

# Your Benefit Summary

## HSA-Qualified Open Option Plan



Co-Pay	What You Pay In-Plan	What You Pay Out-of-Plan	Annual Combined Medical/Pharmacy Out-of-Pocket Maximum	Annual Combined Medical/Pharmacy Deductible	Lifetime Maximum Benefit
\$20	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	\$3,000 per person \$6,000 per family (2 or more)	\$1,500 per person \$3,000 per family (2 or more)	\$2,000,000

### Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for [myProvidence](http://myProvidence) at [www.providence.org/php/getstarted](http://www.providence.org/php/getstarted)

- Not sure what a word or phrase means? See the back for definitions used in this summary.
- The per person deductible and out-of-pocket maximum applies when only the employee is enrolled. The family deductible and out-of-pocket maximum applies when an employee and dependent(s) are enrolled.
- A pre-existing condition clause applies to this plan. See the back for more information.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

HSA-Qualified Open Option Plan Benefit Highlights	After you pay your annual common deductible, then you pay the following for covered services:	
	In-Plan Co-Pay or Coinsurance (when you use a participating provider)	Out-of-Plan Co-Pay or Coinsurance (when you use a non-participating provider)
<ul style="list-style-type: none"> <li>✓ No deductible needs to be met prior to receiving this benefit.</li> </ul>		
<b>Physician / Provider Services</b>		
<ul style="list-style-type: none"> <li>• Office visits to physicians/providers</li> <li>• Office visits to alternative care providers (limited to \$500 per calendar year)</li> <li>• Periodic health exams; well-baby care (from a Personal Physician/Provider only/limited to \$250 per calendar year)</li> <li>• Routine immunizations; shots</li> <li>• Allergy shots; serums; injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> <li>• Other office procedures</li> </ul>	20% 20% \$20 / visit ✓ \$20 / visit ✓ 20% 20% 20% 20%	40% Not covered 40% 40% 40% 40% 40% 40%
<b>Women's Health Services</b>		
<ul style="list-style-type: none"> <li>• Annual gynecological exams (calendar year); Pap tests</li> <li>• Follow-up visits after annual gynecological exam</li> <li>• Mammograms</li> </ul>	\$20 / visit ✓ 20% \$20 ✓	40% 40% 40%
<b>Hospital Services</b>		
<ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Observation care</li> <li>• Rehabilitative care (30 days per calendar year)</li> <li>• Skilled nursing facility (60 days per calendar year)</li> </ul>	20% 20% 20% 20%	40% 40% 40% 40%
<b>Maternity</b>		
<ul style="list-style-type: none"> <li>• Pre- and post-natal visits; delivery</li> <li>• Routine newborn nursery care</li> <li>• Hospital services</li> </ul>	20% 20% 20%	40% 40% 40%
<b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices</b>		
(Removable custom shoe orthotics are limited to \$200 per calendar year)	20% *	40%
<b>Emergency/Urgent Care/Ambulance Services</b>		
(Your emergency/urgent coinsurance is waived if admitted to the hospital within 24 hours)		
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Ambulance services (for emergency transportation only)</li> </ul>	20% 20% 20%	20% 20% 20%

\*Your deductible(s) do not apply to purchases of diabetes supplies.

HSA-Qualified Open Option Plan Benefit Highlights (continued)	In-Plan Co-Pay or Coinsurance	Out-of-Plan Co-Pay or Coinsurance
<b>Prescription Drugs</b> (Up to a 30-day supply/retail & preferred retail pharmacies; 90-day supply/mail order & preferred retail pharmacies)		
• Generic and brand-name drugs	20%	Not covered
• Compounded drugs	50%	Not covered
<b>Other Covered Services</b>		
• X-ray; lab services	20%	40%
• Imaging services (PET, CT, MRI)	20%	40%
• Outpatient rehabilitative services (30 visits per calendar year)	20%	40%
• Outpatient surgery; dialysis; infusion, chemotherapy; radiation therapy	20%	40%
• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)	50%	Not covered
• Home health care	20%	40%
• Hospice care	Covered in full	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	\$10	Not covered
-Formulary brand-name drugs	\$50	Not covered
-Non-formulary brand-name drugs	\$100	Not covered
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient, residential and day treatment services	20%	40%
• Outpatient provider visits	20%	40%

## 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.

### Combined medical/pharmacy deductible

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-plan or out-of-plan providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Services that exceed your plan's lifetime maximum benefit
- 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
- Co-pays or coinsurance for any supplemental benefits provided by your employer, such as routine vision care

### Combined medical/pharmacy out-of-pocket maximum

The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in and out-of-plan services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

### Co-pay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### Formulary

A list of preferred brand name and generic drugs that have been evaluated by us for effectiveness and safety.

### In-plan benefit

The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to the online directory at [www.providence.org/php/providerdirectory](http://www.providence.org/php/providerdirectory)

### Lifetime maximum benefit

The total dollar amount of benefits that you can receive from your plan during your lifetime.

### Non-participating provider

Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

### Out-of-plan

Refers to services you receive from a non participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non participating providers. To find a participating provider, go to the online directory at [www.providence.org/healthplans](http://www.providence.org/healthplans)

### Participating provider

A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, go to the online directory at [www.providence.org/php/providerdirectory](http://www.providence.org/php/providerdirectory)

### Pre-existing condition

A medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your enrollment date. You will need to be enrolled under this plan for six continuous months before services for pre-existing conditions will be covered. See your Member Handbook for details.

### Prior authorization

Some services must be pre-approved. In-Plan, your provider will request prior authorization. Out-of-Plan, you are responsible for obtaining prior authorization or a 50% penalty (up to \$2,500 per occurrence) will apply.

### Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

### Usual, Customary & Reasonable (UCR)

Describes predefined charges established by your plan for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your plan deductibles or 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: **1-800-878-4445**  
TTY: **503-574-8702** or **1-888-244-6642**



Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: [www.providence.org/php/contactus](http://www.providence.org/php/contactus)