April 27, 2018

Lesley Houghton
RFI Coordinator
Washington State Health Care Authority (HCA)
PO Box 42702
Olympia, WA 98501

Subject: RFI 2646 – Request for Information: Fully Insured Group Medical Plans

Dear Lesley:

On behalf of Providence Health Plan (PHP), I am pleased to respond to the request for information for fully insured group medical plans for the School Employees Benefit Board (SEBB) Program.

PHP, in partnership with our parent organization, Providence St. Joseph Health (PSJH), is uniquely positioned to have a meaningful impact on the delivery, financing, and administration of healthcare in the communities we serve. As part of one of the largest non-profit integrated delivery systems in the U.S., PHP is able to offer innovative solutions to providing a better care experience, improving population health, and reducing per capita costs of health care. We have had success in partnering with educational entities, as well as both the Oregon PEBB and OEBB populations, to develop health benefit programs and tailored network solutions to meet the needs of their members. We look forward to demonstrating this strategic value throughout the RFP process.

For reference, we have included draft benefit summaries for our proposed alternative plan options. Please note that not all services outlined in Exhibit 3 appear as line items on our benefit summaries, which does not preclude them from coverage. Additionally, if a dental offering is of interest, Providence offers comprehensive dental benefits to pair alongside our medical plans and is available upon request.

With our breadth of experience serving educators and their families, and concentrated delivery system footprint in areas throughout Washington State (i.e., Seattle, Spokane, Tri-Cities, Vancouver), we believe that Providence would be an excellent and sustainable choice for Washington State educators and their families. We look forward to the opportunity to participate in the upcoming RFP, and to engage in a potential future partnership with the SEBB Program.

Please do not hesitate to contact me if there are any questions.

Sincerely,

Peter Seeley
Program Manager, Business Development
Providence Health Plan
503-962-0397

Washington State Health Care Authority
Request for Information: Fully-Insured Group Medical Plans for the School Employees Benefits Board (SEBB) Program

Providence Health Plan Response
April 27, 2018

A. Types of Plans and Contracts (MANDATORY)

1. **Identify all of the following plans that are offered by your organization: HMO, PPO, ACO, HDHP, High Performance Network, or other? If "other" please provide a brief description. Of the plans identified, which are offered in Washington State?**

   Providence currently offers PPO, ACO, HDHP, and High Performance Network plans. Additionally, we offer Pharmacy Benefit Manager (PBM) Only plans. All of these plan types are currently offered in Washington State.

2. **Please identify how many accounts (employer or purchaser) you have for each type of plan, and the total number of covered lives for each plan. For purchaser contracts, please identify any limitations to providing employer level data.**

Plan Type	# of Accounts	# of Covered Lives
PPO	6,312	257,825
ACO	2	164,064
HDHP	1,056	16,899
High Performance Network	472	7,759
PBM Only	1	10,443

   Our ability to provide employer level data is dependent upon on how the purchaser requests to be set up in our system. In general, we can provide employer level data for fully insured groups with 100+ subscribers.

3. **Given the response to item 2, does your organization have a preference for contracting as a fully-insured HMO or a fully-insured PPO plan under a consolidated statewide procurement? If yes, please explain your preference.**

   We are proficient and experienced at administering fully-insured PPO plans. However, our preference is to provide a solution that meets the needs of each group and their employees and families, and, as such, we are open to further exploring which plan type(s) will be the best fit for the SEBB program population. If HCA would like to consider an ACO or HMO narrow network style plan with Providence, we can explore options to establish these types of plans in certain geographies in Washington State, particularly in areas where Providence St. Joseph Health has a strong delivery system presence (e.g., Seattle, Spokane, Tri-Cities, Vancouver).

