

Your Benefit Summary

Personal Option Plan

Head Start of Lane County



Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
\$15	30% coinsurance (after deductible)	\$3,500 per person \$7,000 per family (2 or more)	\$1,000 per person \$2,000 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- Your deductible is included in the out-of-pocket maximum amount listed above.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- View a list of Providence Signature network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- 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 service	Copay or Coinsurance (from in-network providers only)
Preventive Care	
<ul style="list-style-type: none"> Periodic health exams and well-baby care Routine immunizations and shots Colonoscopy (age 50 +) Gynecological exams (calendar year) and Pap tests Mammograms Tobacco cessation, counseling/classes and deterrent medications 	Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓
Physician / Provider Services	
<ul style="list-style-type: none"> Office visits Office visits to alternative care providers (Chiropractic manipulation & acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.) Phone and video visits Allergy shots, serums, infusions, and injectable medications Inpatient hospital visits Surgery; anesthesia 	\$15 / visit ✓ \$15 / visit ✓ Covered in full ✓ 30% 30% 30%
Diagnostic Services	
<ul style="list-style-type: none"> X-ray and lab services High-tech imaging services (such as PET, CT or MRI) Sleep studies 	30% ✓ 30% ✓ 30% ✓
Emergency and Urgent Services	
<ul style="list-style-type: none"> Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.) Urgent care services (for non-life threatening illness/minor injury) Emergency medical transportation (air and/or ground) 	\$250 ✓ \$15 / visit ✓ 30%
Hospital Services	
<ul style="list-style-type: none"> Inpatient/Observation care Rehabilitative care (limited to 30 days per calendar year) Skilled nursing facility (limited to 60 days per calendar year) 	30% 30% 30%
Outpatient Services	
<ul style="list-style-type: none"> Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy Colonoscopy (non-preventive) Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime) Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year) 	30% 30% 50% \$25 / visit ✓

Personal Option Plan Benefit Highlights (continued)	Copay or Coinsurance
Maternity Services <ul style="list-style-type: none"> • Prenatal office visits • Delivery and postnatal services • Inpatient hospital/facility services • Routine newborn nursery care 	Covered in full ✓ \$150 / delivery ✓ 30% 30% ✓
Medical Equipment, Supplies and Devices <ul style="list-style-type: none"> • Medical equipment, appliances and supplies • Diabetes supplies (lancets, test strips and needles) • Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived) 	30% 30% ✓ 30%
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.) <ul style="list-style-type: none"> • Inpatient and residential services • Day treatment, intensive outpatient, and partial hospitalization services • Applied behavior analysis • Outpatient provider office visits 	30% 30% 30% \$15 / visit ✓
Home Health and Hospice <ul style="list-style-type: none"> • Home health care • Hospice care 	30% Covered in full ✓

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

Formulary

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

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.

Personal physician/provider

A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization

Some services must be pre-approved, your in-network provider will request prior authorization for these services.

Usual, Customary & Reasonable (UCR)

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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: **711**



Have questions about your benefits and want to contact us via email? Go to our website at:
www.ProvidenceHealthPlan.com/contactus