Your Benefit Summary

Individual Personal Option Plan - Prime 10,000

PROVIDENCE Health Plan

What You Pay	Calendar Year Out-of-Pocket Maximum (after deductible)	Calendar Year Deductible
50% coinsurance (after deductible)	**$12,500** per person **$37,500** per family (3 or more)	**$10,000** per person **$30,000** 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 Individual & Family Plan Contract and Plan Guide, register for myProvidence at **www.ProvidenceHealthPlan.com/getstarted.**

- Not sure what a word or phrase means? See last page of this summary for definitions.
- This plan only provides benefits for medically necessary services when provided by a participating provider or physician.
- Your deductible does not apply to covered services required to treat an accidental injury within 90 days following the injury.
- Your deductible and coinsurance for non-chemotherapy medications, and some services do not apply to your out-of-pocket maximum.
- A pre-existing condition exclusion applies to members age 19 and older. See last page of this summary for more information.
- A plan year aggregate limit of $2,000,000 per person applies to Essential Health Benefits.
- Limitations and exclusions apply to your benefits. See your Individual & Family Plan Contract 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.	**Coinsurance** (from participating providers only)
Physician / Provider Services	
• Office visits to Personal Physician/Provider	50%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full✓
• Office visits to all other physicians/providers	50%
• Routine immunizations; shots	Covered in full✓
• Maternity services; delivery, pre- and postnatal visits	50%
• Allergy shots; serums; injectable medications	50%
• Inpatient hospital visits	50%
• Surgery; anesthesia	50%
Women's Health Services	
• Gynecological exams (calendar year); Pap tests	Covered in full✓
• Mammograms	Covered in full✓
Hospital Services	
• Inpatient care	50%
• Observation care	50%
• Maternity care	50%
• Routine newborn nursery care	50%
• Rehabilitative care (30 days per calendar year)	50%
• Skilled nursing facility (60 days per calendar year)	50%
Outpatient Diagnostic Services	
• X-ray; lab services	50%
• Imaging services (such as PET, CT, MRI)	50%
Medical Supplies, Prosthetic and Orthotic Devices (removable custom shoe orthotics are limited to $200 per calendar year)	50%*
Durable Medical Equipment and Appliances (limited to $2,500 per calendar year)	50%
Emergency / Urgent Care / Emergency Medical Transportation	
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	50%
• Urgent care visits (for non-life threatening illness/minor injury)	50%✓
• Emergency medical transportation ($2,000 per calendar year)	50%

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

Personal Option Plan Benefit Highlights (continued)

	Coinsurance
Other Covered Services	
• Outpatient rehabilitative services (30 visits per calendar year)	50%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	50%
• Home health care (limited to 180 visits per calendar year)	50%
• Hospice care	50%
• 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	50%✓
-Formulary brand-name drugs	50%✓
-Non-formulary brand-name drugs	50%✓
Mental Health/Alcohol Dependency	
Prior authorization is required for all Mental Health and Alcohol Dependency treatment. To arrange services, call our authorizing agent at 1-800-711-4577.	
• Mental health (limited to 10 outpatient visits per calendar year for all services)	50%
• Alcohol dependency (limited to 2 days detox and 20 outpatient visits every two calendar years)	50%

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.

Creditable Coverage
Prior health care coverage held by you or your eligible dependents, including any group coverage, individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or coverage under a domestic or foreign public health plan.

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 and coinsurance for services that do not apply to the deductible.

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.

Essential Health Benefits
Established under the Patient Protection and Affordable Care Act, Essential Health Benefits include general categories of health care services. See your Individual & Family Plan Contract for details.

Exclusion Period
A period of time during which all specified treatments or services are excluded from coverage. If treatment was covered under a previous plan, then the exclusion period is reduced by each day of continuous prior creditable coverage.

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. Your deductibles or coinsurance for non-chemotherapy medications, some services and expenses do not apply to your out-of-pocket maximum. See your Individual & Family Plan Contract 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.

Plan year aggregate limit
A plan year aggregate limit is the maximum amount of essential health benefits payable per member under the Individual and Family Plan Contract within a plan year.

Pre-existing condition exclusion
Pre-existing condition means any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your effective date of coverage. Coverage for pre-existing conditions is excluded for members age 19 and older for a period of six months following your effective date of coverage. This exclusion period can be reduced by qualifying creditable coverage. See your Individual & Family Plan Contract for details.

Prior authorization
Some services must be pre-approved. Your provider will request prior authorization.

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