B. Cost and Plan Design (MANDATORY)

1. **Based on the assumptions listed in Exhibit 2 – Financial Assumptions, please provide premium quotes for each Sample Plan listed in Exhibit 3 – Cost Sharing, Benefits, and Covered Services (Table 1 and 2). To provide insight into the population used to develop premiums and the adjustments used to project required revenue for that population to calendar year 2020, please complete Exhibit 4 – SEBB Rate Form. Instructions for the rate form are contained within the Excel document. HCA acknowledges Carriers must make significant assumptions (e.g., with regard to the number of covered dependents that will enroll once the employee contribution methodology is changed) in completing the SEBB Rate Form. Please provide any additional assumptions or insights that inform your organization's RFI response.**

    - **Quotes for each plan must have the same service area, include all counties in which the Carrier participates, and be based on the experience of all currently covered lives. If you have Washington State school employee covered lives, please base your quotes on this population. If you do not, please provide a written description of the population used for development of rates.**
    - **Quotes should include a screen snapshot of the Federal actuarial value (Federal AV) calculator used to calculate the Federal AV section of the form, including inputs and results.**
    - **The pricing actuarial value (Pricing AV) for any plan quoted should reflect only the following:**
        - **Plan Type (HMO, PPO, POS, etc.)**
        - **Provider network reimbursement levels**
        - **Provider network utilization management**
        - **Both point of service cost sharing and overall plan level cost sharing**
        - **Benefit induced utilization**
    - **All premium quotes should include the same non-benefit expense load as a percentage of premium.**

    Please refer to completed Exhibit 4 included with our response. Screen snapshots of the Federal AV calculator for each plan, as requested, are also included.

    Note: Providence Health Plan identifies the completed Exhibit 4 as exempt from disclosure.

    Providence Health Plan believes that its response to Exhibit 4 is exempt from public disclosure under the Freedom of Information Act (FOIA), specifically 5 U.S.C. 552(b)(4) "trade secrets and commercial or financial information obtained from a person and privileged or confidential." Providence asserts that Worksheets 1, 2, 3, and 4, containing claims, actuarial plan values, administrative costs, and demographic information for current Washington State school employee covered lives include proprietary information that would present a competitive business disadvantage to Providence if disclosed. This information is not generally known or readily ascertainable by the public, and Providence takes reasonable steps to secure this information from public disclosure. Any wrongful disclosure of this information would result in measurable losses to Providence. Therefore, Providence requests that this information not be disclosed in response to any FOIA request. If any such disclosure is anticipated, Providence requests that we be notified in advance, as outlined in the RFI (Section 6, Item F).

2. **Based on the Assumptions in Exhibit 2—Financial Assumptions, please provide up to four (4) plan options in addition to the Sample Plan quotes. At least one of the four (4) plan options must be a tax qualified High Deductible Health Plan (HDHP) with a health savings account (HSA). The benefits and covered services outlined in Exhibit 3 – Cost Sharing, Benefits, and Covered Services (Table 2) is to be used as starting point. Any proposed carve-outs and additions to benefits and covered services must be included and captured in the attached SEBB Rate Form.**

   - **Quotes for the alternative plan options must include the same coverage area as the Sample Plans, and be based on the same experience.**
   - **Quotes should include a screen snapshot of the Federal AV calculator used within the individual market.**
   - **The Pricing AV for any of the other plan options you have proposed is under all the same restrictions as Sample Plans, and must reflect only the following: Plan type**
     - **Provider network reimbursement levels**
     - **Provider network utilization management**
     - **Both point of service cost sharing and overall plan level cost sharing**
     - **Benefit induced utilization**
   - **The Federal AV of any such plan option should not be lower than 76 percent (76%). The 76% Sample Plan should have the lowest premium rate of all proposed premium rates. When developing the Pricing AV for such plans, assumptions should be developed on a consistent basis with the Sample Plans.**
   - **For any HDHP, note the impact on AV from any assumed HSA contribution.**
   - **The goal of providing information on other plans is to help HCA understand what Carriers believe will be viable, meaningful options for the SEBB Program. Therefore, such plans must have Federal AVs that are separated by at least two percentage points from any of the other plans provided in your response.**
   - **All plans should be loaded with the same non-benefit expense load.**

   Please refer to completed Exhibit 4 included with our response. Screen snapshots of the Federal AV calculator for each plan and draft benefit summaries for the alternative plan designs are also included.

