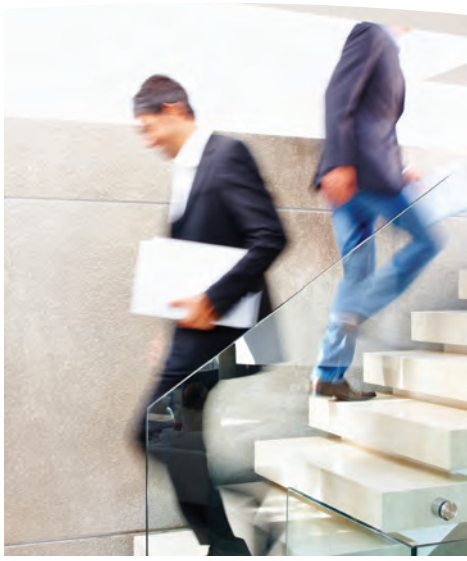
PROVIDENCE
Health Plan



Benefit Guide

Oregon Large Group

For employer groups of 51 or more employees, enrolling or renewing, effective on or after Aug. 1, 2012

www.ProvidenceHealthPlan.com

You choose Bob's Red Mill, **Bob's Red Mill chose Providence.**

"We really liked that Providence is a local partner," said Dennis Gilliam, executive vice president of sales and marketing. "Our employees like that they can call in and talk to a nurse (through the ProvRN program) any time they want. They like having a relationship with their own doctors and the straightforward billing process."

PROVIDENCE Health Plan

It's not just health care, it's how we care.™

Extra Values and Discounts

Health Balance® includes programs to help maintain health, improve health, manage health and have fun with health – ranging from nationally-recognized care management programs and medication therapy management to discounts on healthy activities such as ski lift tickets and massage therapy.

Do you know how many of your members are healthy and what it takes to keep them healthy? Or how best to reduce health risk in your organization?

As part of an integrated health system with hospitals, doctors and clinics, Providence Health Plan has developed market-leading techniques to reduce costs and provide a better overall care experience for your employees and their families.

Member health

Providence RN advice line
Fitness classes
Tobacco cessation
Disease management
Health Coaching

Employer resources

Wellness consulting
Health promotion materials
Free COBRA administration through Ceridian

Optional services

Biometric screenings
Flu shot clinics
Health lectures
Classes
Employee Assistance Program

These add-on services are available to employers at an additional cost and may require a minimum number of participants

Member discounts

Hearing
Vision
Acupuncture
Chiropractic
Massage therapy
Recreational activities
Disneyland
Yoga
Ski lift tickets
Kayaking
Backpacking
Horseback riding
Health club memberships

Get more value from your health care dollar. Exclusively for Providence Health Plan members, our extra values and discounts help members stay active, get healthy and save money. Whether it's a health fair, a company-wide challenge or onsite flu shots, Health Balance is your resource for a healthier tomorrow.

health balance®

Plan Overview

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Plan Type	Number of options	Key Highlights
Core	**18 options available**	The Core plans are designed to offer employees access to the care they use most, while keeping an eye on the premium. With cost savings of 10%-20% over Open Option plans, these plans feature: • Coverage for non-participating providers • Fourth-quarter deductible carryover • Great paired with an integrated HRA from HealthEquity® • Combined in-plan and out-of-plan deductibles and out-of-pocket maximums **Core Essentials** • Deductible plan with more cost sharing to maximize premium savings **Core Advantages** • $25 copay for office visits, $35 for specialist and urgent care • Deductible waived on all office visits and the first $500 in-plan lab and basic X-ray services per year **Core Alternatives** • Deductible waived on the first six visits and the first $500 in-plan lab and basic X-ray services per year • Alternative Care Plus to any licensed provider
Open Option	**16 options available**	The Open Option plans pair a premier level of coverage with the choice to see any provider, in or out of our participating provider network. These plans provide cost predictability through low copays. • Deductible waived on many services, including lab and X-ray, imaging and ER visits • Combined in-plan and out-of-plan deductibles and out-of-pocket maximums • Coverage for non-participating providers • Fourth-quarter deductible carryover
HSA	**5 options available**	The HSA plans can be paired with a tax-free Health Savings Account to offer flexible coverage that provides employees more control over how their health care dollars are spent. • Health Savings Accounts are portable and provide employees the unique ability to plan for expenses now and in the future • Combined in-plan and out-of-plan deductibles and out-of-pocket maximums • Pair with an integrated HSA from HealthEquity® to provide a best-in-class HSA experience • Coverage for non-participating providers
Personal Option	**14 options available**	The Personal Option plans offer the same comprehensive benefits as Open Option while leveraging the premium savings of a closed network. With premium savings of 5% over comparable Open Option plans, employees still have access to nearly a million providers in our network and nearly 80,000 facilities throughout the country.
Dual Option	**Your choice of options**	Ability to pair any two medical plans together

Plan Comparison

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Plan Features	Core	Open Option	HSA	Personal Option
PROVIDER NETWORK				
Broad provider network	⊙	⊙	⊙	⊙
Coverage for non-participating providers	⊙	⊙	⊙	
No referrals required	⊙	⊙	⊙	⊙
BENEFITS				
Fourth-quarter deductible carryover	⊙	⊙		⊙
Combined in-plan and out-of-plan deductibles	⊙	⊙	⊙	N/A
Combined in-plan and out-of-plan out-of-pocket maximums	⊙	⊙	⊙	N/A
Free preventive care	⊙	⊙	⊙	⊙
Deductible waived ER visits		⊙		⊙
Deductible waived maternity prenatal and postnatal visits and delivery		⊙		⊙
Deductible waived lab and X-ray	⊙*	⊙		⊙
Deductible waived high-tech imaging		⊙		⊙
Higher copay for specialist visits and urgent care	⊙		N/A	
Copays apply toward OOP Max		⊙	N/A	⊙
Rx subject to medical deductible			⊙	
No pre-existing condition exclusion period	⊙	⊙	⊙	⊙
HEALTH BALANCE WELLNESS PROGRAM				
Providence RN 24/7 nurse advice line	⊙	⊙	⊙	⊙
LifeBalance recreational discount program	⊙	⊙	⊙	⊙
Disease Management and support for chronic conditions	⊙	⊙	⊙	⊙
INTEGRATED HSA, HRA, AND FSA ACCOUNT ADMINISTRATION				
Can be paired with an integrated HealthEquity® HRA and/or FSA	⊙	⊙		⊙
Can be paired with an integrated HealthEquity® HSA			⊙	

