Your Benefit Summary
Personal Option Plan

PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum (after deductible)	Calendar Year Deductible
$15	20% coinsurance (after deductible)	$2,000 per person $6,000 per family (3 or more)	$500 per person $1,500 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 only provides benefits for medically necessary services when provided by a participating physician or provider.
- 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).
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Personal Option Plan 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 benefit.	Copay or Coinsurance (from participating providers only)
Physician / Provider Services	
• Office visits	$15 / visit✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓
• Routine immunizations; shots	Covered in full✓
• Maternity services; pre- and postnatal visits	$150 / delivery✓
• Allergy shots; serums; injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full✓
• Mammograms	Covered in full✓
Hospital Services	
• Inpatient care	20%
• Observation care	20%
• Maternity care	20%
• Routine newborn nursery care	20%✓
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Outpatient Diagnostic Services	
• X-ray; lab services	20%✓
• Imaging services (such as PET, CT, MRI)	20%✓
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)	20%*
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✓
• Urgent care services (for non-life threatening illness/minor injury)	$15 / visit✓
• Emergency medical transportation	20%

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

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Other Covered Services	
• Outpatient rehabilitative services (30 visits per calendar year)	20%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Home health care	20%
• Hospice care	Covered in full✓
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full✓
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)	
-Generic drugs	$10✓
-Formulary brand-name drugs	$50✓
-Non-formulary brand-name drugs	$100✓
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	20%
• Residential services	20%
• Outpatient provider visits	$15 / visit✓

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

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.

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-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.

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.

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

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