   Note: Providence Health Plan identifies the completed Exhibit 4 as exempt from disclosure.

   Providence Health Plan believes that its response to Exhibit 4 is exempt from public disclosure under the Freedom of Information Act (FOIA), specifically 5 U.S.C. 552(b)(4) “trade secrets and commercial or financial information obtained from a person and privileged or confidential.” Providence asserts that Worksheets 1, 2, 3, and 4, containing claims, actuarial plan values, administrative costs, and demographic information for current Washington State school employee covered lives include proprietary information that would present a competitive business disadvantage to Providence if disclosed. This information is not generally known or readily ascertainable by the public, and Providence takes reasonable steps to secure this information from public disclosure. Any wrongful disclosure of this information would result in measurable losses to Providence. Therefore, Providence requests that this information not be disclosed in response to any FOIA request. If any such disclosure is anticipated, Providence requests that we be notified in advance, as outlined in the RFI (Section 6, Item F).

3. **HCA currently uses the risk model by Verscend Technologies DxCG® Intelligence Commercial All-Medical Predicting Total Risk version 5.1.0 to measure morbidity differences within the PEBB Program population. Please provide feedback on the use of this model to adjust the plans' rates within the risk pool for the SEBB Program population and whether a concurrent or prospective risk score is preferred for 2020.**

   While we are flexible to either approach, we believe that prospective risk adjustment would be simpler for financial planning purposes, based on our experience in the Medicare and ACA markets. More details about the mechanics of the proposed program would enable us to provide more detailed feedback.

C. Geographic Coverage (MANDATORY)

1. **HCA would like to know how many fully insured HMO, PPO, and other plan types your organization currently offers in Washington, Oregon, and Idaho counties, as well as any changes anticipated for the future. Please complete columns c-h in Exhibit 5 – County Coverage, with the information listed below. It is not HCA's intent to develop new markets in Oregon or Idaho, but it would not be unusual for a Washington State school employee to reside in one of those states. Only complete the Oregon and Idaho counties where you already have coverage or are anticipating adding coverage in those counties by January 1, 2020.**

   - **Column "c": The number of HMO plans you currently offer within each county listed;**
   - **Column "d": The number of PPO plans you currently offer within each county listed;**
   - **Column "e": The number of other plan types you currently offer within each county listed;**
   - **Column "f": The number of HMO plans you anticipate for 1/1/2020 within each county listed;**
   - **Column "g": The number of PPO plans you anticipate for 1/1/2020 within each county listed.**
   - **Column "h": The number of other plan types you anticipate for 1/1/2020 within each county listed.**

   Carriers that later choose to bid on an RFP for a SEBB insured health plan will not be locked into providing coverage in the counties they provide in their response to this RFI.

   Please refer to completed Exhibit 5 included with our response.

   Note: Providence Health Plan identifies the completed Exhibit 5 as exempt from disclosure.

   Providence Health Plan believes that its response to columns f-h within Exhibit 5 – County Coverage is exempt from public disclosure under the Freedom of Information Act (FOIA), specifically 5 U.S.C. 552(b)(4) "trade secrets and commercial or financial information obtained from a person and privileged or confidential." More specifically, Providence asserts that the number of plans/networks anticipated in specific counties in 2020 qualifies as valuable commercial information that provides Providence with a business advantage over its competitors who do not have this information. This information is not generally known or readily ascertainable by the public, and Providence takes reasonable steps to secure this information from public disclosure. Any wrongful disclosure of this information would result in measurable losses to Providence. Therefore, Providence requests that this information not be disclosed in response to any FOIA request. If any such disclosure is

anticipated, Providence requests that we be notified in advance, as outlined in the RFI (Section 6, Item F).

D. Provider Network (MANDATORY)

1. If a new client were transitioning members onto your plan(s), would your organization be open to the idea of adding providers to your current network(s)?

