

2011 non-Medicare benefit summary

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

	Clear One Health Plans ¹		Kaiser Foundation Health Plan of the Northwest	ODS PPO Plans		Providence Health Plans	
	In-network	Out-of-network		In-network	Out-of-network	In-network	Out-of-network
Service area	Refer to page 26		Refer to page 27	Refer to page 27		Refer to page 26	
Eligible providers	Plan physicians and hospitals	Any licensed physician or facility	Kaiser physicians and hospitals	Plan providers or facilities	Any licensed physician or facility	Plan physicians and hospitals	Any licensed physician or facility
Lifetime benefit maximum	Unlimited		Unlimited	Unlimited		Unlimited	
Calendar year deductible	\$200 per individual	\$1,000 per individual	None	\$200 per individual		\$200 per individual	
Calendar year medical out-of-pocket maximum	\$2,000 + deductible per individual	\$6,000 + deductible per individual	\$1,000 per individual	\$2,000 + deductible per individual	\$6,000 + deductible per individual	\$2,000 + deductible per individual	\$6,000 + deductible per individual
	Insured pays		Insured pays	Insured pays		Insured pays	
Physician services							
<ul style="list-style-type: none"> ■ Office visits ■ Specialist visits ■ Preventive visits 	<ul style="list-style-type: none"> ■ \$15 copay, no deductible² ■ \$25 copay, no deductible ■ \$15 copay, no deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible 	<ul style="list-style-type: none"> ■ \$15 copay ■ \$15 copay ■ Covered in full 	<ul style="list-style-type: none"> ■ \$20 copay, no deductible ■ \$20 copay, no deductible ■ \$20 copay, no deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible 	<ul style="list-style-type: none"> ■ \$20 copay, no deductible ■ \$20 copay, no deductible ■ \$20 copay, no deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
Lab and X-ray							
<ul style="list-style-type: none"> ■ Routine lab test ■ Routine X-ray procedures ■ Diagnostic procedures 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible 	<ul style="list-style-type: none"> ■ \$10 copay per visit ■ \$10 copay per visit ■ \$10 copay per visit 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible 	<ul style="list-style-type: none"> ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible
Inpatient hospital services							
<ul style="list-style-type: none"> ■ Covered services 	<ul style="list-style-type: none"> ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible 	<ul style="list-style-type: none"> ■ \$200 copay per admit 	<ul style="list-style-type: none"> ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible 	<ul style="list-style-type: none"> ■ 20% after deductible 	<ul style="list-style-type: none"> ■ 30% after deductible
Miscellaneous services							
<ul style="list-style-type: none"> ■ Alternative care ■ Ambulance ■ DME ■ Emergency services³ ■ Outpatient surgery ■ Skilled nursing ■ Urgent care 	<ul style="list-style-type: none"> ■ \$25 copay, no deductible ■ 20%, no deductible ■ 20% after deductible ■ \$100 copay, no deductible ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible ■ \$25 copay, no deductible 	<ul style="list-style-type: none"> ■ \$25 copay, no deductible ■ 20%, no deductible ■ 30% after deductible ■ \$100 copay, no deductible ■ 30% after deductible ■ 30% after deductible ■ 30%, no deductible 	<ul style="list-style-type: none"> ■ Discounts available ■ \$75 copay ■ 20% ■ \$75 copay ■ \$15 copay ■ Covered in full⁴ ■ \$15 copay 	<ul style="list-style-type: none"> ■ Costs vary by service ■ 20% after deductible ■ 20% after deductible ■ \$100 copay, then 20%⁷ ■ 20% after deductible ■ 20% after deductible ■ 20% after deductible ■ \$20 copay, no deductible 	<ul style="list-style-type: none"> ■ Costs vary by service ■ 30% after deductible ■ 30% after deductible ■ \$100 copay, then 30%⁷ ■ 30% after deductible ■ 30% after deductible ■ 30% after deductible 	<ul style="list-style-type: none"> ■ \$15 copay⁵ ■ 20% after deductible ■ 20% after deductible ■ \$100 copay, then 20%⁷ ■ 20% after deductible ■ 20% after deductible ■ 20%, no deductible⁶ 	<ul style="list-style-type: none"> ■ Not covered ■ 20% after deductible ■ 30% after deductible ■ \$100 copay, then 20%⁷ ■ 30% after deductible ■ 30% after deductible ■ 20%, no deductible⁶
Vision							
<ul style="list-style-type: none"> ■ Routine eye exam ■ Hardware 	<ul style="list-style-type: none"> ■ Not covered ■ Not covered 		<ul style="list-style-type: none"> ■ \$15 copay ■ Not covered 	<ul style="list-style-type: none"> ■ Discounts available; contact ODS 		<ul style="list-style-type: none"> ■ Discounts available through Binyon's and TruVision 	
Prescription drugs	Refer to pages 36–37						
<ul style="list-style-type: none"> ■ Retail and mail-order ■ Generic and brand ■ Rx out-of-pocket maximum 	<ul style="list-style-type: none"> ■ 40% of charge, up to a \$150 maximum per prescription, up to a 30-day supply ■ \$4,550 out-of-pocket maximum per member, per calendar year 						

¹ Must select a Primary Care Physician (PCP). Six-month waiting period for pre-existing conditions apply. ² Prenatal, delivery and postnatal physician services require a \$200 copay; deductible does not apply. ³ Copays and coinsurance waived if admitted; applies to all health plans. ⁴ Covered in full in a Medicare-certified facility for up to 100 days per

calendar year. ⁵ \$1,500 calendar year maximum; contact Providence Customer Service for a list of contracted providers. ⁶ Urgent/immediate care – ancillary charges billed separately will be subject to the applicable cost share. The deductible will apply to diagnostics (lab, X-rays, etc.) received during the visit. ⁷ Deductible does not apply.