

# Your Benefit Summary

## Basic Plan



<b>Co-Pay</b>	<b>What You Pay</b>	<b>Annual Out-of-Pocket Maximum</b>	<b>Lifetime Maximum Benefit</b>
<b>\$15</b>	<b>50%</b> coinsurance	<b>\$3,000</b> per person <b>\$9,000</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.
- This plan only provides benefits for medically necessary services when provided by a participating physician or provider.
- A pre-existing condition clause applies to this plan. See the back for more information.
- 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.

Basic Plan Benefit Highlights	You pay the following for covered services:
	Co-Pay or Coinsurance (from participating providers only)
<b>Preventive Health Services</b> (from a personal physician/provider only) <ul style="list-style-type: none"> <li>• Periodic health exams; well-baby care</li> <li>• Vision &amp; hearing screening, including necessary vision exams, for children under 18*</li> </ul>	\$15 / visit \$15 / visit
<b>Physician / Provider Services</b> <ul style="list-style-type: none"> <li>• Office visits to Personal Physician/Provider</li> <li>• Office visits to all other participating providers</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>	\$15 / visit 50% \$15 / visit 50% 50% 50% 50%
<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>	\$15 / visit 50% \$15
<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>	50% 50% 50% 50%
<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>	50% 50% 50%
<b>Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices</b> (Removable custom shoe orthotics are limited to \$200 per calendar year)	50%
<b>Emergency/Urgent Care/Ambulance Services</b> (Your emergency/urgent co-pay 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>	\$125 50% 50%

\*Children 2-6 years are limited to one exam every 12 months; children 7-17 are limited to one exam every 24 months.

Basic Plan 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 condition within 60 days)</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>• Hearing aids; children under age 18 (who lost hearing before age 3)</li> <li>• Dental care; children ages 3-12 (exam/cleaning/fluoride once per year; bitewing x-rays once in 18 months; sealants as appropriate)</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>	50% 50% 50% 50% 50% 50% 50% 50% \$15/visit; \$50 for sealants (from Willamette Dental Group only) \$10 \$50 \$100
<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>	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.

**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)

**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.

**Self-administered chemotherapy**  
Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

**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)