We continually strive to ensure network sufficiency in the communities we serve. If a network deficiency is identified in a geographic area or category of care, we would be open to discussing the process for reviewing and adding providers to the network.

2. Please provide the typical timeframe for adding the following provider types to your network (e.g. 4-6 weeks, 2-3 months, etc.)?

- **a. Primary care physicians:** 2-3 months (30-45 days for credentialing; approx. 30 days for contracting upon approval from credentialing; 14 days for system load).
- **b. Ancillary providers (physical therapists, occupational therapists, massage therapist, chiropractors, etc.):** 2-3 months (30-45 days for credentialing; approx. 30 days for contracting upon approval from credentialing; 14 days for system load).
- **c. Specialists:** 2-3 months (30-45 days for credentialing; approx. 30 days for contracting upon approval from credentialing; 14 days for system load).
- **d. Urgent care:** 2-3 months (30-45 days for credentialing; approx. 30 days for contracting upon approval from credentialing; 14 days for system load).
- **e. Hospitals:** Minimum 2-3 months; timeframes are more variable depending on discussions/negotiations.

3. Do you add providers on a rolling basis throughout the year or only at set times during the year?

Providers are added to the network based on need, not only at set times during the year.

E. Administrative (MANDATORY)

1. Is your organization NCQA/URAC accredited? If yes, for what certification period, and what is your organization's status? If not, what is your organization's plan, if any, to become accredited?

Yes, Providence Health Plan is fully accredited by the National Committee for Quality Assurance (NCQA). NCQA conducted a full survey of our commercial and marketplace products beginning May 12, 2015. The full survey included NCQA standards, HEDIS, and CAHPS measures. On August 20, 2015, NCQA awarded a Commendable Accreditation status for our Oregon Commercial PPO products. PHP is scheduled for an NCQA renewal survey in July 2018, as the current accreditation expires on August 20, 2018.

2. Does your organization have experience in providing an employee assistance program (EAP) for subscribers to access through your fully-insured medical plans?

Yes, Providence Health Plan offers an employee assistance program (EAP) through Providence EAP. This program is available at an additional cost.

a. If yes, please provide a list of the types of EAP benefits you have experience providing (e.g. counseling/assessment/referral, management workplace consultation, employee workplace consultation, critical incident management and debriefing, training, additional work/life benefits such as legal or financial counseling, or other services).

The Providence Employee Assistance Program is a full service, stand-alone program. Services include:

- 24/7 crisis counseling
- Face-to-face counseling and assessments
- Telephonic and video counseling sessions
- Unlimited manager/supervisor /workplace consultations
- Work/life enhanced web resources including monthly webinars
- Legal and financial resources
- Child and eldercare resources and referrals
- Onsite trainings, orientation, and promotional materials
- Critical Incident Stress Management (CISM) support and debriefings
- Monthly newsletters for employees and supervisors
- Utilization reporting
- Access to an EAP national provider network with over 3,500 providers in Oregon and Washington

b. What is the per employee per month (PEPM) cost to employers for providing EAP services to subscribers?

Based on Providence Health Plan's current Washington school district enrollment (1,894 employees as of March 2018), the cost would be $1.30 PEPM for a 3 session model or $2.00 PEPM for a 6 session model. Pricing may vary based on enrollment.

c. What is the average utilization rate of counseling services for school employees?

The average utilization for similar Providence EAP clients is 8%.

3. Please answer the following hypothetical questions regarding implementation, assuming HCA is a new client (this information will help HCA in the development of a procurement and implementation schedule):

a. After being provided with a HIPAA 834 eligibility file, on average how long would it take to collaborate to build the group structure framework and data layouts, assuming there are six (6) subgroups (Reference Exhibit 6 – Group Structure Example)?

On average, building the group structure framework and data layouts requires two business days. However, the complexity of the group structure (number of subgroups, classes, plans) may impact this timeframe.

b. After completion of the group structure framework and data layouts, on average how long would it take to program the groups into your organization's IT systems?

