

IMPORTANT NOTICE

In compliance with federal health care reform, as enacted by the Patient Protection and Affordable Care Act, **the following changes apply to your benefits and supersede those listed in your member materials (including the attached benefit summary):**

- **Lifetime maximum benefit:**
 - Your plan does not include a lifetime maximum benefit.
 - Benefit-specific maximums may apply to some services (e.g., human organ tissue transplants).

- **In-plan preventive care services – when services are received from participating providers:**

Periodic exams and well-baby care (from a Personal Physician/Provider)	Covered in full
Routine immunizations and shots	Covered in full
Gynecological exams (calendar year) and Pap tests	Covered in full
Mammograms	Covered in full

- **Colorectal cancer screenings and exams:**
 - For members age 50 and older:
 - In-plan: All services for colorectal cancer screenings and exams are covered in full.
 - Out-of-plan: All colonoscopy and sigmoidoscopy services are covered under the outpatient surgery benefit. Fecal occult blood tests and double contrast barium enemas are covered under the lab services benefit.
 - For members under age 50: Both in- and out-of-plan, all colonoscopy and sigmoidoscopy services are covered under the outpatient surgery benefit. Fecal occult blood tests and double contrast barium enemas are covered under the lab services benefit.

- **Limiting age:**
 - The minimum limiting age for dependent children is 26. Coverage terminates the end of the month in which the dependent child reaches the limiting age (i.e., the end of the month of the child's 26th birthday).

If you have any questions, please contact Customer Service at:

- **Portland-metro area: call 503-574-7500**
- **All other areas: call 800-878-4445**
- **TTY: 503-574-8702 or 888-244-6642**

(Please **scroll down** to view the Benefit Summary.)

Your Benefit Summary

Open Option Plan

OEBB POS 2



Office Visit Copay	Hospital Copay	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
Covered in full \$10/\$15	\$100 per day	50% coinsurance (after deductible; UCR applies)	\$1,200 per person	\$2,400 per person	\$400 per person \$1,200 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.providence.org/php/getstarted) 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(s) that you pay for services received during the fourth quarter of the plan year will be applied toward next year's deductible(s).
- 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 Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay 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	\$15 / visit	50%
• Office visits for these services: asthma, diabetes and heart-related services including cholesterol and hypertension	\$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%
• Maternity services; pre- and postnatal visits	\$100 / delivery	50%
• Allergy shots; serums; injectable medications	Covered in full	50%
• Inpatient hospital visits	Covered in full	50%
• Surgery; anesthesia	\$100	50%
Women's Health Services		
• Gynecological exams (plan year); Pap tests	Covered in full	50%
• Mammograms	Covered in full	50%
Hospital Services		
• Inpatient care	\$100 per day	50%
• Observation care	\$100 per day	50%
• Maternity care	\$100 per day	50%
• Routine newborn nursery 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%
Outpatient Diagnostic Services		
• X-ray; lab services	\$15	50%
• Imaging services (such as PET, CT, MRI)	\$100	50%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Removable custom shoe orthotics are limited to \$200 per plan year)	\$15 per item	50%
Emergency / Urgent Care / Emergency Medical Transportation (Your emergency services copay 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)	\$15	\$15✓
• Emergency medical transportation	\$100	\$100✓

Open Option Plan Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Other Covered Services <ul style="list-style-type: none"> ● Outpatient surgery ● Outpatient dialysis, infusion, chemotherapy, radiation therapy ● Outpatient rehabilitative services (30 visits per plan year) ● Colorectal cancer screening: sigmoidoscopy, colonoscopy ● Sleep apnea studies ● Home health care ● Hospice care ● Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> -Generic drugs -Formulary brand-name drugs -Non-formulary brand-name drugs 	\$100 \$15 \$15 / visit Covered in full \$100 \$15 / visit Covered in full \$15 \$15 \$15	50% 50% 50% 50% 50% 50% Covered in full✓ Not covered Not covered Not covered
Tobacco Use Cessation (Classes, counseling, and deterrent medications) <ul style="list-style-type: none"> ● Plan Qualified Programs ● Deterrent medications 	Covered in full See Member Handbook	Not covered Not covered
Additional Cost Tier (Inpatient or Outpatient) (Your copayments and coinsurance do not apply to your plan year out-of-pocket maximums) <ul style="list-style-type: none"> ● Upper GI endoscopy ● Spine procedures for pain ● Knee replacement ● Hip replacement ● Knee arthroscopy ● Shoulder surgery 	\$500* \$500* \$500* \$500* \$500* \$500*	50%* 50%* 50%* 50%* 50%* 50%*
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 and day treatment services ● Residential services (limited to 60 days per plan year) ● Outpatient provider visits 	\$100 per day \$100 per day \$15 / visit	50% 50% 50%

* Additional Cost Tier Copayments/Coinsurance apply to Provider Services only. Anesthesiology, facility, or other ancillary services are covered at the applicable benefit level stated in this benefit summary.

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.

Deductible carryover

A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a plan 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.

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, refer to the directory available 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
- 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

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.

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

OEGB Plan 2



Copay

\$15

Plan Year
Maximum
Benefit

\$2,000 per member

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 back for the definitions used in this summary.
- Your copays 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 copay 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 non-participating providers

- In rare circumstances, our national network may not have a participating provider in your area. If this occurs, please contact our authorizing agent at 1-800-678-9133. If our authorizing agent is not able to locate a participating provider within a reasonable distance, authorization for use of a non-participating provider will be provided.
- Non-participating providers must be licensed in the state in which they are practicing and must practice within the scope of their license.
- Payment to non-participating providers is based upon Usual, Customary, and Reasonable (UCR) charges. Amounts in excess of UCR are your responsibility.
- Claims should be submitted to American Specialty Health Network, 777 Front Street, San Diego, CA 92101.
- In some cases, you may need to pay the non-participating provider directly for the full cost of the services received and submit your itemized billing to our authorizing agent for reimbursement.
- You are responsible for obtaining prior authorization from our authorizing agent when receiving services from non-participating providers.

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

Copay

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 participating provider network. To find a participating provider, refer to the directory available at www.providence.org/php/providerdirectory.

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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