Your Benefit Summary

Personal Option Plan

PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum
$10	20% coinsurance	$1,200 per person $3,600 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.
- 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.
- 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	You pay the following for covered services:
	Copay or Coinsurance (from participating providers only)
Physician / Provider Services	
• Office visits	$10 / 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	$100 / 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)	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)	$10 / visit
• Emergency medical transportation	20%

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 (limited to 60 days per calendar year)	20%
• Outpatient provider visits	$10 / 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.

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.

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.

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