

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 Common Deductible | Lifetime Maximum Benefit |
|--------|------------------------------------|---|--|--|--------------------------|
| \$25 | 20% coinsurance (after deductible) | 30% coinsurance (after deductible; UCR applies) | \$2,500 per person \$7,500 per family (3 or more) | \$1,000 per person \$3,000 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 | 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. | | |
| Physician / Provider Services | | |
| • Office visits | \$25 / visit ✓ | 30% ✓ |
| • Periodic health exams; well-baby care (from a Personal Physician/Provider only) | \$25 / visit ✓ | 30% ✓ |
| • Routine immunizations; shots | \$25 / visit ✓ | 30% ✓ |
| • Allergy shots; serums; injectable medications | 20% | 30% |
| • Inpatient hospital visits | 20% | 30% |
| • Surgery; anesthesia | 20% | 30% |
| • Other office procedures | 20% | 30% |
| Women's Health Services | | |
| • Annual gynecological exams (calendar year); Pap tests | \$25 / visit ✓ | 30% ✓ |
| • Follow-up visits after annual gynecological exam | \$25 / visit ✓ | 30% ✓ |
| • Mammograms | \$25 ✓ | 30% |
| Hospital Services | | |
| • Inpatient care | 20% | 30% |
| • Observation care | 20% | 30% |
| • Rehabilitative care (30 days per calendar year) | 20% | 30% |
| • Skilled nursing facility (60 days per calendar year) | 20% | 30% |
| Maternity | | |
| • Pre- and post-natal visits; delivery | \$250 ✓ | 30% |
| • Routine newborn nursery care | 20% ✓ | 30% |
| • Hospital services | 20% | 30% |
| Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Removable custom shoe orthotics are limited to \$200 per calendar year) | 20% * | 30% |
| 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) | \$50 ✓ | \$50 ✓ |
| • Ambulance services (for emergency transportation only) | 20% | 20% |

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

| 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%✓ | 30% |
| • Imaging services (PET, CT, MRI) | 20%✓ | 30% |
| • Outpatient rehabilitative services (30 visits per calendar year) | 20% | 30% |
| • Outpatient surgery; dialysis; infusion, chemotherapy; radiation therapy | 20% | 30% |
| • Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime) | 50% | Not covered |
| • Home health care | 20% | 30% |
| • 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% | 30% |
| • Outpatient provider visits | \$25 / visit✓ | 30%✓ |

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