

Providence Individual and Family Plan rates

Nov. 1, 2009 – Oct. 31, 2010



Annual Deductible	Optimum Plans		Value Plans		Prime Plan	
Individual / Family	Optimum 500	\$500 / \$1,500	Value 500	\$500 / \$1,500	Prime 10000	\$10,000/\$30,000
	Optimum 1000	\$1,000 / \$3,000	Value 1000	\$1,000 / \$3,000		
	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	All Optimum Plans: \$2,500 / \$7,500		Value 500	\$4,000 / \$12,000	Prime 10000	\$7,500/\$22,500
Individual / Family			Value 1000	\$4,500 / \$13,500		
			Value 2500	\$5,500 / \$16,500		
			Value 5000	\$8,500 / \$25,500		
			Value 7500	\$11,000/\$33,000		
	Lifetime Maximum	\$2 million per person		\$2 million per person		\$2 million per person
Accidental Injury Benefit	The deductible is waived for all covered services required to treat an accidental injury within 90 days of injury.					

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 ✓ * Limitations apply. See your Plan Contract for details.

Preventive Care	In-Plan	Out-of-Plan	In-Plan	Out-of-Plan	In-Plan	Out-of-Plan
Periodic health exams, well-baby care	\$20 copay✓	40%✓	\$20 copay✓	50%✓	50%✓	Not Covered
Annual gynecological exam	\$20 copay✓	40%✓	\$20 copay✓	50%✓	50%✓	Not Covered
Routine immunizations/shots	\$20 copay✓	40%✓	\$20 copay✓	50%✓	50%✓	Not Covered
Mammograms	\$20 copay✓	40%	\$20 copay✓	50%	50%✓	Not Covered
Physician/Provider Services						
Office visits	\$20 copay✓	40%✓	\$20 copay✓	50%✓	50%✓	Not Covered
Office visits to specialists	\$20 copay✓	40%✓	30%	50%	50%	Not Covered
Inpatient hospital visits, surgery and other services	20%	40%	30%	50%	50%	Not Covered
Hospital Services						
Inpatient & observation care	20%	40%	30%	50%	50%	Not Covered
Rehabilitative care & services*						
Maternity Care						
Provider & hospital services	20%	40%	30%	50%	50%	Not Covered
Emergency/Urgent care						
Emergency services	\$250 copay		\$250 copay		50%	50%
Urgent care services	\$20 copay✓		\$20 copay✓		50%✓	50%✓
Emergency transportation services*	20%		30%		50%	50%
Other Covered Services						
Medical & diabetes supplies*	20%	40%	30%	50%	50%	Not Covered
Lab & x-ray, outpatient surgery, radiation therapy, chemotherapy						
Home health care*						
Mental health & alcohol treatment*						
Prescription Drugs						
Covered at participating retail and mail-order pharmacies only	Generic drugs - \$10✓ Brand-name drugs - 50%✓		Generic & Brand drugs - 50%✓		Generic drugs - \$15✓ Brand-name drugs - 50%✓	
Routine Vision Services (administered by VSP)						
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.					Routine vision services not covered.	

✓Deductible is waived. This means you can receive coverage for these services prior to meeting your deductible.