## Your Benefit Summary

## **Open Option Plan**

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
\$15	<b>20%</b>	<b>40%</b>	<b>\$5,000</b> per person	<b>\$1,000</b> per person
	coinsurance	coinsurance	<b>\$10,000</b> per family	<b>\$2,000</b> per family
	(after deductible)	(after deductible; UCR applies)	(2 or more)	(2 or more)

## Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com. • Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.

- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Open Option Plan Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
$\checkmark$ No deductible needs to be met prior to receiving this benefit.	In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
Preventive Care  Periodic health exams; well-baby care	Covered in full	40%*
Routine immunizations; shots	Covered in full	40%
Colonoscopy (age 50 +)	Covered in full	40%
Gynecological exams (calendar year) and Pap tests	Covered in full	40%
Mammograms	Covered in full	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full	Not covered
Physician / Provider Services • Office visits	\$15 / visit	40%
<ul> <li>Office visits to alternative care providers         (Chiropractic manipulation &amp; acupuncture services are covered only if a separate benefit         has been purchased by your employer. Consult your member materials for these benefits.)     </li> </ul>	\$15 / visit*	40%*
<ul> <li>Phone and video visits</li> </ul>	Covered in full	Not covered
Allergy shots, serums, infusions and injectable medications	20%	40%
• Inpatient hospital visits	20%	40%
• Surgery; anesthesia	20%	40%
Diagnostic Services		
• X-ray; lab services	20%	40%
High-tech Imaging services (such as PET, CT, MRI)	20%	40%
Sleep studies	20%	40%
Emergency and Urgent Services		
<ul> <li>Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)</li> </ul>	\$250	\$250
• Urgent care services (for non-life threatening illness/minor injury)	\$15 / visit <b>´</b>	40%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
<ul> <li>Inpatient/Observation care</li> </ul>	20%	40%
• Rehabilitative care (limited to 30 days per calendar year)	20%	40%
<ul> <li>Skilled nursing facility (limited to 60 days per calendar year)</li> </ul>	20%	40%

PROVIDENCE

Health Plan

Open Option Plan Benefit Highlights (continued)		In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Outpatient Services			
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation	n therapy	20%	40%
Colonoscopy (non-preventive)	. ,	20%	40%
• Temporomandibular joint (TMJ) service		50%	Not covered
(limited to \$1,000 per calendar year / \$5,000 per lifetime)			
• Outpatient rehabilitative services: physical, occupational or spe	eech	20%	40%
therapy (limited to 30 visits per calendar year)			
Aaternity Services			
Prenatal office visits		Covered in full	40%
Delivery and postnatal services		\$150 / delivery	40%
Inpatient hospital/facility services	20%	40%	
Routine newborn nursery care	20%	40%	
Adical Equipment, Supplies and Devices		2070	4070
		20%	108/
Medical equipment, appliances and supplies			40%
• Diabetes supplies (lancets, test strips and needles)		20%	40%
• Prosthetic and orthotic devices (removable custom shoe orthotics are l	limited to	20%	40%
\$200 per calendar year, deductible waived)			
Aental Health / Chemical Dependency			
o initiate services, you must call 800-711-4577. All services, except outpatient pr	rovider visits,		
must be prior authorized.)		20%	40%
<ul> <li>Inpatient and residential services</li> <li>Day treatment, intensive outpatient and partial hospitalization services</li> </ul>		20%	40%
	I Services	20%	40%
Applied behavior analysis     Outpatient provider office vicits		\$15 / visit	40% 40%
Outpatient provider office visits		\$127 VISIC	40 %
Iome Health and Hospice		200/	40%
Home health care			/111%
		20%	
Hospice care		Covered in full	Covered in full
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## 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: 711 Have questions about your benefits and want to contact us via email? Go to our website at: www.ProvidenceHealthPlan.com/contactus