Your Benefit Summary

Providence Essential

Providence Signature Network	In-Network	Out-of-Network
Individual Calendar Year Deductible (family amount is 2 times individual)	$6,850	$13,700
Individual Out-of-Pocket Maximum (family amount is 2 times individual) This amount includes the deductible.	$6,850	$13,700

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.

- In-network and out-of-network deductibles and out-of-pocket maximums accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- To get the most out of your benefits, use the providers within the Providence Signature network.
- 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. See your handbook for details.

	Below is the amount you pay after you have met your calendar year deductible	
	In-Network	Out-of-Network
Preventive Care		
Periodic health exams and well-baby care	Covered in full✓	Covered in full
Routine immunizations and shots	Covered in full✓	Covered in full
Colonoscopy (preventive, age 50+)	Covered in full✓	Covered in full
Gynecological exams (1 per calendar year) and Pap tests	Covered in full✓	Covered in full
Mammograms	Covered in full✓	Covered in full
Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not Covered
Physician/Professional Services		
Office visits to a Personal Physician/Provider	50% first 3 visits then Covered in full ✓	Covered in full
Visits to a Personal Physician/Provider by phone or video including Providence Health eXpress®	Covered in full	Not Covered
Office visits to an Alternative Care Provider	Covered in full	Covered in full
Office visits to specialists	Covered in full	Covered in full
Visits to a specialist by phone or video	Covered in full	Not Covered
Inpatient hospital visits	Covered in full	Covered in full
Allergy shots, allergy serums, injectable and infused medications	Covered in full	Covered in full
Surgery and anesthesia	Covered in full	Covered in full
Diagnostic Services		
X-ray and lab services	Covered in full	Covered in full
High-tech imaging services (such as PET, CT or MRI)	Covered in full	Covered in full
Sleep studies	Covered in full	Covered in full

Your Benefit Summary (continued)

	Below is the amount you pay after you have met your calendar year deductible	
	In-Network	Out-of-Network
Emergency and Urgent Services		
Emergency services (For emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits.)	Covered in full	Covered in full
Emergency medical transportation (air and/or ground) Emergency transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider.	Covered in full	
Urgent care visits (for non-life threatening illness/minor injury)	Covered in full	Covered in full
Hospital Services		
Inpatient/Observation care	Covered in full	Covered in full
Skilled nursing facility (limited to 60 days per calendar year)	Covered in full	Covered in full
Inpatient rehabilitative care (limited to 30 days per calendar year)	Covered in full	Covered in full
Inpatient habilitative care (limited to 30 days per calendar year)	Covered in full	Covered in full
Outpatient Services		
Outpatient surgery at an ambulatory surgery center or at a hospital-based facility	Covered in full	Covered in full
Colonoscopy (non-preventive) at an ambulatory surgery center at an hospital-based facility	Covered in full	Covered in full
Outpatient dialysis, infusion, chemotherapy and radiation therapy	Covered in full	Covered in full
Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year; up to 30 additional visits per specified condition)	Covered in full	Covered in full
Outpatient habilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year; up to 30 additional visits per specified condition)	Covered in full	Covered in full
Maternity Services		
Prenatal visits	Covered in full✓	Covered in full
Delivery and postnatal physician/provider visits	Covered in full	Covered in full
Inpatient hospital/facility services	Covered in full	Covered in full
Routine newborn nursery care	Covered in full	Covered in full
Medical Equipment, Supplies and Devices		
Medical equipment, appliances and supplies	Covered in full	Covered in full
Diabetes supplies (lancets, test strips and needles)	Covered in full	Covered in full
Prosthetic and orthotic devices	Covered in full	Covered in full
Mental Health and Chemical Dependency To initiate services, call 800-711-4577. All services, except outpatient provider office visits, must be prior authorized.		
Inpatient and residential services	Covered in full	Covered in full
Day treatment, intensive outpatient, and partial hospitalization services	Covered in full	Covered in full
Outpatient provider visits	50% first 3 visits then Covered in full✓	Covered in full
Applied Behavior Analysis	Covered in full	Covered in full
Home Health and Hospice		
Home health care	Covered in full	Covered in full
Hospice care	Covered in full	Covered in full
Respite care (limited to members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime)	Covered in full	Covered in full
Biofeedback		
Biofeedback for specified diagnosis (limited to 10 visits per lifetime)	Covered in full	Covered in full

✓ Deductible does not apply

Prescription Drugs

	Below is the amount you pay after you have met your calendar year deductible
Up to a 30-Day Supply (From a participating retail, preferred or specialty pharmacy)	
Preventive	Covered in full✓
Generic	Covered in full
Preferred brand name	Covered in full
Non-preferred brand name	Covered in full
Specialty and Compound	Covered in full
90-Day Supply (From a participating mail order or preferred retail pharmacy)	
Preventive	Covered in full✓
Generic	Covered in full
Preferred brand name	Covered in full
Non-preferred brand name	Covered in full

Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply as outlined in your handbook 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. 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.
- View a list of our participating pharmacies www.ProvidenceHealthPlan.com/planpharmacies.

Using your prescription drug benefit

- To find if a drug is covered under your plan check online at www.ProvidenceHealthPlan.com/pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy at 3 times the copay. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply under the Specialty drug tier.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefit limitations, and coinsurance. See your Member Handbook for details.
- 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.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Handbook for more information.
- Be sure you present your current Providence Health Plan member identification card.

Routine Vision Services

Provided by VSP

VSP Choice Network (For customer service call 800-877-7195)	Below is the amount you pay after you have met your calendar year deductible In-Network	Out-of-Network
Pediatric Vision Services (under age 19)		
Routine eye exam (limited to 1 exam per calendar year)	Covered in full✓	Covered up to $45✓
Lenses (limited to 1 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 1 pair per calendar year; select from VSP's Otis &Piper ™ Eyewear Collection)	Covered in full✓	Covered up to $70✓
Contact lens services and materials in place of glasses Standard: 1 pair per calendar year (1 contact lens per eye) Monthly: 6 month supply per calendar year (6 lenses per eye) Bi-weekly: 3 month supply per calendar year (6 lenses per eye) Dailies: 3 month supply per calendar year (90 lenses per eye)	Covered in full✓	Covered up to $105✓

Explanation of terms and phrases

Coinsurance – The percentage of the cost that you may need to pay for covered services.

Copay – The fixed dollar amount you pay to a healthcare 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 the plan pays any benefits within a calendar year. The following expenses do not apply to the individual or family deductible: services not covered by the plan; fees that exceed usual, customary and reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the plan's prior authorization requirements; copays and coinsurance for services that do not apply to the deductible.

Formulary – A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drug – Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Generic drugs.

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 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 www.ProvidenceHealthPlan.com/providerdirectory.

Out-of-pocket maximum – The limit on the dollar amount that an individual or family pays for specified covered services in a calendar year. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook or contract for details.

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.

Preferred brand drug /Non-Preferred brand-name drug – Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Preferred Brand-name or Non-Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

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.

Preventive drug – A generic or brand medication included on the formulary and required to be covered at no cost per federal regulation.

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

Contact us

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY:711

www.ProvidenceHealthPlan.com/contactus