Your Benefit Summary

Open Option Plan

Copay	What You Pay In-Plan	What You Pay Out-of-Plan	Calendar Year Common Out-of-Pocket Maximum
$10	10% coinsurance	30% coinsurance (UCR applies)	$1,200 per person $3,600 per family (3 or more)

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.ProvidenceHealthPlan.com/getstarted.

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- 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 Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services		
• Office visits	$10 / visit	30%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full	30%
• Routine immunizations; shots	Covered in full	30%
• Maternity services; pre- and postnatal visits	$100 / delivery	30%
• Allergy shots; serums; injectable medications	10%	30%
• Inpatient hospital visits	10%	30%
• Surgery; anesthesia	10%	30%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full	30%
• Mammograms	Covered in full	30%
Hospital Services		
• Inpatient care	10%	30%
• Observation care	10%	30%
• Maternity care	10%	30%
• Routine newborn nursery care	10%	30%
• Rehabilitative care (30 days per calendar year)	10%	30%
• Skilled nursing facility (60 days per calendar year)	10%	30%
Outpatient Diagnostic Services		
• X-ray; lab services	10%	30%
• Imaging services (such as PET, CT, MRI)	10%	30%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	10%	30%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$250	$250
• Urgent care services (for non-life threatening illness/minor injury)	$10 / visit	30%
• Emergency medical transportation	10%	10%

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services		
• Outpatient rehabilitative services (30 visits per calendar year)	10%	30%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	10%	30%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%	Not covered
• Home health care	10%	30%
• Hospice care	Covered in full	Covered in full
• Tobacco use cessation; counseling/classes and deterrent medications	Covered in full	Not covered
• 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 and day treatment services	10%	30%
• Residential services	10%	30%
• Outpatient provider visits	$10 / 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 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.

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 www.ProvidenceHealthPlan.com/providerdirectory.

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 www.ProvidenceHealthPlan.com/providerdirectory.

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, refer to the directory available at www.ProvidenceHealthPlan.com/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.

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 your plan's allowed charges 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: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus