

Your Benefits Summary

Value Based Open Option Plan



Co-Pay	What You Pay In-Plan	What You Pay Out-of-Plan	Annual Common Out-of-Pocket Maximum (after deductible)	Annual Common Deductible	Lifetime Maximum Benefit
\$10/\$20	30% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	\$3,000 per person \$9,000 per family (3 or more)	\$750 per person \$2,250 per family (3 or more)	\$2,000,000

Important information about your plan

This plan is designed to help you maintain and improve your health. 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

- Not sure what a word or phrase means? See the end of this summary for definitions.
- This plan offers deductible carryover. This means any portion of your deductible that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible.
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary and Reasonable (UCR) charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Value Based 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"> ✓ No deductible needs to be met prior to receiving this benefit. 		
Preventive Health and Wellness Services		
<ul style="list-style-type: none"> • Annual gynecological exams (calendar year); Pap tests • Mammogram • Annual prostate screening exam • Periodic health exams; well-baby care (from a Personal Physician/Provider only) • Colorectal exam • Colorectal cancer screening: sigmoidoscopy, colonoscopy • The following tests (when received with your health maintenance exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood • The following services (for members with diabetes): HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet • Pneumococcal vaccine • Flu vaccine • Routine immunizations/shots • Nutritional counseling for weight loss (limited to two visits per calendar year) • Smoking deterrent medications, including prescription and over the counter (limited to \$500 per lifetime; must be purchased at a participating plan pharmacy) 	\$10 / visit ✓ Covered in full ✓ \$10 / visit ✓ \$10 / visit ✓ \$10 / visit ✓ \$10 ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ Covered in full ✓ \$10 / visit ✓ \$10 ✓	40% ✓ 40% ✓ 40% ✓ 40% ✓ 40% ✓ 40% 40% 40% ✓ 40% ✓ 40% ✓ 40% ✓ 40% ✓ Not covered
Physician / Provider Services		
<ul style="list-style-type: none"> • Office visits • Inpatient hospital visits • Surgery; anesthesia • Allergy shots; serums; injectable medications • Other office procedures 	\$20 / visit ✓ 30% 30% 30% 30%	40% ✓ 40% 40% 40% 40%
Hospital Services		
<ul style="list-style-type: none"> • Inpatient care • Observation care • Rehabilitative care (30 days per calendar year) • Skilled nursing facility (60 days per calendar year) 	30% 30% 30% 30%	40% 40% 40% 40%
Maternity		
<ul style="list-style-type: none"> • Pre- and post-natal visits; delivery • Routine newborn nursery care • Hospital services 	\$200 ✓ 30% ✓ 30%	40% 40% 40%

Value Based Open Option Plan Benefit Highlights (continued)	In-Plan Co-Pay or Coinsurance	Out-of-Plan Co-Pay or Coinsurance
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Removable custom shoe orthotics are limited to \$200 per calendar year)	30%*	40%
Emergency/Urgent Care/Ambulance Services (Your emergency/urgent co-pay is waived if admitted to the hospital within 24 hours)		
• Emergency services (for emergency medical conditions only)	\$125	\$125
• Urgent care services (for non-life threatening illness/minor injury)	\$25✓	\$25✓
• Ambulance services (for emergency transportation only)	30%	30%
Other Covered Services		
• X-ray; lab services	30%	40%
• Imaging services (PET, CT, MRI)	30%	40%
• Outpatient rehabilitative services (30 visits per calendar year)	30%	40%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	30%	40%
• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)	50%	Not covered
• Home health care	30%	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
Mental Health / Chemical Dependency (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	30%	40%
• Outpatient provider visits	\$20 / visit✓	40%✓

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

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.

Common 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 prescription drugs, or routine vision care

Common 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.

Deductible carryover

A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

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

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

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

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