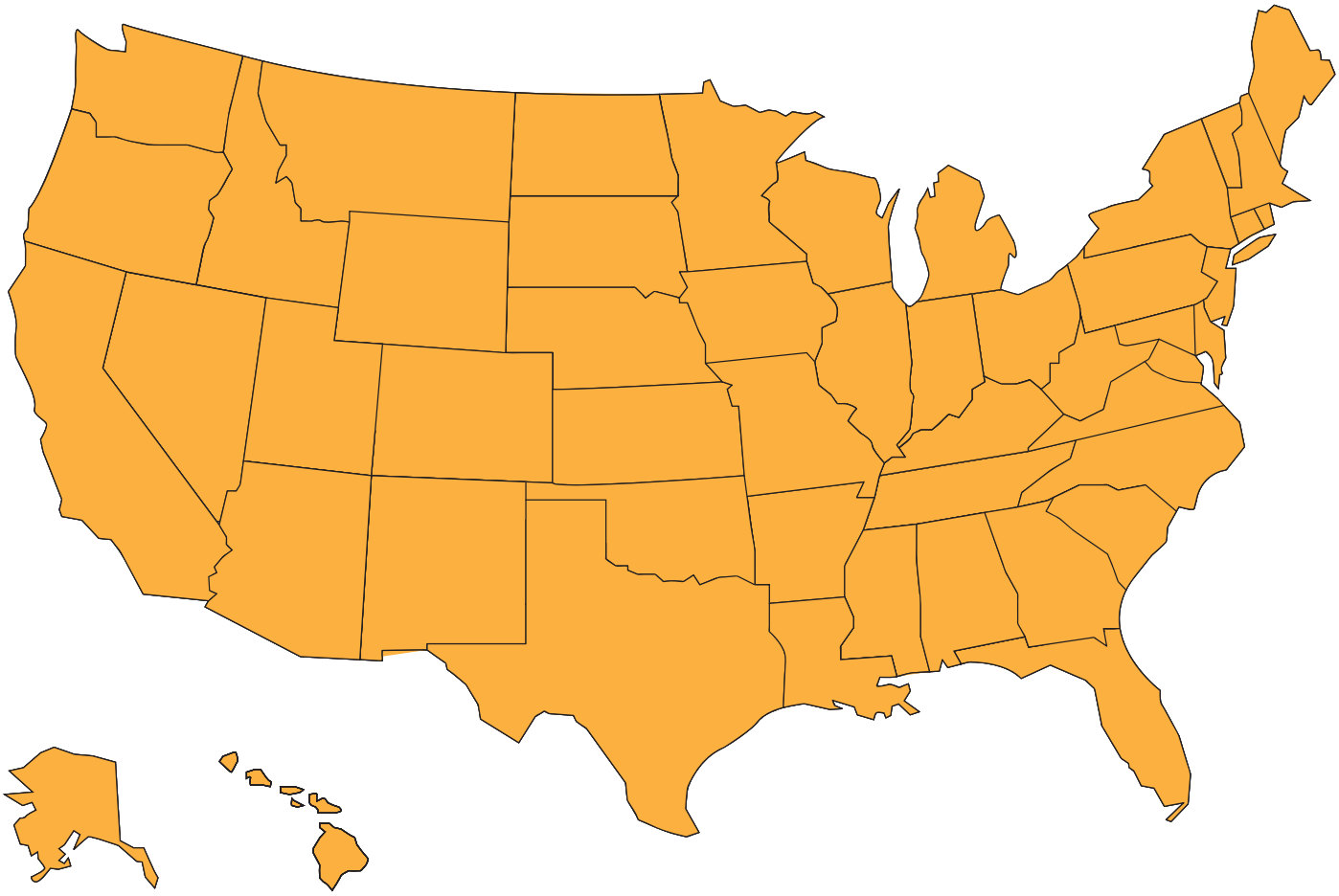
** Deductible waived for first $500 of in-plan services in a calendar year on Core Advantages and Core Alternatives*

The plan information listed in this booklet provides an overview only. Please refer to a Benefit Summary for specific details.

Provider Network

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

We've got you covered with nearly one million providers in our national network. You can receive care at nearly 80,000 facilities throughout the country.



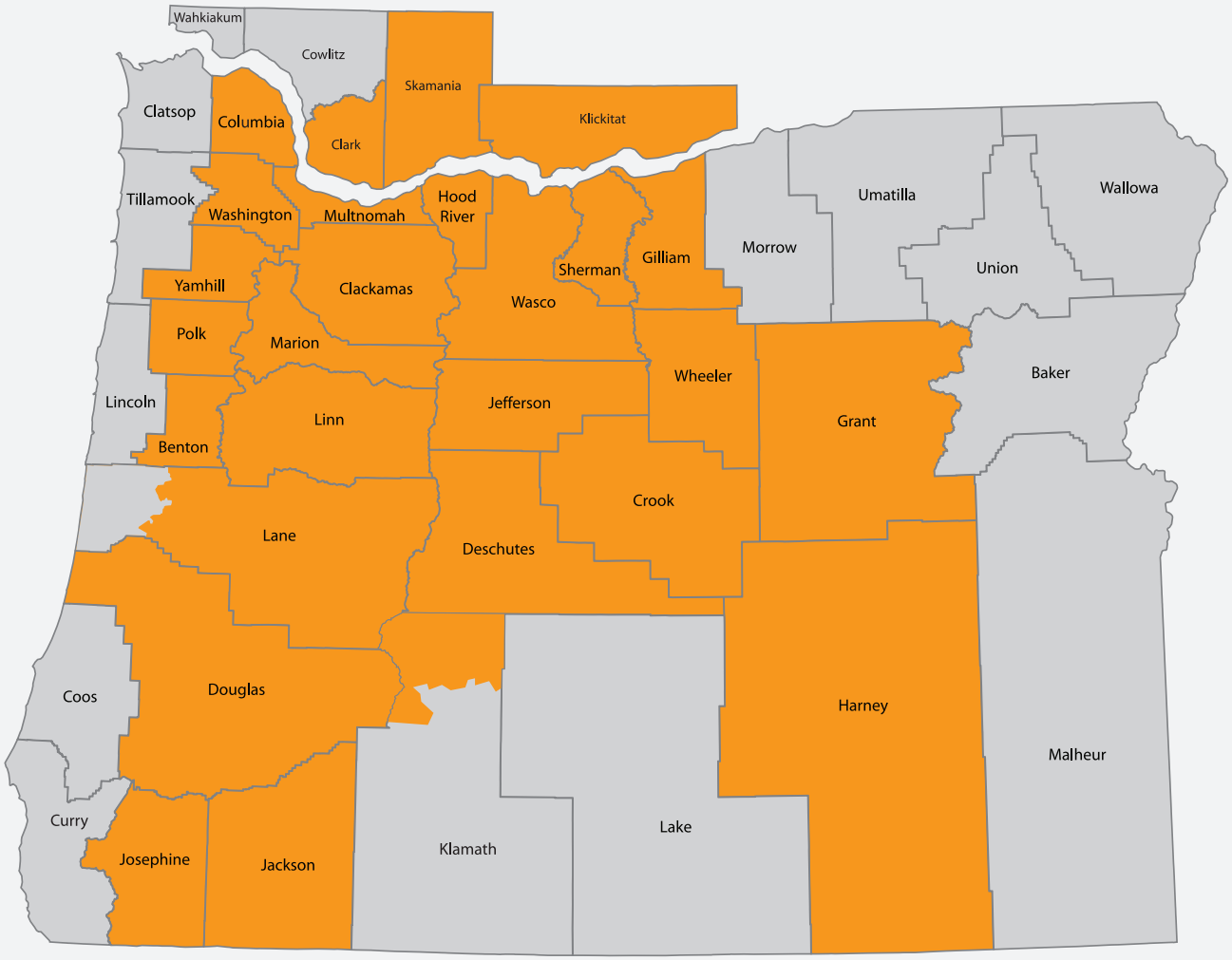
In addition to Providence providers located in our hospitals and clinics, health plan members also have nationwide access to participating providers through our partnerships with MultiPlan/PHCS Network, First Choice Health Network and BrightPath.