On average, we require approximately two business days to program the groups into our system, once the framework is set up.

c. After completion of the programming, on average how long would it take your organization to test?

Standard testing can be completed within 1-2 business weeks. However, this turnaround depends heavily on the timeliness of the test files received and the accuracy of the data to test with.

4. Does your organization contract directly with an HSA vendor to administer your subscribers' qualified HSA benefits? If so, which vendor do you use?

Yes, Providence Health Plan partners with HealthEquity, Inc. to provide integrated HSA, HRA, and FSA administration services. One of the main advantages of electing HealthEquity through PHP is our eligibility and claims integration. PHP sends HealthEquity eligibility files daily, and claims files weekly. This allows HealthEquity to interface with PHP claim files to substantiate members' card transactions. HealthEquity's process for card transaction substantiation is an important and closely monitored function of HSA administration.

If preferred, an employer group/plan sponsor may elect to use an alternative HSA banking partner. We place no restrictions on outside HSA banking partners; however, we only share eligibility and claims information with our preferred partner, HealthEquity.

5. Please provide contact information (name, email, and phone number) for staff that HCA can follow up with for questions pertaining to this RFI.

Peter Seeley
Program Manager, Business Development
peter.seeley@providence.org
503-962-0397

F. Additional Questions (OPTIONAL)

1. What factors would you consider as you look to expand coverage into a new county?

We would consider several factors, including network adequacy in the county, associated provider quality metrics, and carrier competition in the specific county under consideration.

2. What information would your organization typically need from a new client to be able to develop a proposal for a fully-insured group medical insurance plan (data requirements, file exchange requirements, claims and census data, timeline, etc.)?

General Requirements

- Client background information
- RFP timeline
- RFP evaluation and scoring criteria *(preferred, if applicable)*
- Description of client's strategic goals/priorities *(preferred)*

Underwriting Data Requirements

- Effective date
- Anniversary/Renewal date (if different)
- Name of incumbent carrier(s)
- Address of group headquarters
- Employee census including:
    - All eligible employees
    - Employee first and last name *(preferred)*
    - Dependent first and last name *(preferred)*
    - Enrollment status of each employee with enrollment tier (e.g., EE, ES, EC, EF), waiver, or not eligible
    - Zip code
    - Date of birth
- Current plan descriptions
- Plan(s) requested
- Copy of incumbent carrier-generated benefit summary(ies) or benefit booklet(s) *(preferred)*
- Current rates
- Renewal rates
- Incumbent renewal calculation *(preferred)*
- List of any changes to the plan design or contribution levels during the experience period *(preferred)*
- Desired employer contribution strategy and inforce contribution, if different
- For groups with over 100 subscribers:
    - 24 months subscribers, members, premium, claims on a month-by-month basis by plan
    - Large claims for the same time period as the experience provided
- Incumbent carrier reports (top dx/rx, utilization by disease category, network utilization, etc.) *(preferred)*

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount		1st Tier Utilization	
		2nd Tier Utilization	

Tier 1 Plan Benefit Design			
	Medical	Drug	Combined
Deductible ($)			$300.00
Coinsurance (%, Insurer's Cost Share)			85.00%
MOOP ($)			$2,500.00
MOOP if Separate ($)			

Tier 2 Plan Benefit Design			
	Medical	Drug	Combined

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑All	☑All			☑All	☑All			☐All	☐All
Emergency Room Services	☑	☑	92%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑	97%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	85%		☑	☑			☐	☐
Specialist Visit	☑	☑	85%		☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	85%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	85%		☑	☑			☐	☐
Speech Therapy	☑	☑	85%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	85%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	85%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	85%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	97%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	85%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	85%		☑	☑			☐	☐
Drugs	☑All	☑All			☑All	☑All			☐All	☐All
Generics	☐	☐		$11.24	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$3,587.22	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10)	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10)	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10)	

Plan Description:

