

Your Benefit Summary

Open Option Plan

OEBB POS Plan 1



Office Visit Co-Pay	Hospital Co-Pay	What You Pay Out-of-Plan	Plan Year In-Plan Out-of-Pocket Maximum	Plan Year Out-of-Plan Out-of-Pocket Maximum	Plan Year Out-of-Plan Deductible	Lifetime Maximum Benefit
\$10	\$100 per day	50% coinsurance (after deductible; UCR applies)	\$1,000 per person \$2,000 per family (2 or more)	\$2,000 per person \$4,000 per family (2 or more)	\$300 per person \$900 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 the 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 plan year, when coinsurance is not applied to the benefit, will be applied toward next year's deductible.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- 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 (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	\$10 / visit	50%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full	50%
• Routine immunizations; shots	Covered in full	50%
• Allergy shots; serums; injectable medications	Covered in full	50%
• Inpatient hospital visits	Covered in full	50%
• Surgery; anesthesia	Covered in full	50%
Women's Health Services		
• Annual gynecological exams (plan year); Pap tests	Covered in full	50%
• Follow-up visits after annual gynecological exam	\$10 / visit	50%
• Mammograms	Covered in full	50%
Hospital Services		
• Inpatient care	\$100 per day	50%
• Observation care	\$100 per day	50%
• Rehabilitative care (30 days per plan year)	\$100 per day	50%
• Skilled nursing facility (60 days per plan year)	\$100 per day	50%
Maternity		
• Pre- and post-natal visits; delivery	\$100	50%
• Routine newborn nursery care	\$100 per day	50%
• Hospital services	\$100 per day	50%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Removable custom shoe orthotics are limited to \$200 per plan year)	Covered in full	50%
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)	\$100	\$100✓
• Urgent care services (for non-life threatening illness/minor injury)	\$25	\$25✓
• Ambulance services (for emergency transportation only)	\$100	\$100✓

Open Option Plan Benefit Highlights (continued)	In-Plan Co-Pay	Out-of-Plan Co-Pay or Coinsurance
Other Covered Services		
<ul style="list-style-type: none"> • X-ray; lab services • Imaging services (PET, CT, MRI) • Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy • Colorectal cancer screening: sigmoidoscopy, colonoscopy • Outpatient rehabilitative services (30 visits per plan year) • Home health care • Hospice care • Self-administered chemotherapy (Up to a 31-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> -Generic drugs -Formulary brand-name drugs -Non-formulary brand-name drugs 	<ul style="list-style-type: none"> Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full 	<ul style="list-style-type: none"> 50% 50% 50% 50% 50% 50% Covered in full✓ Not covered Not covered 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.)		
<ul style="list-style-type: none"> • Inpatient, residential and day treatment services • Outpatient provider visits 	<ul style="list-style-type: none"> \$100 per day \$10 / visit 	<ul style="list-style-type: none"> 50% 50%

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.

Copay

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

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

Plan Year

The annual benefit period that applies to your covered health services. The benefit period is October 1 to September 30.

Plan year 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 plan 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

Plan year out-of-pocket maximum

The limit on the dollar amount you will have to spend for specified covered health services in a plan year. Your plan has both In Plan and Out of Plan maximums. Some services and expenses do not apply to the out of pocket maximums.

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 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

Your Benefit Summary

Alternative Care Plan

OEBB - POS Plan 1



Co-Pay

\$10

Maximum
Annual Benefit

\$2,500 per member,
per plan year

Important information about your plan

This alternative care benefit is offered as an additional option to your medical 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

- With this benefit you have access to three of the most popular types of alternative health care providers: acupuncturists, chiropractors and naturopaths.
- Not sure what a word or phrase means? See the end of this summary for definitions.
- Your co-pays do not apply to your plan's medical out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

About your alternative care benefit

This plan covers alternative care services when they are:

- Received from a participating licensed chiropractic physician, naturopathic physician or acupuncturist who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

What you need to know before you use this benefit

- While you don't need a physician's referral to see an alternative care provider, you must see a Providence Health Plan participating provider. To find a participating provider in your area, go to www.providence.org/php/providerdirectory or call us.
- Only one co-pay is required per date of service, regardless of the number of covered services received during the visit. You do not need to meet any applicable medical plan deductibles before receiving this benefit.

Using a non-participating provider

- In rare circumstances our national network of participating providers may not include a provider in your area. If this occurs, please contact us before making an appointment with a non-participating provider. If, after contacting us, we are unable to locate a participating provider within a reasonable distance, we will authorize the use of a non-participating provider.
- Non-participating providers must be licensed in the state in which they are practicing and must practice within the scope of their license.
- You will need to pay the non-participating provider directly for the full cost of the services received and submit your itemized billing statement to us for reimbursement.
- If you do not contact us prior to receiving covered services from a non-participating provider, you may still submit your itemized billing to us. Once received, your claim will be reviewed for approval (submission of a claim does not guarantee payment).
- Providence Health Plan's payment is based upon Usual, Customary, and Reasonable (UCR) charges. Amounts in excess of UCR are your responsibility.
- You are responsible for obtaining prior authorization for services from Providence Health Plan or its authorizing agent.

Acupuncture covered services

- Office visits.
- Adjunctive therapy which may include therapies such as acupressure, cupping, moxibustion, or breathing techniques. Adjunctive therapy is only covered when provided during the same course of treatment and in conjunction with acupuncture. All adjunctive therapy must be medically necessary for the treatment of neuromusculoskeletal disorders, nausea or pain and provided together with acupuncture services.

Chiropractic covered services

- Office visits.
- Manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.
- Adjunctive physiotherapy which may include ultrasound, hot packs, cold packs, electrical muscle stimulation or other therapies and procedures which are medically necessary for the treatment of neuromusculoskeletal disorders.
- Related diagnostic x-rays and laboratory service.

Naturopathy covered services

- Services must be provided within a course of treatment that includes both (a) natural treatment methods, modalities, nutritional advice, recommendation of homeopathic protocols, and (b) excludes prescribing prescription or over-the-counter drugs, surgery, or invasive therapeutic procedures.
- Office visits/consultations, therapeutic procedures and other services provided in various combinations.
- Physical therapy which may include ultrasound, hot packs, cold packs, manual, mechanical, or electrical stimulation of the muscles, rehabilitative exercise.
- Related diagnostic x-rays and laboratory services.
- All naturopathic services must be approved by Providence Health Plan or its authorizing agent as medically necessary.

Your guide to the words or phrases used to explain your benefits

Co-pay

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

Maximum annual benefit (plan year)

The total dollar amount of benefits that you can receive, per plan year. The benefit period is October 1 to September 30.

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.

Participating provider

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

Plan Year

The annual benefit period that applies to your covered health services. The benefit period is October 1 to September 30.

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.

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