

Your Benefit Summary

Individual Open Option Plan – HSA 3500



Copay	What You Pay In-Plan	What You Pay Out-of-Plan	Annual Common Medical/Pharmacy Out-of-Pocket Maximum	Annual Common Medical/Pharmacy Deductible	Lifetime Maximum Benefit
\$20	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	\$5,250 per person \$10,500 per family (2 or more)	\$3,500 per person \$7,000 per family (2 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 Individual & Family Plan Contract and Plan Guide, register for myProvidence at www.providence.org/php/getstarted

- Not sure what a word or phrase means? See page three of this summary for definitions.
- Routine vision copays and some services do not apply to out-of-pocket maximum.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- A pre-existing condition exclusion applies to this plan. See page three of this summary for more information.
- Limitations and exclusions apply to your benefits. See your Individual & Family Plan Contract for details.

Open Option Plan Benefit Highlights		After you pay your annual common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.		In-Plan Copay or Coinsurance (when you use a participating provider)	Out-of-Plan Copay or Coinsurance (when you use a non-participating provider)
Physician / Provider Services			
• Office visits to a Personal Physician/Provider		\$20 / visit	40%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only/limited to \$250 per calendar year)		\$20 / visit✓	40%
• Office visits to all other physicians/providers		20%	40%
• Routine immunizations; shots		\$20 / visit✓	40%
• Allergy shots; serums; injectable medications		20%	40%
• Inpatient hospital visits		20%	40%
• Surgery; anesthesia		20%	40%
Women's Health Services			
• Annual gynecological exams (calendar year); Pap tests		\$20 / visit✓	40%
• Follow-up visits after annual gynecological exam		\$20 / visit	40%
• Mammograms		\$20✓	40%
Hospital Services			
• Inpatient care		20%	40%
• Observation care		20%	40%
• Rehabilitative care (30 days per calendar year)		20%	40%
• Skilled nursing facility (60 days per calendar year)		20%	40%
Maternity (see Plan Contract regarding pre-existing conditions)			
• Prenatal and postnatal visits; delivery		20%	40%
• Routine newborn nursery care		20%	40%
• Hospital services		20%	40%
Medical Supplies, including Diabetes Supplies		20% *	40%
Durable Medical Equipment, Appliances and Prosthetic Devices (limited to \$2,500 per calendar year; removable custom shoe orthotics limited to \$200 per calendar year)		20%	40%
Emergency / Urgent Care / Emergency Transportation Services (your emergency/urgent copay is waived if admitted to the hospital within 24 hours)			
• Emergency services (for emergency medical conditions only)		\$250	\$250
• Urgent care services (for non-life threatening illness/minor injury)		\$20 / visit	\$20 / visit
• Emergency medical transportation (\$2,000 per calendar year)		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
Other Covered Services		
• X-ray; lab services	20%	40%
• Imaging services (PET, CT, MRI)	20%	40%
• Outpatient rehabilitative services (30 visits per calendar year)	20%	40%
• Outpatient surgery; dialysis; infusion; chemotherapy; radiation therapy	20%	40%
• Home health care (180 visits per calendar year)	20%	40%
• Hospice care	20%	40%
• Self-administered chemotherapy (up to a 30-day supply from a designated participating pharmacy)		
- Generic drugs	\$10	Not covered
- Formulary brand name drugs	\$50	Not covered
- Non-formulary brand name drugs	\$100	Not covered
Mental Health / Alcohol Dependency		
Prior authorization is required for all Mental Health and Alcohol Dependency treatment. To arrange services, call our authorizing agent at 1-800-711-4577.		
• Mental health (limited to \$2,000 per calendar year for all services, inpatient or outpatient)	20%	40%
• Alcohol dependency (limited to \$4,500 every two calendar years for all services)	20%	40%

Prescription Drugs

To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.providence.org/healthplans or call us.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug	50%	50%	50%
Brand name drug	50%	50%	50%
Compounded drug	50%	Does not apply	Does not apply

Covered medications must be purchased at a participating pharmacy, except for emergency situations.

Our Formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense. Some drugs may require prior authorization by us. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

Covered medications must be FDA approved, medically necessary and require a prescription to dispense the medication. See your Individual & Family Plan Contract for additional prescription drug limitations and exclusions.

Routine Vision Services – Administered by VSP	No deductible needs to be met prior to receiving vision benefits. Vision benefits do not apply to your deductible, out-of-pocket maximum or lifetime maximum.	
To find a VSP Select participating provider go to: www.vsp.com or contact VSP Member Services at 1-800-877-7195	In-Plan	Out-of-Plan Maximum Covered
• Routine Vision Exam (covered once per 12 months)	\$30 copay	Covered up to \$29
• Frames (covered once per 24 months)	Covered up to \$80	Covered up to \$33
• Basic Lenses (covered once per 24 months)		
- Single	Covered in full	Covered up to \$28
- Bifocal	Covered in full	Covered up to \$42
- Trifocal	Covered in full	Covered up to \$56
• Contact Lenses (covered once per 24 months in lieu of a complete pair of glasses)	Covered up to \$80 (for contacts and contact lens services)	Covered up to \$65 (for contacts and contact lens services)
• 15% off contact lens exams (fitting and evaluation)		

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 medical/pharmacy 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.
- 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.
- Copays and coinsurance for services that do not apply to the deductible.
- Copays for routine vision care.

Common medical/pharmacy 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. Your routine vision copays, some services and expenses do not apply to the common out-of-pocket maximum. See your Individual & Family Plan Contract for details.

Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Compounded drug

The combining, mixing, or altering of covered drugs or other ingredients for a customized prescription for an individual as prescribed by a licensed provider.

Creditable coverage

Prior health care coverage held by you or your eligible dependents, including any group coverage, individual health care coverage, Medicare, Medicaid, TRICARE, SCHIP, Indian Health Service or tribal organization coverage, state high-risk pool coverage, or coverage under a domestic or foreign public health plan.

Exclusion period

A period of time during which all specified treatments or services are excluded from coverage. If treatment was covered under a previous plan, then the exclusion period is reduced by each day of continuous prior creditable coverage.

Formulary

A list of preferred brand name and generic drugs that have been evaluated by us for effectiveness and safety.

Generic drug

Generic drugs have the same active-ingredient formula as the brand name drug. Generic drugs are tested by the Food and Drug Administration (FDA) to be as safe and as effective as brand name drugs. Generic drugs are only available after the brand name patent expires. Visit www.providence.org/healthplans for frequently asked questions about generic drugs.

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.

Maintenance drug

Medications that are typically prescribed to treat long term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future.

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.

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

Pre-existing condition

A medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your effective date of coverage. You will need to be covered under this plan for six continuous months before services for pre-existing conditions will be covered. See your Individual & Family Plan Contract 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 or the services requiring pre-approval will not be covered.

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