

Individual and Family Plan Comparison

Effective Nov.1 2010 - Oct. 31, 2011

	Optimum Plans		Value Plans		Prime Plan	HSA Plans	
Annual Deductible Individual/Family	Optimum 1000	\$1,000/\$3,000	Value 1000	\$1,000/\$3,000	\$10,000/\$30,000	HSA 2500 HSA 3500	\$2,500/\$5,000 \$3,500/\$7,000
	Optimum 2500	\$2,500/\$7,500	Value 2500	\$2,500/\$7,500			
	Optimum 5000	\$5,000/\$15,000	Value 5000	\$5,000/\$15,000			
	Optimum 10000	\$10,000/\$30,000	Value 7500	\$7,500/\$22,500			
Annual Out-of-Pocket Maximum Individual/Family	All Optimum Plans \$4,000/\$12,000		Value 1000	\$6,000/\$18,000	\$10,000/\$30,000	HSA 2500 HSA 3500	\$5,000/\$10,000 \$5,250/\$10,500
			Value 2500	\$6,000/\$18,000			
			Value 5000	\$9,000/\$27,000			
			Value 7500	\$11,000/\$33,000			
Accidental Injury Benefit	The deductible is waived for all covered services required to treat an accidental injury within 90 days of injury.					Not covered	
After meeting your deductible, you pay the following amounts for covered services: The deductible is waived for some covered services. These services are marked with ✓							
Preventive Care	In-Plan	Out-of-Plan	In-Plan	Out-of-Plan	In-Plan only	In-Plan	Out-of-Plan
Periodic health exams, well-baby care	Covered in full✓	40%✓	Covered in full✓	50%✓	Covered in full✓	Covered in full✓	40%
Routine immunizations/shots	Covered in full✓	40%✓	Covered in full✓	50%✓	Covered in full✓	Covered in full✓	40%
Mammograms	Covered in full✓	40%	Covered in full✓	50%	Covered in full✓	Covered in full✓	40%
Gynecological exams, Pap tests	Covered in full✓	40%✓	Covered in full✓	50%✓	Covered in full✓	Covered in full✓	40%
Physician/Provider Services							
Office visits	\$20 copay✓	40%✓	\$30 copay✓	50%✓	50%✓	\$20 copay	40%
Office visits to specialists	\$20 copay✓	40%✓	30%	50%	50%	20%	40%
Inpatient hospital visits, surgery, anesthesia	20%	40%	30%	50%	50%	20%	40%
Hospital Services							
Inpatient and observation care	20%	40%	30%	50%	50%	20%	40%
Maternity care	20%	40%	30%	50%	50%	20%	40%
Routine newborn nursery care	20%	40%	30%	50%	50%	20%	40%
Rehabilitative care	20%	40%	30%	50%	50%	20%	40%
Emergency/Urgent care							
Emergency services	\$250 copay		\$250 copay		50%	\$250 copay	
Urgent care visits	\$20 copay✓	40%✓	\$30 copay✓	50%✓	50%✓	\$20 copay	40%
Emergency transportation	20%	20%	30%	50%	50%	20%	20%
Outpatient Diagnostic Services							
X-ray, lab services	20%	40%	30%	50%	50%	20%	40%
Imaging services (PET, CT, MRI)	20%	40%	50%	50%	50%	20%	40%
Other covered services							
Medical & diabetes supplies**	20%	40%	30%	50%	50%	20%	40%
Outpatient surgery, radiation therapy, chemotherapy	20%	40%	30%	50%	50%	20%	40%
Home health care*	20%	40%	30%	50%	50%	20%	40%
Tobacco use cessation*	Covered in full✓	Not covered	Covered in full✓	Not covered	Covered in full✓	Covered in full✓	Not covered
Mental health & alcohol treatment*	20%	40%	30%	50%	50%	20%	40%
Prescription drugs							
Covered at participating retail and mail-order pharmacies only	Generic drugs - \$10✓ Brand name drugs - 50%✓		Generic and brand name drugs - 50%✓		Generic drugs - \$20✓ Brand name drugs - 50%✓	Generic and brand name drugs - 50%	
Routine vision services							
Optimum, Value and HSA Plans provide benefits for certain vision services. Benefits include coverage for routine vision exams (\$30 copay in-plan), frames, basic lenses and contact lenses. Visit www.providence.org/healthplans for details.							
*Limitations apply. See your Plan Contract for details. **Your deductible does not apply to purchases of diabetes supplies							