

# 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 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.
- 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)
✓ No deductible needs to be met prior to receiving this benefit.		
<b>Physician / Provider Services</b>		
• Office visits to physicians/providers	20%	40%
• Office visits to alternative care providers (limited to \$500 per calendar year)	20%	Not covered
• Periodic health exams; well-baby care (from a Personal Physician/Provider only/limited to \$250 per calendar year)	\$20 / visit ✓	40%
• Routine immunizations; shots	\$20 / visit ✓	40%
• Allergy shots; serums; injectable medications	20%	40%
• Inpatient hospital visits	20%	40%
• Surgery; anesthesia	20%	40%
• Other office procedures	20%	40%
<b>Women's Health Services</b>		
• Annual gynecological exams (calendar year); Pap tests	\$20 / visit ✓	40%
• Follow-up visits after annual gynecological exam	20%	40%
• Mammograms	\$20 ✓	40%
<b>Hospital Services</b>		
• Inpatient care	20%	40%
• Observation care	20%	40%
• Rehabilitative care (30 days per calendar year)	20%	40%
• Skilled nursing facility (60 days per calendar year)	20%	40%
<b>Maternity</b>		
• Pre- and post-natal visits; delivery	20%	40%
• Routine newborn nursery care	20%	40%
• Hospital services	20%	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)		
• Emergency services (for emergency medical conditions only)	20%	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%	20%
• Ambulance services (for emergency transportation only)	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)		
<ul style="list-style-type: none"> <li>• Generic and brand-name drugs</li> <li>• Compounded drugs</li> </ul>	<p>20%</p> <p>50%</p>	<p>Not covered</p> <p>Not covered</p>
<b>Other Covered Services</b>		
<ul style="list-style-type: none"> <li>• X-ray; lab services</li> <li>• Imaging services (PET, CT, MRI)</li> <li>• Outpatient rehabilitative services (30 visits per calendar year)</li> <li>• Outpatient surgery; dialysis; infusion, chemotherapy; radiation therapy</li> <li>• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>• Home health care</li> <li>• Hospice care</li> <li>• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> <li>-Generic drugs</li> <li>-Formulary brand-name drugs</li> <li>-Non-formulary brand-name drugs</li> </ul> </li> </ul>	<p>20%</p> <p>20%</p> <p>20%</p> <p>20%</p> <p>50%</p> <p>20%</p> <p>Covered in full</p> <p>\$10</p> <p>\$50</p> <p>\$100</p>	<p>40%</p> <p>40%</p> <p>40%</p> <p>40%</p> <p>Not covered</p> <p>40%</p> <p>Covered in full</p> <p>Not covered</p> <p>Not covered</p> <p>Not covered</p>
<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.)		
<ul style="list-style-type: none"> <li>• Inpatient, residential and day treatment services</li> <li>• Outpatient provider visits</li> </ul>	<p>20%</p> <p>20%</p>	<p>40%</p> <p>40%</p>

## 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)

### 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)