

# 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 (after deductible)	Calendar Year Common Deductible
\$20	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	\$4,000 per person \$12,000 per family (3 or more)	\$5,000 per person \$15,000 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](http://www.ProvidenceHealthPlan.com/getstarted) at [www.ProvidenceHealthPlan.com/getstarted](http://www.ProvidenceHealthPlan.com/getstarted).

- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- A pre-existing condition exclusion applies to this plan. This exclusion does not apply to members who are under the age of 19. See the back for more information.
- This plan offers deductible carryover. This means any portion of your deductible(s) that you pay during the fourth quarter of the calendar year will be applied toward next year's deductible(s).
- 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

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year common deductible, then 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)
<b>Physician / Provider Services</b>		
• Office visits	\$20 / visit ✓	40% ✓
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	Covered in full ✓	40% ✓
• Routine immunizations; shots	Covered in full ✓	40% ✓
• Maternity services; pre- and postnatal visits	\$200 / delivery ✓	40%
• Allergy shots; serums; injectable medications	20%	40%
• Inpatient hospital visits	20%	40%
• Surgery; anesthesia	20%	40%
<b>Women's Health Services</b>		
• Gynecological exams (calendar year); Pap tests	Covered in full ✓	40% ✓
• Mammograms	Covered in full ✓	40%
<b>Hospital Services</b>		
• Inpatient care	20%	40%
• Observation care	20%	40%
• Maternity care	20%	40%
• Routine newborn nursery care	20% ✓	40%
• Rehabilitative care (30 days per calendar year)	20%	40%
• Skilled nursing facility (60 days per calendar year)	20%	40%
<b>Outpatient Diagnostic Services</b>		
• X-ray; lab services	20% ✓	40%
• Imaging services (such as PET, CT, MRI)	20% ✓	40%
<b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices</b>	20%*	40%
<small>(Removable custom shoe orthotics are limited to \$200 per calendar year; deductible waived)</small>		
<b>Emergency / Urgent Care / Emergency Medical Transportation</b>		
• 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)	\$20 / visit ✓	40% ✓
• Emergency medical transportation	20%	20%

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

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
<b>Other Covered Services</b>		
<ul style="list-style-type: none"> <li>• Outpatient rehabilitative services (30 visits per calendar year)</li> <li>• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>• Home health care</li> <li>• Hospice care</li> <li>• Tobacco use cessation; counseling/classes and deterrent medications</li> <li>• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> <li>-Generic drugs</li> <li>-Formulary brand-name drugs</li> <li>-Non-formulary brand-name drugs</li> </ul> </li> </ul>	20% 20% 50% 20% Covered in full✓ Covered in full✓ \$10✓ \$50✓ \$100✓	40% 40% Not covered 40% Covered in full✓ Not covered Not covered Not covered
<b>Mental Health / Chemical Dependency</b>		
(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"> <li>• Inpatient and day treatment services</li> <li>• Residential services (limited to 60 days per calendar year)</li> <li>• Outpatient provider visits</li> </ul>	20% 20% \$20 / visit✓	40% 40% 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 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
- 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
- Copays 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.

### Copay

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 [www.ProvidenceHealthPlan.com/providerdirectory](http://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](http://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](http://www.ProvidenceHealthPlan.com/providerdirectory).

### Pre-existing condition exclusion

A pre-existing condition is any medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your enrollment date. Coverage for pre-existing conditions is excluded for a period of six months following your enrollment date. This exclusion period can be reduced by qualifying Creditable Coverage. The pre-existing condition exclusion does not apply to members who are under the age of 19. See your Member Handbook for details.

### 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](http://www.ProvidenceHealthPlan.com/contactus)