

Your Benefit Summary

Providence Choice Open Option Plan

OEBB Medical Home Plan 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 Common Deductible
Covered in full; \$10/\$15	20%	50% coinsurance (after deductible; UCR applies)	\$1,200 per person \$3,600 per family (3 or more)	\$2,400 per person \$7,200 per family (3 or more)	\$100 per person \$300 per family (3 or more)

Important information about your plan

This plan is a medical home plan. You choose a medical home in a clinic, staffed by a team of health care professionals led by your primary provider. This team coordinates your care, including referrals when needed. You have higher out-of-pocket costs if you use services not coordinated through your medical home.

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 the 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 will be applied toward next year's deductible.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Your deductibles, copayments, and some services do not apply to out-of-pocket maximums.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Providence Choice Open Option Plan Highlights

After you pay your plan year common deductible, then you pay the following for covered services:

✓ No deductible needs to be met prior to receiving this benefit.	In-Plan (Medical Home provider or with referral)	Out-of-Plan (non-Medical Home provider or without referral)
Physician / Provider Services		
• Office visits	\$15 / visit✓	50%
• Office visits to specialist	20%	50%
• Office visits for these services: asthma, diabetes and heart-related services including cholesterol and hypertension	\$10 / visit✓	50%
• Periodic health exams; (from a Personal Physician/Provider only)	Covered in full✓	50%
• Routine immunizations; shots	Covered in full✓	50%
• Maternity services; pre- and postnatal visits	20%	50%
• Allergy shots; serums; injectable medications	20%	50%
• Inpatient hospital visits	20%	50%
• Surgery; anesthesia	20%	50%
Women's Health Services		
• Gynecological exams (plan year); Pap tests	Covered in full✓	50%
• Mammograms	Covered in full✓	50%
Hospital Services		
• Inpatient care	20%	50%
• Observation care	20%	50%
• Maternity care	20%	50%
• Routine newborn nursery care	20%	50%
• Rehabilitative care (30 days per plan year)	20%	50%
• Skilled nursing facility (60 days per plan year)	20%	50%
Outpatient Diagnostic Services		
• X-ray; lab services	20%	50%
• Imaging services (such as PET, CT, MRI)	\$100, plus 20%	\$100, plus 50%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices	20%*	50%

(Removable custom shoe orthotics are limited to \$200 per calendar year; deductible waived)

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

Providence Choice Open Option Plan Highlights (continued)	In-Plan	Out-of-Plan
Emergency / Urgent Care / Emergency Medical Transportation (your emergency/urgent copay is waived if admitted to the hospital within 24 hours)		
<ul style="list-style-type: none"> • Emergency services (for emergency medical conditions only) • Urgent care services (for non-life threatening illness/minor injury) • Emergency medical transportation 	\$100, plus 20% \$50✓ 20%	\$100, plus 20% \$50✓ 20%
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 31-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> -Generic drugs -Formulary brand-name drugs -Non-formulary brand-name drugs • Hearing Aids (limited to \$4,000 per every four plan years) 	20% 20% 20% Covered in full✓ \$100, plus 20% 20% Covered in full✓ 20% 20% 20% 10%	50% 50% 50% 50% \$100, plus 50% 50% Covered in full✓ Not covered Not covered Not covered 50%
Tobacco Use Cessation		
<ul style="list-style-type: none"> • Free & Clear Quit for Life Program • Counseling/classes and deterrent medications 	Covered in full✓ Covered in full✓	Not applicable 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 arthroscopy 	\$100, plus 20% \$500, plus 20% \$500, plus 20% \$500, plus 20% \$500, plus 20% \$500, plus 20%	\$100, plus 50% \$500, plus 50% \$500, plus 50% \$500, plus 50% \$500, plus 50% \$500, plus 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 • Outpatient provider visits 	20% 20% \$15 / visit✓	50% 50% 50%

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 in the Providence Choice Medical Home network, 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.providence.org/php/providerdirectory.

Medical Home Provider

A full service health care clinic within the Providence Choice Network which provides and coordinates members' medical care.

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 or when services have not been coordinated through the Medical Home. 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/php/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.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 common deductible

The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a plan 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
- Copays or coinsurance for any supplemental benefits provided by your employer, such as prescription drugs, or routine vision care
- 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 and coinsurance for services that do not apply to the deductible

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