Providence | Health Plan
A caring difference you can feel

summary of benefits

oregon – hsa qualified

open option $20 / 20% / 40% / $5,000
+ $2,600 combined deductible

This is a summary of benefits only. Please consult your Member Handbook for detailed information on plan use and benefit coverage. **Benefits are provided after a $2,600 Individual or $5,150 Family annual (calendar year) combined medical/pharmacy deductible has been met. IN-PLAN** benefits are provided for medically necessary services when provided by participating providers. **OUT-OF-PLAN** benefits are provided when services are received from non-participating providers. These benefits are provided 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.

Annual (calendar year) combined medical/pharmacy out-of-pocket maximum: $5,000 Individual or $10,000 Family. Copayments, coinsurance and deductibles apply to your out-of-pocket maximum. The **Individual** deductible and out-of-pocket maximum applies when only the employee is enrolled. The **Family** deductible and out-of-pocket maximum applies when an employee and dependent(s) are enrolled. The 50% penalty and some services do not apply to out-of-pocket maximums. **The lifetime maximum coverage for benefits is $2,000,000.**

benefits	you pay deductible, then: in-plan	out-of-plan
Women's Health Care Services		
• Annual (calendar year) gynecological exams, Pap tests	$20/visit*	40%
• Follow-up visits after annual gynecological exam	20%	40%
• Mammograms	$20*	40%
Physician / Provider Services		
• Office visits to physicians/providers	20%	40%
• Office visits to alternative care providers ($500 per calendar year limit)	20%	Not covered
• Periodic health exams and well-baby care† (limited to $250 per calendar year)	$20/visit*	40%
• Inpatient hospital visits	20%	40%
• Surgery & anesthesia	20%	40%
• Allergy shots & serums, injectable medications	20%	40%
• Routine immunizations/shots	$20/visit*	40%
• Other office procedures	20%	40%
Hospital Services		
• Acute care	20%	40%
• Rehabilitative care (30 days per calendar year)	20%	40%
• Skilled nursing facility (60 days per calendar year)	20%	40%
Maternity		
• Pre-natal visits, delivery, & post-natal visits	20%	40%
• Hospital services	20%	40%
• Routine newborn nursery care	20%	40%
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Orthotics covered up to $200 per calendar year)	20%**	40%
Emergent/Urgent & Ambulance Services (your Emergent/Urgent copayment is waived if admitted to hospital within 24 hours)		
• Emergency services (for the treatment of emergency medical conditions only)	20%	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%	20%
• Ambulance services (for emergency transportation only)	20%	20%
Other Covered Services		
• X-ray & lab services	20%	40%
• Outpatient rehabilitative services (30 visits per calendar year)	20%	40%
• Outpatient surgery, dialysis, chemotherapy & radiation therapy	20%	40%
• Temporomandibular joint (TMJ) services	50%	Not covered
• Home health care	20%	40%
• Hospice care	Covered in full	Covered in full
Prescription Drugs (up to a 30-day supply/retail pharmacy; 90-day supply/mail order & preferred retail pharmacies)		
• Generic and brand-name drugs	20%	N/A
• Compound drugs	50%	N/A

***Deductible does not apply**
****Deductible does not apply to diabetes supplies**
†From a Personal Physician/Provider only

benefits	you pay deductible, then: in-plan	out-of-plan
Mental Health / Chemical Dependency		
(**To initiate services, call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)**		
• Inpatient/residential services		
- Facility	20%	40%
- Provider visits	20%	40%
• Day treatment services		
- Facility	20%	40%
• Outpatient services		
- Provider visits	20%	40%

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.

- Some services do not apply to **annual out-of-pocket maximums** or deductibles. Please see your Member Handbook for a complete listing.
- **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.
- **Massage therapy.**
- 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, supplies and prescription drugs for **sexual dysfunction or sexual transformation.**
- Voluntary **sterilization** or **termination of pregnancy.**
- **TMJ** 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 24 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 deductibles or out-of-pocket maximums.
- Routine **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**. Services covered by **motor vehicle insurance** or other liability insurance.

Other Important Information

- A **Deductible Carryover does** not apply to this plan.

customer service:
- 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**