For participating providers, please visit our online provider directory.

Selling Area

Employers' business must be located in the Providence Health Plan selling area.

SELLING AREA



Open Option, Core and HSA plans: To be eligible for these products employers must have at least 51% of enrolling employees or members residing and working within the selling area.

Personal Option: Available to employers with all employees residing within Oregon or Washington. To be eligible for these products, employers must have 67% of enrolling employees or members residing and working within the selling area.

Contact your Providence sales representative for details.

Selling area is not related to our provider network.
Providence group members can see any provider who participates in our nationwide network.

Integrated HSA, HRA and FSA

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Providence Health Plan partners with HealthEquity® to bring you best-in-class consumer-directed health plans. They lower costs, support choice and flexibility, and provide tax advantages. They also encourage employees to be more judicious with their health care dollars and make better health care decisions.

Teaming up with HealthEquity, the nation's oldest and largest dedicated health savings trustee, makes it easy on you.

- 24/7 customer service
- View claims and payment information all in one place, anytime, anywhere
- Pay providers online
- Integrated plan setup, enrollment and billing: set up your health plan and employee health care accounts in one place.
- Fully equipped employer portal: manage contributions, view reporting and upload contribution information.

Account type	Employee account activation and set-up	Monthly administration	Employer plan set-up and annual plan maintenance fee (paid directly to HealthEquity)
Health Savings Account (HSA) HSAs are employee-owned bank accounts where money earned can be used for employees' current and future health care expenses. HSAs can be paired with any HSA-qualified plan.	Free	$2.70 per account (paid as part of Providence bill)	Free
Health Reimbursement Arrangement (HRA) HRAs are employer-owned accounts that are set up to reimburse employees for their qualified medical expenses and can be paired with any non-HSA plan. Employers have flexibility in designing a plan to meet their unique needs.	Free	$3.45 per account (paid as part of Providence bill)	1-100 accounts: $250 101-1,000 accounts: $500
Flexible Spending Account (FSA) FSAs allow employees to set aside pre-tax dollars from their paycheck to help pay for their eligible health care costs throughout the year. FSAs can be paired with any non-HSA plan.	Free	$3.45 per account (paid directly to HealthEquity)	1-100 accounts: $250 101-1,000 accounts: $500
Limited Purpose Flexible Spending Account (LPFSA) LPFSAs can be paired with an HSA and can be used to reimburse employees for dental and vision care.	Free	$1.95 per account (paid directly to HealthEquity)	Free

Separate plan set-up and annual plan maintenance fees apply.

Core Essentials

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Basic coverage includes preventive care paired with solid financial protection for members.

	$25/30%/50%/$5,000 with choice of deductible	
Calendar-year common coinsurance maximum (individual/family)	$5,000/$15,000	
PHYSICIAN / PROVIDER SERVICES	**In plan**	**Out of plan**
Periodic health exams; well-baby care (from a personal physician/provider only)	Covered in full✓	50%✓
Routine immunizations; shots	Covered in full✓	50%
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	50%
Office visits to personal physician/provider	$25/visit	50%
Specialist visits	$50/visit	50%
Maternity services; prenatal and postnatal visits	30%	50%
Allergy shots, serums and injectable medications	30%	50%
Inpatient hospital visits	30%	50%
Surgery and 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%
Maternity care	30%	50%
Routine newborn nursery care	30%	50%
OUTPATIENT DIAGNOSTIC SERVICES		
X-ray and lab services	30%	50%
Imaging services (such as PET, CT, MRI)	30%	50%
DURABLE MEDICAL EQUIPMENT		
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	30%*	50%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION		
Emergency services	$250	$250
Urgent care services	$50/visit	50%
Emergency medical transportation	30%	30%
OTHER COVERED SERVICES		
Outpatient rehabilitative services (30 visits per calendar year)	30%	50%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	30%	50%

✓ No deductible needs to be met prior to receiving this benefit.
* Deductible does not apply to diabetes supplies.

KEY FEATURES:

- Basic coverage with a lower premium
- Deductible applies to office visits

DEDUCTIBLE OPTIONS:

Choose from the following calendar-year common deductibles (individual/family):

- $1,000/$3,000
- $1,500/$4,500
- $2,000/$6,000
- $3,000/$9,000
- $5,000/$15,000
- $7,500/$22,500

Core Advantages

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Preventive services plus first-dollar coverage on commonly used benefits, such as office visits and lab services.

	$25/30%/50%/$5,000 with choice of deductible	
Calendar-year common coinsurance maximum (individual/family)	$5,000/$15,000	
PHYSICIAN / PROVIDER SERVICES	**In plan**	**Out of plan**
Periodic health exams; well-baby care (from a personal physician/provider only)	Covered in full✓	50%✓
Routine immunizations; shots	Covered in full✓	50%
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	50%
Office visits to personal physician/provider	$25/visit✓	50%✓
Specialist visits	$35/visit✓	50%✓
Maternity services; prenatal and postnatal visits	30%	50%
Allergy shots, serums and injectable medications	30%	50%
Inpatient hospital visits	30%	50%
Surgery and 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%
Maternity care	30%	50%
Routine newborn nursery care	30%	50%
OUTPATIENT DIAGNOSTIC SERVICES		
X-ray and lab services (deductible is waived for the first $500 of in-plan services in a calendar year)	30%	50%
Imaging services (such as PET, CT, MRI)	30%	50%
DURABLE MEDICAL EQUIPMENT		
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	30%*	50%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION		
Emergency services	$250	$250
Urgent care services	$35/visit✓	50%
Emergency medical transportation	30%	30%
OTHER COVERED SERVICES		
Outpatient rehabilitative services (30 visits per calendar year)	30%	50%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	30%	50%

✓ No deductible needs to be met prior to receiving this benefit.
* Deductible does not apply to diabetes supplies.

KEY FEATURES:

- No deductible before office visits, both in- and out-of-network
- Deductible waived for first $500 for X-ray and lab services

DEDUCTIBLE OPTIONS:

Choose from the following calendar-year common deductibles (individual/family):

- $1,000/$3,000
- $1,500/$4,500
- $2,000/$6,000
- $3,000/$9,000
- $5,000/$15,000
- $7,500/$22,500

DID YOU KNOW?

Only one in five of our members uses more than $500 in lab and X-ray claims per year

Preventive services plus coverage of the first six visits before the deductible.

