Providence | Health Plan

A caring difference you can feel

summary of benefits

washington – large group

personal option $15 / 30% / $2,000 + $1,000 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 for medically necessary services only when provided by a participating physician or provider.

The annual deductible is $1,000 per person/$3,000 per family. The annual (calendar year) out-of-pocket maximum payable by you for covered services is $2,000 per person/$6,000 per family. Your deductible and some services do not apply to the maximum. The lifetime maximum coverage for benefits is $2,000,000.

benefits	you pay deductible, then:
Women's Health Care Services	
• Annual (calendar year) gynecological exams, Pap tests	$15/visit*
• Follow-up visits & diagnostic procedures	$15/visit*
• Mammograms	$15*
Physician / Provider Services	
• Office visits	$15/visit*
• Inpatient hospital visits	30%
• Periodic health exams and well-baby care (from a Personal Physician/Provider only)	$15/visit*
• Surgery & anesthesia	30%
• Allergy shots & serums, injectable medications	30%
• Routine immunizations/shots	$15/visit*
Hospital Services	
• Acute care	30%
• Rehabilitative care (30 days per calendar year)	30%
• Skilled nursing facility (60 days per calendar year)	30%
Maternity	
• Pre-natal visits, delivery, post-natal visits	$150*
• Hospital services	30%
• Routine newborn nursery care	30%*
Medical & Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic Devices (Orthotics covered up to $200 per calendar year)	30%**
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)	$125*
• Urgent care services (for non-life threatening illness/minor injury)	$25*
• Ambulance services (for emergency transportation only)	30%
Other Covered Services	
• X-ray & lab services	30%*
• Outpatient rehabilitative services (30 visits per calendar year)	30%
• Outpatient surgery, dialysis, chemotherapy & radiation therapy	30%
• Temporomandibular joint (TMJ) services	50% to limit
• Home health care (130 visits per calendar year)	30%
• Neuro-developmental therapy (30 visits per calendar year) for children aged six and under	30%
• Hospice care	Covered in full

***Deductible does not apply**
****Deductible does not apply to diabetes supplies**

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**
Inpatient – Adult	30%	15 days	Day/Visit maximum benefits are per person, per two calendar year period	30%	$14,000 maximum benefit is per person, per two calendar year period
Inpatient – Child		15 days			
Outpatient visits – Adult	$15/visit*	29 visits		$15/visit*	
Outpatient visits – Child		29 visits			
Residential/Day – Adult	30%	19 days		30%	
Residential/Day – Child		19 days			

***Deductible does not apply**

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** 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.
- **Non-participating provider** services unless prior authorized by us or in an emergency.
- **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

- If you have an enrolled out-of-area dependent, please refer to the **Out-of-area Dependent Summary of Benefits.**
- **Deductible carryover**- Applicable charges used to meet any portion of the deductible during the fourth quarter of a calendar year will be applied toward the next year's deductible.

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**