

Providence Individual and Family HSA-Qualified Benefits & Rates



Nov. 1, 2010 – Oct. 31, 2011

HSA-Qualified Plan Benefits	HSA 2500	HSA 3500
Calendar Year Deductible		
Individual / Family	\$2,500/ \$5,000	\$3,500 / \$7,000
Calendar Year Out-of-Pocket Maximum		
Individual / Family	\$5,000 / \$10,000	\$5,250 / \$10,500

After meeting your deductible, you pay the following amounts for covered services:

The deductible is waived for some covered services. These services are marked with ✓ * Limitations apply. See your Plan Contract for details.

Preventive Care	In-Plan	Out-of-Plan	In-Plan	Out-of-Plan
Periodic health exams, well-baby care*	covered in full✓	40%	covered in full✓	40%
Annual gynecological exam	covered in full✓	40%	covered in full✓	40%
Routine immunizations/shots	covered in full✓	40%	covered in full✓	40%
Mammograms	covered in full✓	40%	covered in full✓	40%
Physician/Provider Services				
Office visits to a Personal Physician/Provider	\$20 copay	40%	\$20 copay	40%
Office visits to all other physicians/providers	20%	40%	20%	40%
Inpatient hospital visits and surgery	20%	40%	20%	40%
Hospital Services				
Inpatient & observation care				
Maternity care	20%	40%	20%	40%
Rehabilitative care & services*				
Outpatient Diagnostic Services				
X-ray; lab services	20%	40%	20%	40%
Imaging services (such as PET, CT, MRI)				
Emergency/Urgent care				
Emergency services	\$250 copay		\$250 copay	
Urgent care visits	\$20 copay		\$20 copay	
Emergency transportation services*	20%		20%	
Other Covered Services				
Medical and diabetes supplies*				
Outpatient surgery, radiation therapy, chemotherapy	20%	40%	20%	40%
Home health care*				
Mental health and alcohol treatment*				
Tobacco use cessation*				
Prescription Drugs				
Covered at participating retail and mail order pharmacies only	Generic and brand name drugs – 50%		Generic & Brand drugs – 50%	
Routine Vision Services (administered by VSP)				
HSA-Qualified plans provide benefits for certain vision services. Benefits include coverage for routine vision exams (\$30 copay in-plan), frames, basic lenses and contact lenses. Visit www.providence.org/healthplans for details.				

HSA-Qualified Plan Rates

To determine premium, use the age of the oldest covered family member.

Age		0 - 17	18 - 20	21 - 24	25 - 29	30 - 34	35 - 39	40 - 44	45 - 49	50 - 54	55 - 59	60 - 64
HSA 2500	Individual	\$132	\$158	\$189	\$204	\$232	\$248	\$318	\$374	\$435	\$523	\$600
	Individual & Spouse		\$294	\$353	\$381	\$433	\$463	\$591	\$696	\$809	\$974	\$1,117
	Individual & Children		\$228	\$274	\$295	\$336	\$360	\$459	\$541	\$628	\$756	\$867
	Individual & Family		\$422	\$506	\$575	\$665	\$699	\$877	\$891	\$953	\$1,146	\$1,258
HSA 3500	Individual	\$124	\$148	\$176	\$191	\$217	\$232	\$296	\$349	\$406	\$488	\$559
	Individual & Spouse		\$272	\$326	\$352	\$400	\$429	\$547	\$645	\$749	\$901	\$1,033
	Individual & Children		\$211	\$253	\$273	\$311	\$333	\$424	\$501	\$581	\$699	\$802
	Individual & Family		\$390	\$468	\$532	\$615	\$647	\$811	\$825	\$882	\$1,061	\$1,164