	$25/30%/50%/$5,000 with choice of deductible	
Calendar-year common coinsurance maximum (individual/family)	$5,000/$15,000	
PHYSICIAN / PROVIDER SERVICES	**In plan**	**Out of plan**
Periodic health exams; well-baby care (from a personal physician/provider only)	Covered in full✓	50%✓
Routine immunizations; shots	Covered in full✓	50%
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	50%
Office visits to personal physician/provider	My Choice Benefit $25 / visit	50%
Specialist visits	My Choice Benefit $25 / visit	50%
Alternative care provider visits (any licensed provider; limited to $500 per calendar year)	My Choice Benefit $25 / visit	My Choice Benefit $25 / visit
Maternity services; prenatal and postnatal visits	30%	50%
Allergy shots, serums and injectable medications	30%	50%
Inpatient hospital visits	30%	50%
Surgery and 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%
Maternity care	30%	50%
Routine newborn nursery care	30%	50%
OUTPATIENT DIAGNOSTIC SERVICES		
X-ray and lab services (deductible is waived for the first $500 of in-plan services in a calendar year)	30%	50%
Imaging services (such as PET, CT, MRI)	30%	50%
DURABLE MEDICAL EQUIPMENT		
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	30%*	50%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION		
Emergency services	$250	$250
Urgent care services	My Choice Benefit $25 / visit	50%
Emergency medical transportation	30%	30%
OTHER COVERED SERVICES		
Outpatient rehabilitative services (30 visits per calendar year)	30%	50%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	30%	50%

✓ No deductible needs to be met prior to receiving this benefit.
* Deductible does not apply to diabetes supplies.

KEY FEATURES:

- Alternative care coverage from any licensed provider
- **My Choice Benefit** Deductible is waived for the first six visits per calendar year for the following services:
  - Office visits
  - Specialist visits
  - Alternative care
  - Urgent care

DEDUCTIBLE OPTIONS:

Choose from the following calendar-year common deductibles (individual/family):

- $1,000/$3,000
- $1,500/$4,500
- $2,000/$6,000
- $3,000/$9,000
- $5,000/$15,000
- $7,500/$22,500

DID YOU KNOW?

Only one in 10 of our members uses more than six office visits per year

Open Option

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

A premier level of coverage with the choice to see any provider, in or out of our participating provider network.

	$10/10%/30%/$1,200		$10/10%/20%/$1,700 with $250cd	
Calendar-year common deductible (individual/family)	no deductible		$250/$750	
Calendar-year common out-of-pocket maximum (individual/family)	$1,200/$3,600		$1,700/$5,100	
PHYSICIAN / PROVIDER SERVICES	In plan	Out of plan	In plan	Out of plan
Office visits to personal physician/provider	$10/visit	30%	$10/visit✓	20%✓
Specialist visits	$10/visit	30%	$10/visit✓	20%✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full	30%	Covered in full✓	20%✓
Routine immunizations/shots	Covered in full	30%	Covered in full✓	20%✓
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full	30%	Covered in full✓	20%
Maternity services; prenatal and postnatal visits	$100/delivery	30%	$100/delivery✓	20%
Allergy shots, serums and injectable medications	10%	30%	10%	20%
Inpatient hospital visits	10%	30%	10%	20%
Surgery and anesthesia	10%	30%	10%	20%
WOMEN'S HEALTH SERVICES				
Gynecological exams (calendar-year), Pap tests	Covered in full	30%	Covered in full✓	20%✓
Mammograms	Covered in full	30%	Covered in full✓	20%
HOSPITAL SERVICES				
Inpatient care	10%	30%	10%	20%
Maternity care	10%	30%	10%	20%
Routine newborn nursery care	10%	30%	10%✓	20%
OUTPATIENT DIAGNOSTIC SERVICES				
X-ray and lab services	10%	30%	10%✓	20%
Imaging services (such as PET, CT, MRI)	10%	30%	10%✓	20%
DURABLE MEDICAL EQUIPMENT				
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	10%	30%	10%*	20%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION				
Emergency services	$250	$250	$250✓	$250✓
Urgent care services	$10/visit	30%	$10/visit✓	20%✓
Emergency medical transportation	10%	10%	10%	10%
OTHER COVERED SERVICES				
Outpatient rehabilitative services (30 visits per calendar year)	10%	30%	10%	20%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	10%	30%	10%	20%

✓ No deductible needs to be met prior to receiving this benefit.

*Deductible does not apply to diabetes supplies.

$15/20%/40%/$1,700 with $250cd		$20/10%/30%/$2,000 with $500cd		$20/30%/40%/$2,000 with $250cd	
$250/$750		$500/$1,500		$250/$750	
$1,700/$5,100		$2,000/$6,000		$2,000/$6,000	
In plan	**Out of plan**	**In plan**	**Out of plan**	**In plan**	**Out of plan**
$15/visit✓	40%✓	$20/visit✓	30%✓	$20/visit✓	40%✓
$15/visit✓	40%✓	$20/visit✓	30%✓	$20/visit✓	40%✓
Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Covered in full✓	40%	Covered in full✓	30%	Covered in full✓	40%
$150/delivery✓	40%	$200/delivery✓	30%	$200/delivery✓	40%
20%	40%	10%	30%	30%	40%
20%	40%	10%	30%	30%	40%
20%	40%	10%	30%	30%	40%
Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Covered in full✓	40%	Covered in full✓	30%	Covered in full✓	40%
20%	40%	10%	30%	30%	40%
20%	40%	10%	30%	30%	40%
20%✓	40%	10%✓	30%	30%✓	40%
20%✓	40%	10%✓	30%	30%✓	40%
20%✓	40%	10%✓	30%	30%✓	40%
20%*	40%	10%*	30%	30%*	40%
$250✓	$250✓	$250✓	$250✓	$250✓	$250✓
$15/visit✓	40%✓	$20/visit✓	30%✓	$20/visit✓	40%✓
20%	20%	10%	10%	30%	30%
20%	40%	10%	30%	30%	40%
20%	40%	10%	30%	30%	40%

Open Option

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

A premier level of coverage with the choice to see any provider, in or out of our participating provider network.

	$15/20%/40%/$2,000 with $500cd		$25/20%/30%/$2,000 with $500cd	
Calendar-year common deductible (individual/family)	$500/$1,500		$500/$1,500	
Calendar-year common out-of-pocket maximum (individual/family)	$2,000/$6,000		$2,000/$6,000	
PHYSICIAN / PROVIDER SERVICES	In plan	Out of plan	In plan	Out of plan
Office visits to personal physician/provider	$15/visit✓	40%✓	$25/visit✓	30%✓
Specialist visits	$15/visit✓	40%✓	$25/visit✓	30%✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	40%✓	Covered in full✓	30%✓
Routine immunizations/shots	Covered in full✓	40%✓	Covered in full✓	30%✓
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	40%	Covered in full✓	30%
Maternity services; prenatal and postnatal visits	$150/delivery✓	40%	$250/delivery✓	30%
Allergy shots, serums and injectable medications	20%	40%	20%	30%
Inpatient hospital visits	20%	40%	20%	30%
Surgery and anesthesia	20%	40%	20%	30%
WOMEN'S HEALTH SERVICES				
Gynecological exams (calendar-year), Pap tests	Covered in full✓	40%✓	Covered in full✓	30%✓
Mammograms	Covered in full✓	40%	Covered in full✓	30%
HOSPITAL SERVICES				
Inpatient care	20%	40%	20%	30%
Maternity care	20%	40%	20%	30%
Routine newborn nursery care	20%✓	40%	20%✓	30%
OUTPATIENT DIAGNOSTIC SERVICES				
X-ray and lab services	20%✓	40%	20%✓	30%
Imaging services (such as PET, CT, MRI)	20%✓	40%	20%✓	30%
DURABLE MEDICAL EQUIPMENT				
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	20%*	40%	20%*	30%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION				
Emergency services	$250✓	$250✓	$250✓	$250✓
Urgent care services	$15/visit✓	40%✓	$25/visit✓	30%✓
Emergency medical transportation	20%	20%	20%	20%
OTHER COVERED SERVICES				
Outpatient rehabilitative services (30 visits per calendar year)	20%	40%	20%	30%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	20%	40%	20%	30%

