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) (after deductible)	**$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 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's next year's deductible.
- 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

You pay the following for covered services:

✓ No deductible needs to be met prior to receiving this benefit.	**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)
Physician / Provider Services		
• Office visits	$10 / visit	50%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	covered in full	50%
• Colorectal cancer screening exams	covered in full	50%
• Office visits to alternative care providers (any licensed provider, limited to $2,500 per plan year)	$10 / visit	$10 / visit✓
• 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%
• Other office procedures	covered in full	50%
Women's Health Services		
• Gynecological exams (plan year); Pap tests	covered in full	50%
• Follow-up visits after gynecological exam (plan year)	$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/Emergency Transportation 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✓
• Emergency medical transportation	$100	$100✓

Open Option Plan Benefit Highlights (continued)	In-Plan Co-Pay or Coinsurance	Out-of-Plan Co-Pay or Coinsurance
Other Covered Services		
• X-ray; lab services	covered in full	50%
• Imaging services (PET, CT, MRI)	covered in full	50%
• Outpatient rehabilitative services (30 visits per plan year)	covered in full	50%
• Outpatient surgery; dialysis; infusion; chemotherapy; radiation therapy	covered in full	50%
• Home health care	covered in full	50%
• Hospice care	covered in full	covered in full
• Self-administered chemotherapy (Up to a 31-day supply from a designated participating pharmacy)		
-Generic drugs	covered in full	Not covered
-Formulary brand-name drugs	covered in full	Not covered
-Non-formulary brand-name drugs	covered in full	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, residential and day treatment services	$100 per day	50%
• Outpatient provider visits	$10 / visit	50%

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

Alternative Care Provider
A licensed chiropractic physician, naturopathic physician or acupuncturist who is practicing within the scope of his or her license.

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Co-pay
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.

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

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 common out-of-pocket maximum. See your Member Handbook for details.

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.

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 plan deductibles or 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