

# Your Benefit Summary

## Out-of-Area Dependent



<b>What You Pay</b>	<b>Annual Out-of-Pocket Maximum</b>	<b>Lifetime Maximum Benefit</b>
<b>20%</b> coinsurance	<b>\$1,000</b> per person <b>\$3,000</b> per family (3 or more)	<b>\$2,000,000</b>

### 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](http://www.providence.org/php/getstarted)

- Not sure what a word or phrase means? See the back for definitions used in this summary.
- 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
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits</li> <li>• Periodic health exams; well-baby care (from a Personal Physician/Provider only)</li> <li>• Routine immunizations; shots</li> <li>• Allergy shots; serums; injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> <li>• Other office procedures</li> </ul>	20% 20% 20% 20% 20% 20% 20%
<b>Women's Health Services</b>	
<ul style="list-style-type: none"> <li>• Annual gynecological exams (calendar year); Pap tests</li> <li>• Follow-up visits after annual gynecological exam</li> <li>• Mammograms</li> </ul>	20% 20% 20%
<b>Hospital Services</b>	
<ul style="list-style-type: none"> <li>• Inpatient care</li> <li>• Observation care</li> <li>• Rehabilitative care (30 days per calendar year)</li> <li>• Skilled nursing facility (60 days per calendar year)</li> </ul>	20% 20% 20% 20%
<b>Maternity</b>	
<ul style="list-style-type: none"> <li>• Pre- and post-natal visits; delivery</li> <li>• Routine newborn nursery care</li> <li>• Hospital services</li> </ul>	20% 20% 20%
<b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices</b>	
(Removable custom shoe orthotics are limited to \$200 per calendar year)	20%
<b>Emergency/Urgent Care/Ambulance Services</b>	
(Your emergency/urgent coinsurance is waived if admitted to the hospital within 24 hours)	
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Ambulance services (for emergency transportation only)</li> </ul>	20% 20% 20%

Out-of-Area Dependent Benefit Highlights (continued)	Co-Pay or Coinsurance
<b>Other Covered Services</b> <ul style="list-style-type: none"> <li>• X-ray; lab services</li> <li>• Imaging services (PET, CT, MRI)</li> <li>• Outpatient rehabilitative services (30 visits per calendar year)</li> <li>• Outpatient surgery; dialysis; infusion, chemotherapy; radiation therapy</li> <li>• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>• Home health care</li> <li>• Hospice care</li> <li>• Outpatient prescription drugs (if provided through supplemental coverage)</li>   <li>• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) <ul style="list-style-type: none"> <li>-Generic drugs</li> <li>-Formulary brand-name drugs</li> <li>-Non-formulary brand-name drugs</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>20%</li> <li>20%</li> <li>20%</li> <li>20%</li> <li>50%</li> <li>20%</li> <li>20%</li> <li>See your Prescription Drug Summary of Benefits for details</li>   <li>\$10</li> <li>\$50</li> <li>\$100</li> </ul>
<b>Mental Health / Chemical Dependency</b> (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"> <li>• Inpatient, residential and day treatment services</li> <li>• Outpatient provider visits</li> </ul>	<ul style="list-style-type: none"> <li>20%</li> <li>20%</li> </ul>

**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](http://www.providence.org/php/providerdirectory)

**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](http://www.providence.org/php/contactus)