Your Benefit Summary

Core Essentials Plan

PROVIDENCE Health Plan

Copay	What You Pay In-Plan	What You Pay Out-of-Plan	Calendar Year Common Coinsurance Maximum (after deductible)	Calendar Year Common Deductible
$25/$50	30%	50%	$5,000 per person $15,000 per family (3 or more)	$1,000 per person $3,000 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for myProvidence at www.ProvidenceHealthPlan.com/getstarted.

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- A pre-existing condition exclusion applies to this plan. This exclusion does not apply to members who are under the age of 19. See the back for more information.
- Your deductibles, copayments, some services and penalties do not apply to coinsurance maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Core Essentials 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-Plan Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services		
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓	50%✓
• Routine immunizations; shots	Covered in full✓	50%
• Office visits to Personal Physician/Provider	$25 / visit	50%
• Office visits to specialist	$50 / visit	50%
• Maternity services; pre- and postnatal visits, delivery	30%	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%
Hospital Services		
• Inpatient care	30%	50%
• Observation care	30%	50%
• Maternity care	30%	50%
• Routine newborn nursery care	30%	50%
• Rehabilitative care (30 days per calendar year)	30%	50%
• Skilled nursing facility (60 days per calendar year)	30%	50%
Outpatient Diagnostic Services		
• X-ray; lab services	30%	50%
• 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, copayment is not applied; all services subject to inpatient benefits.)	$250	$250
• Urgent care services (for non-life threatening illness/minor injury)	$50 / visit	50%
• Emergency medical transportation	30%	30%

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

Core Essentials Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services		
• Outpatient rehabilitative services (30 visits per calendar year)	30%	50%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	30%	50%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓
• 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 drugs	$10✓	Not covered
-Formulary brand-name drugs	$50✓	Not covered
-Non-formulary brand-name drugs	$100✓	Not covered
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient and day treatment services	30%	50%
• Residential services (limited to 60 days per calendar year)	30%	50%
• Outpatient provider visits	$25 / visit	50%

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

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Common coinsurance maximum
The limit on the coinsurance you will have to spend for specified covered health services (a combination of both in and out-of-plan services) in a calendar year. Copayments, some services and expenses do not apply to the common coinsurance maximum. See your Member Handbook for details.

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-plan or out-of-plan 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 or coinsurance for any supplemental benefits provided by your employer, such as prescription drugs, or routine vision care

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

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.

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

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

Non-participating provider
Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-plan
Refers to services you receive from a non-participating 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.

Participating provider
A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

Pre-existing condition exclusion
A pre-existing condition is any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your enrollment date. Coverage for pre-existing conditions is excluded for a period of six months following your enrollment date. This exclusion period can be reduced by qualifying Creditable Coverage. The pre-existing condition exclusion does not apply to members who are under the age of 19. See your Member Handbook for details.

Prior authorization
Some services must be pre-approved. In-Plan, your provider will request prior authorization. Out-of-Plan, 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-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

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