

Your Benefit Summary

Personal Option Plan



Copay	What You Pay	Calendar Year Out-of-Pocket Maximum (after deductible)	Calendar Year Deductible
\$25	20% coinsurance (after deductible)	\$3,000 per person \$9,000 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.
- 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.
- 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	
<ul style="list-style-type: none"> • Office visits • Periodic health exams; well-baby care (from a Personal Physician/Provider only) • Routine immunizations; shots • Maternity services; pre- and postnatal visits • Allergy shots; serums; injectable medications • Inpatient hospital visits • Surgery; anesthesia 	\$25 / visit ✓ Covered in full ✓ Covered in full ✓ \$250 / delivery ✓ 20% 20% 20%
Women's Health Services	
<ul style="list-style-type: none"> • Gynecological exams (calendar year); Pap tests • Mammograms 	Covered in full ✓ Covered in full ✓
Hospital Services	
<ul style="list-style-type: none"> • Inpatient care • Observation care • Maternity care • Routine newborn nursery care • Rehabilitative care (30 days per calendar year) • Skilled nursing facility (60 days per calendar year) 	20% 20% 20% 20% ✓ 20% 20%
Outpatient Diagnostic Services	
<ul style="list-style-type: none"> • X-ray; lab services • Imaging services (such as PET, CT, MRI) 	20% ✓ 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	
<ul style="list-style-type: none"> • Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.) • Urgent care services (for non-life threatening illness/minor injury) • Emergency medical transportation 	\$250 ✓ \$25 / visit ✓ 20%

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

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Other Covered Services <ul style="list-style-type: none"> • Outpatient rehabilitative services (30 visits per calendar year) • Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy • Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime) • Home health care • Hospice care • Tobacco use cessation; counseling/classes and deterrent medications • Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> -Generic drugs -Formulary brand-name drugs -Non-formulary brand-name drugs 	20% 20% 50% 20% Covered in full✓ Covered in full✓ \$10✓ \$50✓ \$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.) <ul style="list-style-type: none"> • Inpatient and day treatment services • Residential services (limited to 60 days per calendar year) • Outpatient provider visits 	20% 20% \$25 / 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.

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