Your Benefit Summary
Out-of-Area Dependent

What You Pay	Annual Out-of-Pocket Maximum	Lifetime Maximum Benefit
20% coinsurance	**$1,000** per person **$3,000** 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.
- A pre-existing condition clause applies to this plan. See the back for more information.
- Some services must be prior authorized by us or a penalty will apply. See your Member Handbook for a list of these services.
- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- 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.

Out-of-Area Dependent Benefit Highlights	You pay the following for covered services: Co-Pay or Coinsurance
Physician / Provider Services	
• Office visits	20%
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	20%
• Routine immunizations; shots	20%
• Allergy shots; serums; injectable medications	20%
• Inpatient hospital visits	20%
• Surgery; anesthesia	20%
• Other office procedures	20%
Women's Health Services	
• Annual gynecological exams (calendar year); Pap tests	20%
• Follow-up visits after annual gynecological exam	20%
• Mammograms	20%
Hospital Services	
• Inpatient care	20%
• Observation care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%
Maternity	
• Pre- and post-natal visits; delivery	20%
• Routine newborn nursery care	20%
• Hospital services	20%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Removable custom shoe orthotics are limited to $200 per calendar year)	20%
Emergency/Urgent Care/Ambulance Services (Your emergency/urgent coinsurance is waived if admitted to the hospital within 24 hours)	
• Emergency services (for emergency medical conditions only)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Ambulance services (for emergency transportation only)	20%

Out-of-Area Dependent Benefit Highlights (continued)

	Co-Pay or Coinsurance
Other Covered Services	
• X-ray; lab services	20%
• Imaging services (PET, CT, MRI)	20%
• Outpatient rehabilitative services (30 visits per calendar year)	20%
• Outpatient surgery; dialysis; infusion, chemotherapy; radiation therapy	20%
• Temporomandibular joint (TMJ) service (limited to $1,000 per calendar year / $5,000 per lifetime)	50%
• Home health care	20%
• Hospice care	50%
• Outpatient prescription drugs (if provided through supplemental coverage)	See your Prescription Drug Summary of Benefits for details
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)	
-Generic drugs	$10
-Formulary brand-name drugs	$50
-Non-formulary brand-name drugs	$100
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	20%
• Outpatient provider visits	20%

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.

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.

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-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the 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

Pre-existing condition
A medical condition for which medical advice, diagnosis, care or treatment was recommended or received within six months prior to your enrollment date. You will need to be enrolled under this plan for six continuous months before services for pre-existing conditions will be covered. See your Member Handbook for details.

Prior authorization
Some services must be pre-approved. 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