✓ No deductible needs to be met prior to receiving this benefit.

*Deductible does not apply to diabetes supplies.

$20/20%/40%/$2,500 with $750cd		$15/20%/30%/$2,000 with $1,000cd		$25/20%/30%/$2,500 with $1,000cd	
$750/$2,250		$1,000/$3,000		$1,000/$3,000	
$2,500/$7,500		$2,000/$6,000		$2,500/$7,500	
In plan	**Out of plan**	**In plan**	**Out of plan**	**In plan**	**Out of plan**
$20/visit✓	40%✓	$15/visit✓	30%✓	$25/visit✓	30%✓
$20/visit✓	40%✓	$15/visit✓	30%✓	$25/visit✓	30%✓
Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	30%✓
Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	30%✓
Covered in full✓	40%	Covered in full✓	30%	Covered in full✓	30%
$200/delivery✓	40%	$150/delivery✓	30%	$250/delivery✓	30%
20%	40%	20%	30%	20%	30%
20%	40%	20%	30%	20%	30%
20%	40%	20%	30%	20%	30%
Covered in full✓	40%✓	Covered in full✓	30%✓	Covered in full✓	30%✓
Covered in full✓	40%	Covered in full✓	30%	Covered in full✓	30%
20%	40%	20%	30%	20%	30%
20%	40%	20%	30%	20%	30%
20%✓	40%	20%✓	30%	20%✓	30%
20%✓	40%	20%✓	30%	20%✓	30%
20%✓	40%	20%✓	30%	20%✓	30%
20%*	40%	20%*	30%	20%*	30%
$250✓	$250✓	$250✓	$250✓	$250✓	$250✓
$20/visit✓	40%✓	$15/visit✓	30%✓	$25/visit✓	30%✓
20%	20%	20%	20%	20%	20%
20%	40%	20%	30%	20%	30%
20%	40%	20%	30%	20%	30%

Open Option

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

A premier level of coverage with the choice to see any provider, in or out of our participating provider network.

	$15/30%/50%/$2,500 with $1,000cd		$25/20%/30%/$2,500 with $1,500cd	
Calendar-year common deductible (individual/family)	$1,000/$3,000		$1,500/$4,500	
Calendar-year common out-of-pocket maximum (individual/family)	$2,500/$7,500		$2,500/$7,500	
PHYSICIAN / PROVIDER SERVICES	In plan	Out of plan	In plan	Out of plan
Office visits to personal physician/provider	$15/visit✓	50%✓	$25/visit✓	30%✓
Specialist visits	$15/visit✓	50%✓	$25/visit✓	30%✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	50%✓	Covered in full✓	30%✓
Routine immunizations/shots	Covered in full✓	50%✓	Covered in full✓	30%✓
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	50%	Covered in full✓	30%
Maternity services; prenatal and postnatal visits	$150/delivery✓	50%	$250/delivery✓	30%
Allergy shots, serums and injectable medications	30%	50%	20%	30%
Inpatient hospital visits	30%	50%	20%	30%
Surgery and anesthesia	30%	50%	20%	30%
WOMEN'S HEALTH SERVICES				
Gynecological exams (calendar-year), Pap tests	Covered in full✓	50%✓	Covered in full✓	30%✓
Mammograms	Covered in full✓	50%	Covered in full✓	30%
HOSPITAL SERVICES				
Inpatient care	30%	50%	20%	30%
Maternity care	30%	50%	20%	30%
Routine newborn nursery care	30%✓	50%	20%✓	30%
OUTPATIENT DIAGNOSTIC SERVICES				
X-ray and lab services	30%✓	50%	20%✓	30%
Imaging services (such as PET, CT, MRI)	30%✓	50%	20%✓	30%
DURABLE MEDICAL EQUIPMENT				
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	30%*	50%	20%*	30%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION				
Emergency services	$250✓	$250✓	$250✓	$250✓
Urgent care services	$15/visit✓	50%✓	$25/visit✓	30%✓
Emergency medical transportation	30%	30%	20%	20%
OTHER COVERED SERVICES				
Outpatient rehabilitative services (30 visits per calendar year)	30%	50%	20%	30%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	30%	50%	20%	30%

✓ No deductible needs to be met prior to receiving this benefit.

*Deductible does not apply to diabetes supplies.

$15/30%/50%/$2,500 with $1,500cd		$20/20%/30%/$3,000 with $2,000cd		$25/20%/40%/$3,000 with $3,000cd	
$1,500/$4,500		$2,000/$6,000		$3,000/$9,000	
$2,500/$7,500		$3,000/$9,000		$3,000/$9,000	
In plan	**Out of plan**	**In plan**	**Out of plan**	**In plan**	**Out of plan**
$15/visit✓	50%✓	$20/visit✓	30%✓	$25/visit✓	40%✓
$15/visit✓	50%✓	$20/visit✓	30%✓	$25/visit✓	40%✓
Covered in full✓	50%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Covered in full✓	50%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Covered in full✓	50%	Covered in full✓	30%	Covered in full✓	40%
$150/delivery✓	50%	$200/delivery✓	30%	$250/delivery✓	40%
30%	50%	20%	30%	20%	40%
30%	50%	20%	30%	20%	40%
30%	50%	20%	30%	20%	40%
Covered in full✓	50%✓	Covered in full✓	30%✓	Covered in full✓	40%✓
Covered in full✓	50%	Covered in full✓	30%	Covered in full✓	40%
30%	50%	20%	30%	20%	40%
30%	50%	20%	30%	20%	40%
30%✓	50%	20%✓	30%	20%✓	40%
30%✓	50%	20%✓	30%	20%✓	40%
30%✓	50%	20%✓	30%	20%✓	40%
30%*	50%	20%*	30%	20%*	40%
$250✓	$250✓	$250✓	$250✓	$250✓	$250✓
$15/visit✓	50%✓	$20/visit✓	30%✓	$25/visit✓	40%✓
30%	30%	20%	20%	20%	20%
30%	50%	20%	30%	20%	40%
30%	50%	20%	30%	20%	40%

Open Option

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

A premier level of coverage with the choice to see any provider, in or out of our participating provider network.

