

2009 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 handbook and the plan document, the information in the plan document shall prevail.

	Clear Choice Health Plans ²		Kaiser Permanente	ODS PPO Plan		Providence Health Plan	
	In-Plan	Out-of-Plan		In-Network	Out-of-Network	In-Plan	Out-of-Plan
Service Area	Refer to pages 24-25		Refer to pages 26-27	Refer to pages 28-29		Refer to pages 30-31	
Eligible Providers	Plan Physicians and Hospitals	Any Licensed Physician or Facility	Kaiser Physicians and Hospitals	Preferred Physicians and Providers	Any Licensed Physician or Facility	Plan Physicians and Hospitals	Any Licensed Physician or Facility
Lifetime Benefit Maximum	\$2,000,000		Unlimited	\$2,000,000		\$2,000,000	
Calendar Year Deductible	\$200 per Member	\$1,000 per Member	None	\$200 per Member		\$200 per Member	
Calendar Year Medical Out-of-Pocket Maximum	\$2,000 + Deductible per Member	\$6,000 + Deductible per Member	\$1,000 per Member	\$2,000 + Deductible per Member	\$6,000 + Deductible per Member	\$2,000 + Deductible per Member	\$6,000 + Deductible per Member
	Insured Pays		Insured Pays	Insured Pays		Insured Pays	
Physician Services							
<ul style="list-style-type: none"> ■ Office Visits ■ Specialist Services ■ Preventive Services 	<ul style="list-style-type: none"> ■ \$15 co-pay, no Deductible³ ■ \$25 co-pay, no Deductible ■ \$15 co-pay, no Deductible 	<ul style="list-style-type: none"> ■ 30% after Deductible ■ 30% after Deductible ■ 30% after Deductible 	<ul style="list-style-type: none"> ■ \$15 co-pay per visit ■ \$15 co-pay per visit ■ \$15 co-pay per visit⁴ 	<ul style="list-style-type: none"> ■ \$20 co-pay, no Deductible ■ \$20 co-pay, no Deductible ■ \$20 co-pay, no Deductible 	<ul style="list-style-type: none"> ■ 30% after Deductible ■ 30% after Deductible ■ 30% after Deductible 	<ul style="list-style-type: none"> ■ \$20 co-pay, no Deductible ■ \$20 co-pay, no Deductible ■ \$20 co-pay, 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 co-pay per visit ■ \$10 co-pay per visit ■ \$10 co-pay 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 co-pay 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 Services¹ ■ Outpatient Surgery ■ Skilled Nursing ■ Urgent Care 	<ul style="list-style-type: none"> ■ \$25 co-pay, no Deductible ■ 20%, no Deductible ■ 20% after Deductible ■ \$100 co-pay, no Deductible ■ 20% after Deductible ■ 20% after Deductible ■ \$25 co-pay, no Deductible 	<ul style="list-style-type: none"> ■ \$25 co-pay, no Deductible ■ 20%, no Deductible ■ 30% after Deductible ■ \$100 co-pay, no Deductible ■ 30% after Deductible ■ 30% after Deductible ■ 30% after Deductible 	<ul style="list-style-type: none"> ■ Discounts available ■ \$75 co-pay (one way) ■ 20% ■ \$75 co-pay per visit ■ \$15 co-pay per visit ■ Covered in full⁵ ■ \$15 co-pay per visit 	<ul style="list-style-type: none"> ■ Costs vary by service ■ 20% after Deductible ■ 20% after Deductible ■ \$100 co-pay, then 20% ■ 20% after Deductible ■ 20% after Deductible ■ \$20 co-pay, no Deductible 	<ul style="list-style-type: none"> ■ Costs vary by service ■ 30% after Deductible ■ 30% after Deductible ■ \$100 co-pay, then 30% ■ 30% after Deductible ■ 30% after Deductible ■ 30% after Deductible 	<ul style="list-style-type: none"> ■ \$15 co-pay⁶ ■ 20% after Deductible ■ 20% after Deductible ■ \$100 co-pay, then 20% ■ 20% after Deductible ■ 20% after Deductible ■ 20%, no Deductible 	<ul style="list-style-type: none"> ■ Not Covered ■ 20% after Deductible ■ 30% after Deductible ■ \$100 co-pay, then 20% ■ 30% after Deductible ■ 30% after Deductible ■ 20%, no Deductible
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 co-pay per visit ■ Not covered 	<ul style="list-style-type: none"> ■ Routine eye exams and eyewear discounts available through Binyon's and TruVision 		<ul style="list-style-type: none"> ■ Discounts available through Binyon's and TruVision 	
Prescription Drugs							
<ul style="list-style-type: none"> ■ Retail and Mail Order ■ Generic and Brand 	Refer to Page 32-33						
<ul style="list-style-type: none"> ■ Rx Out-of-Pocket Maximum 	<ul style="list-style-type: none"> ■ 40% of charge for up to a \$150 maximum per prescription, up to a 30-day supply ■ \$4,350 Out-of-Pocket maximum per member per calendar year 						

1 Co-pays and co-insurance waived if admitted; applies to all health plans.

2 Must select a Primary Care Physician (PCP). Six-month waiting period for pre-existing conditions apply.

3 Prenatal, delivery and postnatal physician services require a \$200 co-pay, deductible does not apply.

4 Ages 0 – 2 preventive and prenatal office visits covered in full.

5 Covered in full in a Medicare-certified facility for up to 100 days per calendar year.

6 \$1,500 calendar year maximum; Contact Providence Customer Service for a list of contracted providers.