

Your Benefit Summary

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 Out-of-Plan Deductible	Lifetime Maximum Benefit
\$15	20% coinsurance	40% coinsurance (after deductible; UCR applies)	\$2,000 per person \$6,000 per family (3 or more)	\$250 per person \$750 per family (3 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

- Not sure what a word or phrase means? See the back for definitions used in this summary.
- 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 & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Open Option Plan Benefit Highlights	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 (After deductible, when you use a non-participating provider)
✓ No deductible needs to be met prior to receiving this benefit.		
Physician / Provider Services		
• Office visits	\$15 / visit	40%✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	\$15 / visit	40%✓
• Routine immunizations; shots	\$15 / visit	40%✓
• Allergy shots; serums; injectable medications	20%	40%
• Inpatient hospital visits	20%	40%
• Surgery; anesthesia	20%	40%
• Other office procedures	20%	40%
Women's Health Services		
• Annual gynecological exams (calendar year); Pap tests	\$15 / visit	40%✓
• Follow-up visits after annual gynecological exam	\$15 / visit	40%✓
• Mammograms	\$15	40%
Hospital Services		
• 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%
Maternity		
• Pre- and post-natal visits; delivery	\$150	40%
• Routine newborn nursery care	20%	40%
• Hospital services	20%	40%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Removable custom shoe orthotics are limited to \$200 per calendar year)	20%	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)	20%	20%

Open Option Plan Benefit Highlights (continued)	In-Plan Co-Pay or Coinsurance	Out-of-Plan Co-Pay or Coinsurance
Other Covered Services		
• 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
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	20%	40%
• Outpatient provider visits	\$15 / visit	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.

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

Out-of-plan deductible

The dollar amount that an individual or family pays for out-of plan covered services before your plan pays any benefits within a calendar year. 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

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