

Your Benefit Summary

Open Option Plan

Intel - Connected Care
Primary Care Plus Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
\$10	5% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	\$1,500 per person \$3,000 per family (2 or more)	\$250 per person \$500 per family (2 or more)	\$250 per person \$500 per family (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 myprovidence.com.

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network deductibles accumulate separately and are not combined.
- Prior authorization is required for some services when received outside of the Connected Care network.
- To get the most out of your benefits, use providers within the Connected Care network. View a list of network providers and pharmacies at www.providenceoregon.org/intel.
- 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 Intel Pay, Stock and Benefits Handbook for details.

Open Option Plan Benefit Highlights

	After you pay your calendar year deductible(s), then you pay the following for covered services:	
	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)
<ul style="list-style-type: none"> No deductible needs to be met prior to receiving this benefit. 		
Preventive Care		
• Periodic health exams and well-baby care	Covered in full ✓	40%
• Routine immunizations; shots	Covered in full ✓	40%
• Colonoscopy	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 to Primary Care Physician (PCP)-Including phone & video visits	\$10 / visit ✓	40%
• Providence ExpressCare Retail Health Clinics	\$10 / visit ✓	Not applicable
• Office visits to specialist	5%	40%
• Office visits to Alternative Care Provider	5%	40%
• Infusions and injectable medications	5%	40%
• Allergy shots and serums	Covered in full ✓	40%
• Inpatient hospital visits	5%	40%
• Surgery; anesthesia	5%	40%
Diagnostic Services		
• X-ray; lab services	5%	40%
• High-tech Imaging services (such as PET, CT, MRI)	5%	40%
• Sleep studies	5%	40%
Emergency and Urgent Services		
• Emergency services	5%	5%
• Urgent care services (for non-life threatening illness/minor injury)	5%	40%
• Emergency medical transportation (air and/or ground)	5%	5%
Hospital Services		
• Inpatient/Observation care	5%	40%
• Rehabilitative care	5%	40%
• Skilled nursing facility (in-network no limit; out-of-network limited to 100 days)	5%	40%
• Bariatric surgery	5%	40%

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 therapy	5%	40%
• Temporomandibular joint (TMJ) service	5%	40%
• Outpatient rehabilitative services; physical, occupational or speech therapy	5%	40%
• Outpatient rehabilitative services for treatment of developmental delay	5%	40%
• Chiropractic manipulation (limited to 30 visits per calendar year)	5%	40%
• Acupuncture treatment (limited to 30 visits per calendar year)	5%	40%
Maternity Services		
Initial visit to confirm pregnancy \$10, deductible waived, then the following:		
• Prenatal office visits	Covered in full ✓	40%
• Delivery and postnatal services	Covered in full ✓	40%
• Inpatient hospital/facility services	Covered in full	40%
• Routine newborn nursery care	Covered in full	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	5%	40%
• Diabetes supplies (lancets, test strips, needles, insulin and glucose monitors)	Covered in full ✓	40%
• Prosthetic and orthotic devices	5%	40%
Behavioral Health / Chemical Dependency		
(To initiate services, call 800-878-4445.)		
• Inpatient and residential services	5%	40%
• Partial Hospitalization Services (requires authorization out-of-network)	5%	40%
• Intensive outpatient services (requires authorization if facility is out of network)	5%	40%
• Applied behavioral analysis (no authorization required)	5%	5%
• Transcranial Magnetic Stimulation (requires authorization if provider is out of network)	\$10 / visit ✓	40%
• Outpatient provider office visits (no authorization required)	5% up to \$10 ✓	40%
Home Health and Hospice		
• Home health care	5%	40%
• Hospice care	Covered in full	40%
Prescription Drugs - All Network Pharmacies (for up to a 34 day supply) - Deductible waived		
• Preventive drugs - Covered in full		
• Generic - \$10		
• Formulary brand - \$20		
• Non-formulary brand - \$35		
Prescription Drugs - All Network Pharmacies (for up to a 90 day supply of maintenance drugs) - Deductible waived		
• Preventive drugs - Covered in full		
• Generic - \$30		
• Formulary brand - \$60		
• Non-formulary brand - \$105		
Prescription Drugs - All Mail Order and Preferred Network Pharmacies (for up to a 90 day supply of maintenance prescriptions) - Deductible waived		
• Preventive drugs - Covered in full		
• Generic - \$25		
• Formulary brand - \$50		
• Non-formulary brand - \$90		
Prescription Drugs - All Network Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs) - Deductible waived		
• Specialty drugs - \$20		

Coinsurance

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

Deductible

The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. 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 and coinsurance for services that do not apply to the deductible

Copay

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

Formulary

A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

In-Network

Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

Limitations and Exclusions

All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-network

Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to ProvidenceHealthPlan.com/findaprovider.

Out-of-Pocket Maximum

The limit on the dollar amount that an individual or family pays for specified covered services in a calendar year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

Primary Care Physician (PCP)

A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization

Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Usual, Customary & Reasonable (UCR)

Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network 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: **800-878-4445**
TTY: **503-574-8702 or 888-244-6642**



Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
 - Qualified sign language interpreters
 - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY:711) for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit <https://dfr.oregon.gov/Pages/index.aspx>.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ：日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711)まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistentendienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់: បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ເລື່ອງສຳຄັນ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).