

Providence Health Plan

Summary of Benefits

	<i>Medicare</i>		<i>Non-Medicare</i>	
			In-Plan	Out-of-Plan
SERVICE AREA	See service information on pages 24 and 25			
PROVIDERS	Plan physician's and hospitals			
LIFETIME MAXIMUM	None		\$2,000,000	
CALENDAR YEAR MEDICAL OUT-OF-POCKET MAXIMUM	None		\$2,000 per Individual \$6,000 per Family does not include deductible	\$6,000 per Individual \$18,000 per Family does not include deductible
CALENDAR YEAR DEDUCTIBLE	None		\$200 per Individual / \$600 per Family	
OFFICE VISIT	\$15 co-pay		\$20 co-pay (no deductible)	30% co-insurance after deductible
PREVENTIVE CARE	\$15 co-pay		\$20 co-pay (no deductible)	Not covered
LAB, X-RAY & DIAGNOSTIC PROCEDURES	Covered in full		20% co-insurance after deductible	30% co-insurance after deductible
HOSPITAL CARE	\$250 per admission. \$500 maximum per calendar year		20% co-insurance after deductible	30% co-insurance after deductible
EMERGENCY <ul style="list-style-type: none"> • Urgent Care • Ambulance • Emergency Room 	<ul style="list-style-type: none"> • \$25 co-pay • \$50 co-pay • \$50 co-pay, waived if admitted 		<ul style="list-style-type: none"> • 20% co-insurance (no deductible) • 20% co-insurance after deductible • \$100 co-pay, then 20%; waived if admitted 	<ul style="list-style-type: none"> • 20% co-insurance (no deductible) • 30% co-insurance after deductible • \$100 co-pay, then 20%; waived if admitted
SKILLED NURSING	Covered in full in a Medicare facility for up to 100 days		20% co-insurance after deductible	30% co-insurance after deductible
ROUTINE EYE EXAM & EYE GLASSES	\$15 co-pay for eye exam. Hardware discounts available through Tru-Vision		Not covered	Not covered
ALTERNATIVE CARE	Discounts available. Contact Providence Customer Service		\$15 co-pay — \$1,500 calendar year maximum Contact Providence Customer Service for a list of contracted providers.	
PRESCRIPTION DRUGS	See pages 28 and 29			

This is a summary of benefits only for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

*Premium Rates***RHIA Contribution Premium Rates**

The monthly premiums shown below are after the \$60 Retirement Health Insurance Account (RHIA) contribution. More information on the RHIA contribution and eligibility can be found on page 11 of this handbook.

RETIREE WITH MEDICARE	\$77.37
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$213.00
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$662.58

Rates are effective January 1, 2006 through December 31, 2006.

* Family includes spouse and/or dependents enrolled in the PERS plan.

Non-Contribution Premium Rates

The monthly premiums shown below are without the contribution from RHIA or Retiree Health Insurance Premium Account (RHIPA). More information on RHIA and RHIPA contributions and eligibility can be found on pages 11 and 12 of this handbook.

RETIREE WITHOUT MEDICARE	\$554.49
RETIREE WITHOUT MEDICARE FAMILY* WITHOUT MEDICARE	\$1,139.70
RETIREE WITHOUT MEDICARE FAMILY* WITH MEDICARE	\$681.30
RETIREE WITH MEDICARE	\$137.37
RETIREE WITH MEDICARE FAMILY* WITH MEDICARE	\$273.00
RETIREE WITH MEDICARE FAMILY* WITHOUT MEDICARE	\$722.58

Rates are effective January 1, 2006 through December 31, 2006.

* Family includes spouse and/or dependents enrolled in the PERS plan.