Name: 1 WA SEBB Sample Plan 1
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Status/Error Messages	Calculation Successful.
Actuarial Value	88.55%
Metal Tier	Platinum
Additional Notes	
Calculation Time	0.1797 seconds

Draft 2019 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount		1st Tier Utilization	
		2nd Tier Utilization	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			70.00%			
MOOP ($)			$4,000.00			
MOOP if Separate ($)						

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	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑All	☑All			☑All	☑All			☐All	☐All
Emergency Room Services	☑	☑	92%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑	97%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	70%		☑	☑			☐	☐
Specialist Visit	☑	☑	70%		☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	70%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	70%		☑	☑			☐	☐
Speech Therapy	☑	☑	70%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	70%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	70%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	70%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	97%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	70%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	70%		☑	☑			☐	☐
Drugs	☑All	☑All			☑All	☑All			☐All	☐All
Generics	☐	☐		$11.24	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$3,587.22	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10)	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10)	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10)	

Plan Description:

Name: 1 WA SEBB Sample Plan 2
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Status/Error Messages: Error Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value: 82.98%
Metal Tier:

Additional Notes:

Calculation Time: 0.1914 seconds

Draft 2019 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount		1st Tier Utilization	
		2nd Tier Utilization	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			65.00%			
MOOP ($)			$5,500.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑All	☑All			☑All	☑All			☐All	☐All
Emergency Room Services	☑	☑	92%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑	97%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	65%		☑	☑			☐	☐
Specialist Visit	☑	☑	65%		☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	65%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	65%		☑	☑			☐	☐
Speech Therapy	☑	☑	65%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	65%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	65%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	65%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	97%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	65%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	65%		☑	☑			☐	☐
Drugs	☑All	☑All			☑All	☑All			☐All	☐All
Generics	☐	☐		$11.24	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$3,587.22	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10)	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10)	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10)	

Plan Description:

Name: 1 WA SEBB Sample Plan 3
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Status/Error Messages	Calculation Successful.
Actuarial Value	77.81%
Metal Tier	Gold
Additional Notes	
Calculation Time	0.1797 seconds

Draft 2019 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount		1st Tier Utilization	
		2nd Tier Utilization	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$300.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
MOOP ($)			$2,500.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑All	☑All			☑All	☑All			☐All	☐All
Emergency Room Services	☑	☑	92%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑	97%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	85%		☑	☑			☐	☐
Specialist Visit	☑	☑	85%		☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	85%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	85%		☑	☑			☐	☐
Speech Therapy	☑	☑	85%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	85%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	85%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	85%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	97%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	85%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	85%		☑	☑			☐	☐
Drugs	☑All	☑All			☑All	☑All			☐All	☐All
Generics	☐	☐		$11.24	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$3,587.22	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10)	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10)	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10)	

Plan Description:

Name: 1 WA SEBB Alt Plan 1
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Status/Error Messages	Calculation Successful.
Actuarial Value	88.55%
Metal Tier	Platinum
Additional Notes	
Calculation Time	0.207 seconds

Draft 2019 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Platinum

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount		1st Tier Utilization	
		2nd Tier Utilization	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$4,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑All	☑All			☑All	☑All			☐All	☐All
Emergency Room Services	☑	☑	92%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑	97%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑			☐	☐
Specialist Visit	☑	☑	80%		☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	80%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑			☐	☐
Speech Therapy	☑	☑	80%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	80%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	97%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑			☐	☐
Drugs	☑All	☑All			☑All	☑All			☐All	☐All
Generics	☐	☐		$11.24	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$3,587.22	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10)	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10)	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10)	

Plan Description:

Name: 1 WA SEBB Alt Plan 2
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Status/Error Messages	Error Result is outside of [-4, +2] percent de minimis variation.
Actuarial Value	84.72%
Metal Tier	
Additional Notes	
Calculation Time	0.1953 seconds

