		
• Knee arthroscopy	$500	$500 then 50%
• Knee, hip replacement	$500	$500 then 50%
• Knee, hip resurfacing	$500	$500 then 50%
• Shoulder arthroscopy	$500	$500 then 50%
• Sinus surgery	$500	$500 then 50%
• Sleep studies	$100	$100 then 50%
• Spinal injections for pain	$100	$100 then 50%
• Spine procedures	$500	$500 then 50%
• Upper GI endoscopy	$100	$100 then 50%

Connect Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All inpatient, residential, and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	30%	50%
• Residential services	30%	50%
• Outpatient provider visits	$25✓	50%
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
• Generic	$15✓	Not covered
• Preferred brand name	$45	Not covered
• Non-preferred brand name	50%	Not covered
• Specialty	50%	Not covered
Pediatric Vision Services To find a VSP Advantage participating provider, go to www.vsp.com or contact VSP Member Services at 800-877-7195.		
• Routine eye exam (limited to one exam per calendar year)	Covered in full✓	Covered up to $47✓
• Lenses (limited to one pair per calendar year)		
-Single vision	Covered in full✓	Covered up to $30✓
-Lined bifocal	Covered in full✓	Covered up to $50✓
-Lined trifocal	Covered in full✓	Covered up to $70✓
• Frames (limited to one pair per calendar year)	Covered in full✓	Covered up to $45✓
• Contact lens services and materials (in place of glasses. Annual limits apply; limited to the following):	Covered in full✓	Covered up to $100✓
-Standard (one pair annually) - 1 contact lens per eye (total 2 lenses)		
-Monthly (six month supply) - 6 lenses per eye (total 12 lenses)		
-Bi-weekly (three month supply) - 6 lenses per eye (total 12 lenses)		
-Dailies (one month supply) - 30 lenses per eye (total 60 lenses)		
Supplemental Benefit - Adult Vision Services To find a VSP Advantage participating provider, go to www.vsp.com or contact VSP Member Services at 800-877-7195. (Your deductible does not apply to vision services. Copayments do not apply to your Out-of-Pocket maximums.)		
• Routine eye exam (limited to one exam per calendar year)	$25✓	Covered up to $47✓

* Your deductible(s) do not apply to purchases of diabetes supplies

Pediatric and Supplemental Adult Vision Exclusions

The following items are excluded under this plan:

- Two pairs of glasses instead of bifocals
- Replacement of lenses, frames or contacts
- Medical or surgical treatment
- Orthoptics, vision training or supplemental testing

Items not covered under the contact lens benefit:

- Insurance policies or service agreements
- Artistically painted or non-prescription lenses
- Additional office visits for contact lens pathology
- Contact lens modification, polishing or cleaning

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.

Deductible carryover
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

Exclusion Period
A period of time during which all specified treatments or services are excluded from coverage. If treatment was covered under a previous plan, then the exclusion period is reduced by each day of continuous prior creditable coverage.

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

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 preferred brand-name copay. Visit us online for answers to frequently asked questions about generic drugs.

In-network benefit
The in-network benefit is a network of highly qualified physicians and health care providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers. To find a participating provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Medical Neighborhood
A full service health care clinic which has been designated as a Medical Neighborhood clinic providing and coordinating members' medical care.

Medical Neighborhood referral
Medical Neighborhood referral means a referral from your Neighborhood clinic to receive services from a Participating Provider outside of your Neighborhood clinic.

Non-preferred brand drug
A brand name drug that is included on the formulary at a higher cost share.

Out-of-network
Refers to services received without a referral or from a non-network provider. Your out-of-pocket costs are generally higher when you receive covered services from non-network providers. To find a participating 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.

Preferred brand drug
A brand name drug that is included on the formulary.

Prescription drug 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.

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.

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

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: 711

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