Summary of Benefits

washington – small group

value based open option
$10 / $20 / 30% / 40% / $3,000
+ $750 common 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 $750 per person/$2,250 per family annual (calendar year) deductible has been met.

IN-PLAN benefits are provided for medically necessary services when provided by a participating physician or provider. **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.

The annual (calendar year) common out-of-pocket maximum payable by you for any covered services is: $3,000 per person/$9,000 per family. The 50% penalty, your deductibles and some services do not apply to your maximums. The lifetime maximum coverage for benefits is $2,000,000.

A pre-existing condition exclusion applies to this plan.

benefits	you pay deductible, then: in-plan	out-of-plan
Preventive Health and Wellness Services		
• Annual (calendar year) gynecological exams, Pap tests	$10/visit*	40%*
• Mammogram	Covered in full	Covered in full
• Periodic health exams; well-baby care (from a Personal Physician/Provider only)	$10/visit*	40%*
• Colorectal exam	$10*	40%
• Colorectal cancer screening: sigmoidoscopy, colonoscopy	Covered in full	40%
• The following tests (when received with your health maintenance exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood	Covered in full	40%
• The following services (for members with diabetes): HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet	Covered in full	40%
• Pneumococcal vaccine	Covered in full	40%*
• Flu vaccine	Covered in full	40%*
• Routine immunizations/shots	Covered in full	40%*
• Nutritional counseling for weight loss (limited to two visits per calendar year)	$10/visit*	40%*
• Smoking deterrent medications, including prescription and over the counter (limited to $500 per lifetime; must be purchased at a participating plan pharmacy)	$10*	Not covered
Physician / Provider Services		
• Office visits	$20/visit*	40%*
• Inpatient hospital visits	30%	40%
• Surgery & anesthesia	30%	40%
• Allergy shots & serums, injectable medications	30%	40%
• Other office procedures	30%	40%
Hospital Services		
• Acute care	30%	40%
• Observation care	30%	40%
• Rehabilitative care (30 days per calendar year)	30%	40%
• Skilled nursing facility (60 days per calendar year)	30%	40%
Maternity		
• Pre-natal visits, delivery, post-natal visits	$200*	40%
• Hospital services	30%	40%
• Routine newborn nursery care	30%*	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)	30%**	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)	$125	$125
• Urgent care services (for non-life threatening illness/minor injury)	$25*	$25*
• Emergency medical transportation (limited to $1,000 per calendar year)	30%	30%

Other Covered Services

• X-ray & lab services	30%	40%
• Imaging services (PET, CT, MRI)	30%	40%
• Outpatient rehabilitative services (30 visits per calendar year)	30%	40%
• Outpatient surgery, dialysis, infusion, chemotherapy & radiation therapy	30%	40%
• Temporomandibular joint (TMJ) services	50% to limit	Not covered
• Home health care (130 visits per calendar year)	30%	40%
• Neuro-developmental therapy (30 visits per calendar year) for children aged six and under	30%	40%
• Hospice care	Covered in full	Covered in full
• Spinal manipulations (12 visits per calendar year)	$20/visit*	40%*
• Acupuncture (12 visits per calendar year)	$20/visit*	40%*

***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**
	IN-PLAN	**OUT-OF-PLAN**			**IN-PLAN**	**OUT-OF-PLAN**	
Inpatient	30%	40%	15 days	Day/Visit maximum benefits are per person, per two calendar year period	30%	40%	$14,500 maximum benefit is per person, per two calendar year period
Outpatient visits	$20/visit*	40%*	29 visits		$20/visit*	40%*	
Residential/Day	30%	40%	19 days		30%	40%	

***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.
- Services for **pre-existing conditions** are excluded for a period of six months. Credit will be given for prior creditable coverage. See 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 $200,000 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**: 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**

www.providence.org/healthplans