Draft 2019 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount		1st Tier Utilization	
		2nd Tier Utilization	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,000.00			
Coinsurance (%, Insurer's Cost Share)			85.00%			
MOOP ($)			$5,500.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑All	☑All			☑All	☑All			☐All	☐All
Emergency Room Services	☑	☑	92%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑	97%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	85%		☑	☑			☐	☐
Specialist Visit	☑	☑	85%		☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	85%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	85%		☑	☑			☐	☐
Speech Therapy	☑	☑	85%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	85%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	85%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	85%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	97%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	85%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	85%		☑	☑			☐	☐
Drugs	☑All	☑All			☑All	☑All			☐All	☐All
Generics	☐	☐		$11.24	☑	☑			☐	☐
Preferred Brand Drugs	☐	☐		$45.00	☑	☑			☐	☐
Non-Preferred Brand Drugs	☐	☐		$75.00	☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☐	☐		$3,587.22	☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10)	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10)	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10)	

Plan Description:

Name: 1 WA SEBB Alt Plan 3
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Status/Error Messages	Calculation Successful.
Actuarial Value	81.18%
Metal Tier	Gold
Additional Notes	
Calculation Time	0.1914 seconds

Draft 2019 AV Calculator

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate MOOP for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR or Expanded Bronze AV Standard?	☐
Desired Metal Tier	Gold

HSA/HRA Options		Tiered Network Option	
HSA/HRA Employer Contribution?	☐	Tiered Network Plan?	☐
Annual Contribution Amount		1st Tier Utilization	
		2nd Tier Utilization	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)			$1,500.00			
Coinsurance (%, Insurer's Cost Share)			80.00%			
MOOP ($)			$4,000.00			
MOOP if Separate ($)						

Click Here for Important Instructions

	Tier 1				Tier 2				Tier 1	Tier 2
Type of Benefit	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Subject to Deductible?	Subject to Coinsurance?	Coinsurance, if different	Copay, if separate	Copay applies only after deductible?	
Medical	☑All	☑All			☑All	☑All			☐All	☐All
Emergency Room Services	☑	☑	80%		☑	☑			☐	☐
All Inpatient Hospital Services (inc. MH/SUD)	☑	☑	80%		☑	☑			☐	☐
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑	80%		☑	☑			☐	☐
Specialist Visit	☑	☑	70%		☑	☑			☐	☐
Mental/Behavioral Health and Substance Use Disorder Outpatient Services	☑	☑	80%		☑	☑			☐	☐
Imaging (CT/PET Scans, MRIs)	☑	☑	80%		☑	☑			☐	☐
Speech Therapy	☑	☑	80%		☑	☑			☐	☐
Occupational and Physical Therapy	☑	☑	80%		☑	☑			☐	☐
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00		
Laboratory Outpatient and Professional Services	☑	☑	80%		☑	☑			☐	☐
X-rays and Diagnostic Imaging	☑	☑	80%		☑	☑			☐	☐
Skilled Nursing Facility	☑	☑	80%		☑	☑			☐	☐
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑	80%		☑	☑			☐	☐
Outpatient Surgery Physician/Surgical Services	☑	☑	80%		☑	☑			☐	☐
Drugs	☑All	☑All			☑All	☑All			☐All	☐All
Generics	☑	☑	80%		☑	☑			☐	☐
Preferred Brand Drugs	☑	☑	80%		☑	☑			☐	☐
Non-Preferred Brand Drugs	☑	☑	50%		☑	☑			☐	☐
Specialty Drugs (i.e. high-cost)	☑	☑	50%		☑	☑			☐	☐

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10)	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10)	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10)	

Plan Description:

Name: 1 WA SEBB Alt QHP
Plan HIOS ID: [Input Plan HIOS ID]
Issuer HIOS ID: [Input Issuer HIOS ID]

Output

Status/Error Messages	Calculation Successful.
Actuarial Value	77.42%
Metal Tier	Gold
	NOTE Office-visit-specific cost-sharing is applying to x-rays in office settings.
Additional Notes	
Calculation Time	0.1875 seconds

