

Summary of Benefits



washington – large group hsa qualified **open option \$20 / 20% / 40% / \$3,000**

+ \$1,500 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 \$1,500 Individual or \$3,000 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: \$3,000 Individual or \$6,000 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 & diagnostic procedures | 20% | 40% |
| • Mammograms | \$20* | 40% |
| Physician / Provider Services | | |
| • Office visits | 20% | 40% |
| • Inpatient hospital visits | 20% | 40% |
| • Periodic health exams and well-baby care†(limited to \$250 per calendar year) | \$20/visit* | 40% |
| • Surgery & anesthesia | 20% | 40% |
| • Allergy shots & serums, injectable medications | 20% | 40% |
| • Routine immunizations/shots | \$20/visit* | 40% |
| Hospital Services | | |
| • Acute care | 20% | 40% |
| • Observation 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 & Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Removable custom shoe orthotics, for conditions other than diabetes, are limited to \$200 per calendar year) | | |
| | 20%** | 40% |
| Emergency / Urgent Care / Emergency Transportation Services (your emergency/urgent co-pay 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% |
| • Emergency medical transportation | 20% | 20% |
| Other Covered Services | | |
| • X-ray & lab services | 20% | 40% |
| • Imaging services (PET, CT, MRI) | 20% | 40% |
| • Outpatient rehabilitative services (30 visits per calendar year) | 20% | 40% |
| • Outpatient surgery, dialysis, infusion, chemotherapy & radiation therapy | 20% | 40% |
| • Temporomandibular joint (TMJ) services | 50% to limit | Not covered |
| • Home health care (130 visits per calendar year) | 20% | 40% |
| • Neuro-developmental therapy (30 visits per calendar year) for children aged six and under | 20% | 40% |
| • Hospice care | Covered in full | Covered in full |
| Prescription Drugs (up to a 30-day supply/retail & preferred retail pharmacies; 90-day supply/mail order & preferred retail pharmacies) | | |
| • Generic and brand-name drugs | 20% | Not covered |
| • Compounded drugs | 50% | Not covered |

*Deductible does not apply

**Deductible does not apply to diabetes supplies

†From a Personal Physician/Provider only

| 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 deductible, then: | | Limits | | You pay deductible, then: | | Limits |
| | IN-PLAN | OUT-OF-PLAN | | | IN-PLAN | OUT-OF-PLAN | |
| Inpatient | 20% | 40% | 15 days | Day/Visit maximum benefits are per person, per two calendar year period | 20% | 40% | \$14,500 maximum benefit is per person, per two calendar year period |
| Outpatient visits | 20% | 40% | 29 visits | | | | |
| Residential/Day | 20% | 40% | 19 days | | | | |

general limitations and exclusions

Following are the most common limitations and exclusions. Please refer to your Member Handbook, Alternative Care Summary of Benefits or Prescription Drug Summary of Benefits 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 **annual out-of-pocket maximums** or deductibles. 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, 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 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 deductibles or out-of-pocket maximums.
- 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**.

Other Important Information

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

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| 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 |
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www.providence.org/healthplans