	$20/20%/40%/$4,000 with $5,000cd	
Calendar-year common deductible (individual/family)	$5,000/$15,000	
Calendar-year common out-of-pocket maximum (individual/family)	$4,000/$12,000	
PHYSICIAN / PROVIDER SERVICES	**In plan**	**Out of plan**
Office visits to personal physician/provider	$20/visit✓	40%✓
Specialist visits	$20/visit✓	40%✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	40%✓
Routine immunizations/shots	Covered in full✓	40%✓
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	40%
Maternity services; prenatal and postnatal visits	$200/delivery✓	40%
Allergy shots, serums and injectable medications	20%	40%
Inpatient hospital visits	20%	40%
Surgery and anesthesia	20%	40%
WOMEN'S HEALTH SERVICES		
Gynecological exams (calendar-year), Pap tests	Covered in full✓	40%✓
Mammograms	Covered in full✓	40%
HOSPITAL SERVICES		
Inpatient care	20%	40%
Maternity care	20%	40%
Routine newborn nursery care	20%✓	40%
OUTPATIENT DIAGNOSTIC SERVICES		
X-ray and lab services	20%✓	40%
Imaging services (such as PET, CT, MRI)	20%✓	40%
DURABLE MEDICAL EQUIPMENT		
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	20%*	40%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION		
Emergency services	$250✓	$250✓
Urgent care services	$20/visit✓	40%✓
Emergency medical transportation	20%	20%
OTHER COVERED SERVICES		
Outpatient rehabilitative services (30 visits per calendar year)	20%	40%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	20%	40%

✓ No deductible needs to be met prior to receiving this benefit.
*Deductible does not apply to diabetes supplies.

Health Savings Account (HSA) Plans

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Comprehensive coverage that can be paired with an integrated Health Savings Account provided by HealthEquity.

	20%/40%/$5,500 with choice of deductible below	
Calendar-year medical/pharmacy common deductible (individual/family)	$1,500/$3,000 $2,500/$5,000 $3,500/$7,000	
Calendar-year medical/pharmacy common out-of-pocket maximum, including deductibles (individual/family)	$5,500/$11,000	
PHYSICIAN / PROVIDER SERVICES	**In plan**	**Out of plan**
Office visits to personal physician/provider	20%	40%
Specialist visits	20%	40%
Office visits to alternative care providers (any licensed provider; limited to $500 per calendar year)	20%	20%
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	40%
Routine immunizations/shots	Covered in full✓	40%
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	40%
Maternity services; prenatal and postnatal visits	20%	40%
Allergy shots, serums and injectable medications	20%	40%
Inpatient hospital visits	20%	40%
Surgery and anesthesia	20%	40%
WOMEN'S HEALTH SERVICES		
Gynecological exams (calendar-year), Pap tests	Covered in full✓	40%
Mammograms	Covered in full✓	40%
HOSPITAL SERVICES		
Inpatient care	20%	40%
Maternity care	20%	40%
Routine newborn nursery care	20%	40%
OUTPATIENT DIAGNOSTIC SERVICES		
X-ray and lab services	20%	40%
Imaging services (such as PET, CT, MRI)	20%	40%
DURABLE MEDICAL EQUIPMENT		
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	20%	40%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION		
Emergency services	20%	20%
Urgent care services	20%	40%
Emergency medical transportation	20%	20%
OTHER COVERED SERVICES		
Outpatient rehabilitative services (30 visits per calendar year)	20%	40%
Outpatient surgery, chemotherapy, infusion, dialysis and radiation therapy	20%	40%
PRESCRIPTION DRUGS		
Retail pharmacy (30-day supply; generic or brand)	20%	Not covered
Mail-order pharmacy (90-day supply; generic or brand)	20%	Not covered

✓ No deductible needs to be met prior to receiving this benefit.

Health Savings Account (HSA) Plans

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Comprehensive coverage that can be paired with an integrated Health Savings Account provided by HealthEquity.

	50%/50%/$5,500 with $1,500cd		0%/0%/$5,500cod	
Calendar-year common medical/pharmacy deductible (individual/family)	$1,500/$3,000		Combined medical/pharmacy deductible and out-of-pocket maximum $5,500/$11,000	
Calendar-year common medical/pharmacy out-of-pocket maximum, including deductibles (individual/family)	$5,500/$11,000			
PHYSICIAN / PROVIDER SERVICES	In plan	Out of plan	In plan	Out of plan
Office visits to personal physician/provider	50%	50%	Covered in full	Covered in full
Specialist visits	50%	50%	Covered in full	Covered in full
Office visits to alternative care providers (any licensed provider; limited to $500 per calendar year)	50%	50%	Covered in full	Covered in full
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	50%	Covered in full✓	Covered in full
Routine immunizations/shots	Covered in full✓	50%	Covered in full✓	Covered in full
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	50%	Covered in full✓	Covered in full
Maternity services; prenatal and postnatal visits	50%	50%	Covered in full	Covered in full
Allergy shots, serums and injectable medications	50%	50%	Covered in full	Covered in full
Inpatient hospital visits	50%	50%	Covered in full	Covered in full
Surgery and anesthesia	50%	50%	Covered in full	Covered in full
WOMEN'S HEALTH SERVICES				
Gynecological exams (calendar-year), Pap tests	Covered in full✓	50%	Covered in full✓	Covered in full
Mammograms	Covered in full✓	50%	Covered in full✓	Covered in full
HOSPITAL SERVICES				
Inpatient care	50%	50%	Covered in full	Covered in full
Maternity care	50%	50%	Covered in full	Covered in full
Routine newborn nursery care	50%	50%	Covered in full	Covered in full
OUTPATIENT DIAGNOSTIC SERVICES				
X-ray and lab services	50%	50%	Covered in full	Covered in full
Imaging services (such as PET, CT, MRI)	50%	50%	Covered in full	Covered in full
DURABLE MEDICAL EQUIPMENT				
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	50%	50%	Covered in full	Covered in full
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION				
Emergency services	50%	50%	Covered in full	Covered in full
Urgent care services	50%	50%	Covered in full	Covered in full
Emergency medical transportation	50%	50%	Covered in full	Covered in full
OTHER COVERED SERVICES				
Outpatient rehabilitative services (30 visits per calendar year)	50%	50%	Covered in full	Covered in full
Outpatient surgery, chemotherapy, infusion, dialysis and radiation therapy	50%	50%	Covered in full	Covered in full
PRESCRIPTION DRUGS				
Retail pharmacy (30-day supply; generic or brand)	50%	Not covered	Covered in full	Not covered
Mail-order pharmacy (90-day supply; generic or brand)	50%	Not covered	Covered in full	Not covered

✓ No deductible needs to be met prior to receiving this benefit.

Personal Option

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Plans that exclusively utilize our participating provider network.

