

## washington – small group

## out-of-area dependent

This is a summary of benefits only and supplements your employer group's in-area summary of benefits document. Please consult your Member Handbook for detailed information on plan use and benefit coverage. Benefits are provided for medically necessary services received from non-participating providers at usual, customary and reasonable (UCR) charges. Many services must be prior authorized or a 50% penalty of UCR charges (up to \$2,500 per occurrence) will apply.

**The annual (calendar year) out-of-pocket maximum payable by you for covered services is \$1,000 per person/\$3,000 per family and accumulates separately from in-area maximums. The 50% penalty and some services do not apply to the maximum. Deductibles specified for in-area members do not apply to out-of-area dependents. The lifetime maximum coverage for benefits is \$2,000,000.**

### benefits

### you pay:

#### Women's Health Care Services

• Annual (calendar year) gynecological exams, Pap tests	20%
• Follow-up visits after annual gynecological exam	20%
• Mammograms	20%

#### Physician / Provider Services

• Office visits	20%
• Inpatient hospital visits	20%
• Periodic health exams and well-baby care	20%
• Surgery & anesthesia	20%
• Allergy shots & serums, injectable medications	20%
• Routine immunizations/shots	20%

#### Hospital Services

• Acute care	20%
• Rehabilitative care (30 days per calendar year)	20%
• Skilled nursing facility (60 days per calendar year)	20%

#### Maternity (employee and spouse only)

• Pre-natal visits, delivery, post-natal visits	20%
• Hospital services	20%
• Routine newborn nursery care	20%

#### Medical Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices

(Orthotics covered up to \$200 per calendar year)	20%
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#### Emergency/Urgent & Ambulance Services (your Emergency/Urgent copayment is waived if admitted to hospital within 24 hours)

• Emergency services (for the treatment of emergency medical conditions only)	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%
• Ambulance services (for emergency transportation only; limited to \$1,000 per calendar year)	20%

#### Other Covered Services

• X-ray & lab services	20%
• Outpatient rehabilitative services (30 visits per calendar year)	20%
• Outpatient surgery, dialysis, chemotherapy & radiation therapy	20%
• Temporomandibular joint (TMJ) medical services	50% to limit
• Home health care (130 visits per calendar year)	20%
• Neuro-developmental therapy (30 visits per calendar year) for children aged six and under	20%
• Hospice care	20%
• Spinal manipulations (12 visits per calendar year)	20%
• Acupuncture (12 visits per calendar year)	20%
• Outpatient prescription drugs (must use participating pharmacies)	See your Prescription Drug Summary of Benefits for details

To initiate Mental Health or Chemical Dependency services, call 1-800-711-4577  All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.	Mental Health Services		Chemical Dependency Services		
	You pay:	Limits	You pay:	Limits	
<b>Inpatient – Adult</b>	20%	15 days	Day/Visit maximum benefits are per person, per two calendar year period	20%	\$14,000 maximum benefit is per person, per two calendar year period
<b>Inpatient – Child</b>		15 days			
<b>Outpatient visits – Adult</b>	20%	29 visits			
<b>Outpatient visits – Child</b>		29 visits			
<b>Residential/Day – Adult</b>	20%	19 days			
<b>Residential/Day – Child</b>		19 days			

## general limitations and exclusions

Following are the most common limitations and exclusions. Please refer to your Member Handbook for a complete listing. Your employer may have purchased a supplemental benefit offering some of the services listed below. Please call your Customer Service team if you have questions.

- Certain **alternative care services** as specified in your Member Handbook.
- Some services do not apply to the **annual out-of-pocket maximums**. Please see your Member Handbook for a complete listing.
- Services provided by **any category of provider** that is not regulated by the state of Washington including, but not limited to, homeopaths, faith healers and lay midwives.
- Over-the-counter **contraceptive supplies and devices**.
- **Cosmetic surgery**.
- **Custodial care** and private nursing services.
- **Dental care**, including orthognathic surgery, except as otherwise stated in your Member Handbook.
- **Experimental/investigational procedures**.
- **Eye surgery** which alters the refractive character of the eye, including laser eye and radial keratotomy.
- Services and supplies for **fertility/infertility treatment**, including in vitro fertilization.
- Routine **foot care**, except for diabetes.
- **Genetic testing**, except as otherwise stated in your Member Handbook.
- **Hearing aids**, hearing therapies and hearing devices used in association with hearing therapies or training.
- **Home births** and all related services, except for low risk pregnancies.
- Certain **mental health services**, such as treatment of developmental or learning disabilities and self-help programs, including family, marriage, sex and career counseling in the absence of illness.
- **Physical exams** primarily for camps, sports, insurance, licensing, employment, or other third-party purposes.
- Services and supplies for **sexual dysfunction or sexual transformation**.
- Voluntary **sterilization** or **termination of pregnancy**.
- **TMJ** medical services are limited to \$1,000 per calendar year, \$5,000 per lifetime.
- Organ **transplants**, except as otherwise stated in your Member Handbook. No benefits will be provided during the first 12 months of coverage unless you meet the circumstances outlined in your Member Handbook. Approved transplants are limited to \$250,000 per lifetime.
- Amounts in excess of **usual, customary and reasonable (UCR) charges**. These amounts do not apply to annual out-of-pocket maximums or any applicable deductibles.
- Routine **vision screenings, vision exams and eyeglasses**.
- **Weight loss programs** and other services and supplies for the treatment of **obesity**.
- Services for injury/illness sustained as a result of any **work for wage or profit** are only available for owner/proprietor subscribers, and covered employees of employers not required to carry worker's compensation coverage. Benefits are limited to \$50,000 per lifetime.

<b>customer service:</b>	• Portland Metro Area: 503-574-7500	• All Other Areas: 1-800-878-4445	• TTY (For the Hearing Impaired): 503-574-8702 or 1-888-244-6642
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