

2010 Non-Medicare Benefit Summary

	Clear Choice Health Plans ¹		Kaiser Permanente
	In-Network	Out-of-Network	
Service Area	Refer to page 24		Refer to page 24
Eligible Providers	Plan Physicians and Hospitals	Any Licensed Physician or Facility	Kaiser Physicians and Hospitals
Lifetime Benefit Maximum	\$2,000,000		Unlimited
Calendar Year Deductible	\$200 per Individual	\$1,000 per individual	None
Calendar Year Medical Out-of-Pocket Maximum	\$2,000 + Deductible per Individual	\$6,000 + Deductible per Individual	\$1,000 per Individual
	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 Deductible² ■ \$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 ■ \$15 co-pay ■ \$15 co-pay³
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
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
Miscellaneous Services			
<ul style="list-style-type: none"> ■ Alternative Care ■ Ambulance ■ DME ■ Emergency Services⁴ ■ 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 ■ 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 ■ 20% ■ \$75 co-pay ■ \$15 co-pay ■ Covered in full⁵ ■ \$15 co-pay
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 ■ Not covered
Prescription Drugs			
<ul style="list-style-type: none"> ■ Retail and Mail Order ■ Generic and Brand 	Refer to Page 34-35		
<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 ■ \$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 Pre-natal, delivery and postnatal physician services require a \$200 co-pay, deductible does not apply.
 3 Ages 0 - 2 preventive and prenatal office visits covered in full.

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.

ODS PPO Plan		Providence Health Plan	
In-Network	Out-of-Network	In-Network	Out-of-Network
Refer to page 25		Refer to page 25	
Preferred Physicians and Providers	Any Licensed Physician or Facility	Plan Physicians and Hospitals	Any Licensed Physician or Facility
\$2,000,000		\$2,000,000	
\$200 per Individual		\$200 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	
<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
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<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
<ul style="list-style-type: none"> ■ Discounts available, contact ODS 		<ul style="list-style-type: none"> ■ Discounts available through Binyon's and TruVision 	

o a 30-day supply

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

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.