	$10/10%/$1,200	$10/10%/$1,700 with $250d	$15/20%/$2,000
Calendar-year deductible (individual/family)	no deductible	$250/$750	no deductible
Calendar-year out-of-pocket maximum (individual/family)	$1,200/$3,600	$1,700/$5,100	$2,000/$6,000
PHYSICIAN / PROVIDER SERVICES			
Office visits to personal physician/provider	$10/visit	$10/visit✓	$15/visit
Specialist visits	$10/visit	$10/visit✓	$15/visit
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full	Covered in full✓	Covered in full
Routine immunizations/shots	Covered in full	Covered in full✓	Covered in full
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full	Covered in full✓	Covered in full
Maternity services; prenatal and postnatal visits	$100/delivery	$100/delivery✓	$150/delivery
Allergy shots, serums and injectable medications	10%	10%	20%
Inpatient hospital visits	10%	10%	20%
Surgery and anesthesia	10%	10%	20%
WOMEN'S HEALTH SERVICES			
Gynecological exams (calendar-year), Pap tests	Covered in full	Covered in full✓	Covered in full
Mammograms	Covered in full	Covered in full✓	Covered in full
HOSPITAL SERVICES			
Inpatient care	10%	10%	20%
Maternity care	10%	10%	20%
Routine newborn nursery care	10%	10%✓	20%
OUTPATIENT DIAGNOSTIC SERVICES			
X-ray and lab services	10%	10%✓	20%
Imaging services (such as PET, CT, MRI)	10%	10%✓	20%
DURABLE MEDICAL EQUIPMENT			
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	10%	10%*	20%
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION			
Emergency services	$250	$250✓	$250
Urgent care services	$10/visit	$10/visit✓	$15/visit
Emergency medical transportation	10%	10%	20%
OTHER COVERED SERVICES			
Outpatient rehabilitative services (30 visits per calendar year)	10%	10%	20%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	10%	10%	20%

✓ No deductible needs to be met prior to receiving this benefit.
*Deductible does not apply to diabetes supplies.

Personal Option

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Plans that exclusively utilize our participating provider network.

	$10/20%/$1,700 with $250d	$15/20%/$2,000 with $250d	$15/20%/$2,000 with $500d
Calendar-year deductible (individual/family)	$250/$750	$250/$750	$500/$1,500
Calendar-year out-of-pocket maximum (individual/family)	$1,700/$5,100	$2,000/$6,000	$2,000/$6,000
PHYSICIAN / PROVIDER SERVICES			
Office visits to personal physician/provider	$10/visit✓	$15/visit✓	$15/visit✓
Specialist visits	$10/visit✓	$15/visit✓	$15/visit✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	Covered in full✓	Covered in full✓
Routine immunizations/shots	Covered in full✓	Covered in full✓	Covered in full✓
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	Covered in full✓	Covered in full✓
Maternity services; prenatal and postnatal visits	$100/delivery✓	$150/delivery✓	$150/delivery✓
Allergy shots, serums and injectable medications	20%	20%	20%
Inpatient hospital visits	20%	20%	20%
Surgery and anesthesia	20%	20%	20%
WOMEN'S HEALTH SERVICES			
Gynecological exams (calendar-year), Pap tests	Covered in full✓	Covered in full✓	Covered in full✓
Mammograms	Covered in full✓	Covered in full✓	Covered in full✓
HOSPITAL SERVICES			
Inpatient care	20%	20%	20%
Maternity care	20%	20%	20%
Routine newborn nursery care	20%✓	20%✓	20%✓
OUTPATIENT DIAGNOSTIC SERVICES			
X-ray and lab services	20%✓	20%✓	20%✓
Imaging services (such as PET, CT, MRI)	20%✓	20%✓	20%✓
DURABLE MEDICAL EQUIPMENT			
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	20%*	20%*	20%*
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION			
Emergency services	$250✓	$250✓	$250✓
Urgent care services	$10/visit✓	$15/visit✓	$15/visit✓
Emergency medical transportation	20%	20%	20%
OTHER COVERED SERVICES			
Outpatient rehabilitative services (30 visits per calendar year)	20%	20%	20%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	20%	20%	20%

✓ No deductible needs to be met prior to receiving this benefit.

*Deductible does not apply to diabetes supplies.

$20/20%/$2,000 with $500d	$20/20%/$2,500 with $750d	$15/30%/$2,500 with $1,000d	$25/30%/$3,000 with $1,000d	$15/30%/$2,000 with $1,500d
$500/$1,500	$750/$2,250	$1,000/$3,000	$1,000/$3,000	$1,500/$4,500
$2,000/$6,000	$2,500/$7,500	$2,500/$7,500	$3,000/$9,000	$2,000/$6,000
$20/visit✓	$20/visit✓	$15/visit✓	$25/visit✓	$15/visit✓
$20/visit✓	$20/visit✓	$15/visit✓	$25/visit✓	$15/visit✓
Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓
Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓
Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓
$200/delivery✓	$200/delivery✓	$150/delivery✓	$250/delivery✓	$150/delivery✓
20%	20%	30%	30%	30%
20%	20%	30%	30%	30%
20%	20%	30%	30%	30%
Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓
Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓	Covered in full✓
20%	20%	30%	30%	30%
20%	20%	30%	30%	30%
20%✓	20%✓	30%✓	30%✓	30%✓
20%✓	20%✓	30%✓	30%✓	30%✓
20%✓	20%✓	30%✓	30%✓	30%✓
20%*	20%*	30%*	30%*	30%*
$250✓	$250✓	$250✓	$250✓	$250✓
$20/visit✓	$20/visit✓	$15/visit✓	$25/visit✓	$15/visit✓
20%	20%	30%	30%	30%
20%	20%	30%	30%	30%
20%	20%	30%	30%	30%

Personal Option

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

Plans that exclusively utilize our participating provider network.

	$25/30%/$3,000 with $2,000d	$25/20%/$3,000 with $3,000d	$20/20%/$4,000 with $5,000d
Calendar-year deductible (individual/family)	$2,000/$6,000	$3,000/$9,000	$5,000/$15,000
Calendar-year out-of-pocket maximum (individual/family)	$3,000/$9,000	$3,000/$9,000	$4,000/$12,000
PHYSICIAN / PROVIDER SERVICES			
Office visits to personal physician/provider	$25/visit✓	$25/visit✓	$20/visit✓
Specialist visits	$25/visit✓	$25/visit✓	$20/visit✓
Periodic health exams, well-baby care (from a personal physician/provider only)	Covered in full✓	Covered in full✓	Covered in full✓
Routine immunizations/shots	Covered in full✓	Covered in full✓	Covered in full✓
Colorectal cancer screening; sigmoidoscopy, colonoscopy (for members age 50 and older)	Covered in full✓	Covered in full✓	Covered in full✓
Maternity services; prenatal and postnatal visits	$250/delivery✓	$250/delivery✓	$200/delivery✓
Allergy shots, serums and injectable medications	30%	20%	20%
Inpatient hospital visits	30%	20%	20%
Surgery and anesthesia	30%	20%	20%
WOMEN'S HEALTH SERVICES			
Gynecological exams (calendar-year), Pap tests	Covered in full✓	Covered in full✓	Covered in full✓
Mammograms	Covered in full✓	Covered in full✓	Covered in full✓
HOSPITAL SERVICES			
Inpatient care	30%	20%	20%
Maternity care	30%	20%	20%
Routine newborn nursery care	30%✓	20%✓	20%✓
OUTPATIENT DIAGNOSTIC SERVICES			
X-ray and lab services	30%✓	20%✓	20%✓
Imaging services (such as PET, CT, MRI)	30%✓	20%✓	20%✓
DURABLE MEDICAL EQUIPMENT			
Medical and diabetes supplies, appliances, prosthetic and orthotic devices	30%*	20%*	20%*
EMERGENCY / URGENT CARE / EMERGENCY MEDICAL TRANSPORTATION			
Emergency services	$250✓	$250✓	$250✓
Urgent care services	$25/visit✓	$25/visit✓	$20/visit✓
Emergency medical transportation	30%	20%	20%
OTHER COVERED SERVICES			
Outpatient rehabilitative services (30 visits per calendar year)	30%	20%	20%
Outpatient surgery, infusion, dialysis, chemotherapy and radiation therapy	30%	20%	20%

✓ No deductible needs to be met prior to receiving this benefit.
*Deductible does not apply to diabetes supplies.

VISION RIDERS

	Vision $400	Vision $300	Vision $200
Providers	Any licensed provider	Any licensed provider	Any licensed provider
Benefit limit	Adults: $400 maximum per two calendar years Children: $400 maximum per calendar year	Adults: $300 maximum per two calendar years Children: $300 maximum per calendar year	Adults: $200 maximum per two calendar years Children: $200 maximum per calendar year
Covered services	Exam and hardware	Exam and hardware	Exam and hardware

ALTERNATIVE CARE RIDERS

	Alternative Care $10/$1,500	Alternative Care $15/$1,500
Providers	Participating chiropractor, naturopath or acupuncturist only	Participating chiropractor, naturopath or acupuncturist only
Copay	$10/visit	$15/visit
Benefit limit	$1,500 maximum per calendar year	$1,500 maximum per calendar year

	Alternative Care Plus $15/$1,500	Alternative Care Plus $15/$1,000	Alternative Care Plus $15/$500
Providers	Any licensed chiropractor, naturopath or acupuncturist	Any licensed chiropractor, naturopath or acupuncturist	Any licensed chiropractor, naturopath or acupuncturist
Copay	$15/visit	$15/visit	$15/visit
Benefit limit	$1,500 maximum per calendar year	$1,000 maximum per calendar year	$500 maximum per calendar year

	Chiropractic $10/$1,500	Chiropractic $15/$1,500
Providers	Participating chiropractor only	Participating chiropractor only
Copay	$10/visit	$15/visit
Benefit limit	$1,500 maximum per calendar year	$1,500 maximum per calendar year

HEALTH COACH RIDERS

	Health Coach 24	Health Coach 52
Benefit limit	24 30-minute sessions per calendar year	52 30-minute sessions per calendar year

Rx Pharmacy Riders

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

PHARMACY RIDERS	Rx $10/$20	Rx $10/$30	Rx $10/50%/ $1,000	Rx $15/$30	Rx $15/$45
Calendar-year deductible (individual/family)	None	None	None	None	None
Calendar-year out-of-pocket maximum (individual/family)	None	None	$1,000/ $3,000	None	None
RETAIL PHARMACY (30-DAY SUPPLY)					
Generic	$10	$10	$10	$15	$15
Brand	$20	$30	50%	$30	$45
MAIL-ORDER PHARMACY (90-DAY SUPPLY)					
Generic	$30	$30	$30	$45	$45
Brand	$60	$90	50%	$90	$135

PHARMACY RIDERS	Rx $20/$40	Rx $15/$60	Rx $15/$45 with $250d	Rx $15/$75	Rx $15/$45 with $500d	Rx $15/50%
Calendar-year deductible (individual/family)	None	None	$250/$750	None	$500/$1,500	None
Calendar-year out-of-pocket maximum (individual/family)	None	None	None	None	None	None
RETAIL PHARMACY (30-DAY SUPPLY)						
Generic	$20	$15	$15	$15	$15	$15 or 50% (whichever is greater)
Brand	$40	$60	$45 (after deductible)	$75	$45 (after deductible)	$15 or 50% (whichever is greater)
MAIL-ORDER PHARMACY (90-DAY SUPPLY)						
Generic	$60	$45	$45	$45	$45	$45 or 50% (whichever is greater)
Brand	$120	$180	$135 (after deductible)	$225	$135 (after deductible)	$45 or 50% (whichever is greater)

RXtra Pharmacy Riders

PROVIDENCE HEALTH PLAN **OREGON LARGE GROUP**

RXtra plans provide an extra measure of savings on maintenance drugs. You may purchase up to a 90-day supply at one time through a preferred or a mail-order pharmacy for two copayments.

RXTRA PHARMACY RIDERS	RXtra $10/$20	RXtra $10/$30	RXtra $15/$30	RXtra $15/$45
Calendar-year deductible (individual/family)	None	None	None	None
RETAIL PHARMACY (30-DAY SUPPLY)				
Generic	$10	$10	$15	$15
Brand	$20	$30	$30	$45
MAIL-ORDER PHARMACY (90-DAY SUPPLY)				
Generic	$20	$20	$30	$30
Brand	$40	$60	$60	$90

RXTRA PHARMACY RIDERS	RXtra $15/$60	RXtra $15/$75	RXtra $15/$45 with $250d	RXtra $15/$45 with $500d
Calendar-year deductible (individual/family)	None	None	$250/$750	$500/$1,500
RETAIL PHARMACY (30-DAY SUPPLY)				
Generic	$15	$15	$15	$15
Brand	$60	$75	$45 (after deductible)	$45 (after deductible)
MAIL-ORDER PHARMACY (90-DAY SUPPLY)				
Generic	$30	$30	$30	$30
Brand	$120	$150	$90 (after deductible)	$90 (after deductible)

Pharmacy Tips

USE A PARTICIPATING PHARMACY

Fill your prescriptions at one of more than 25,000 participating pharmacies nationwide.

BE INFORMED

Knowledge is power. Visit us online to access resources including the formulary, answers to frequently asked questions, generic drug facts, coupons and forms.

SAVE A TRIP

Maintenance medications for chronic conditions may be purchased for up to a 90-day supply at one time through a preferred or a mail-order pharmacy.

Local **preferred pharmacies** include, but are not limited to:

- Albertsons/Sav-on
- Costco
- Fred Meyer/Kroger/QFC
- Safeway
- Walgreens

Prescriptions filled by a **mail-order pharmacy** can be sent to your home, office or other preferred U.S. address. You may choose from the following mail-order vendors:

- Postal Prescriptions Services
- Walgreens Mail Service
- Wellpartner

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

Dedicated customer service resources

503-574-7500 or 800-878-4445
TTY: 503-574-8702 or 888-244-6642
Monday through Friday, 8 a.m. to 5 p.m.

Sales

503-574-6300 or 877-245-4077

www.ProvidenceHealthPlan.com

PROVIDENCE
Health Plan

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