Draft 2019 AV Calculator

Your Benefit Summary

Option Advantage

WA SEBB Alternate Plan 1

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
See benefit details below	15% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$2,500 per person $7,500 per family (3 or more)	$5,000 per person $15,000 per family (3 or more)	$300 per person $900 per family (3 or more)	$600 per person $1,800 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Option Advantage Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible(s), then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	5%✓	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%✓
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	40%✓
• Mammograms	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	15%	40%
• Office visits to Alternative Care Provider (Includes Chiropractic manipulation, acupuncture and massage therapy.)	15%	40%
• Office visits to Specialists/Other Providers	15%	40%
• Hearing exam	Covered in full✓	Covered in full✓
• Allergy shots and serums	15%	40%
• Infusions and injectable medications	15%	40%
• Surgery; anesthesia in an office or facility	15%	40%
• Inpatient hospital visits	15%	40%
Diagnostic Services		
• X-ray and lab services	15%	40%
• Imaging services (such as PET, CT, MRI)	15%	40%
• Sleep studies	20%	40%

Option Advantage Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$75	$75
• Urgent care services (for non-life threatening illness/minor injury)	15%	40%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	15%	15%
Hospital Services		
• Inpatient/Observation care	$200 / day, $600 max / year	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	$200 / day, $600 max / year	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	$200 / day, $600 max / year	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	15%	40%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Colonoscopy (non-preventive)	15%	40%
• Outpatient rehabilitative physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	15%	40%
• Neurodevelopmental therapy	15%	40%
• Massage therapy (limited to 30 visits per calendar year)	15%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	15%	40%
• Inpatient hospital/facility services	$200 / day, $600 max / year	40%
• Routine newborn nursery care	15%	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	15%	40%
• Diabetes supplies (such as lancets, test strips and needles)	15%✓	40%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	15%	40%
• Hearing aids	Covered in full up to $1000✓	Covered in full up to $1000✓
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	$200 / day, $600 max / year	40%
• Day treatment, intensive outpatient and partial hospitalization services	15%	40%
• Applied behavior analysis	15%	40%
• Outpatient provider office visits	15%	40%
Home Health and Hospice		
• Home health care	15%	40%
• Hospice care	Covered in full✓	Covered in full✓

Your guide to the words or phrases used to explain your benefits

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Deductible
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan.
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan.
- Penalties incurred if you do not follow your plan's prior authorization requirements.
- Copays and coinsurance for services that do not apply to the deductible

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered ervices from in-network providers.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Member Handbook or contract for a complete list.

Out-of-network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a plan year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

Primary Care Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Retail Health Clinic
A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

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Your Benefit Summary

Option Advantage

WA SEBB Alternate Plan 2

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
See benefit details below	20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$4,000 per person $12,000 per family (3 or more)	$8,000 per person $24,000 per family (3 or more)	$500 per person $1,500 per family (3 or more)	$1,000 per person $3,000 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Option Advantage Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible(s), then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	5%✓	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%✓
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	40%✓
• Mammograms	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	20%	40%
• Office visits to Alternative Care Provider (Includes Chiropractic manipulation, acupuncture and massage therapy.)	20%	40%
• Office visits to Specialists/Other Providers	20%	40%
• Hearing exam	Covered in full✓	Covered in full✓
• Allergy shots and serums	20%	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%
Diagnostic Services		
• X-ray and lab services	20%	40%
• Imaging services (such as PET, CT, MRI)	20%	40%
• Sleep studies	20%	40%

Option Advantage Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$75	$75
• Urgent care services (for non-life threatening illness/minor injury)	20%	40%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	20%	40%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Colonoscopy (non-preventive)	20%	40%
• Outpatient rehabilitative physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Neurodevelopmental therapy	20%	40%
• Massage therapy (limited to 30 visits per calendar year)	20%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	20%	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	20%	40%
• Diabetes supplies (such as lancets, test strips and needles)	20%✓	40%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	20%	40%
• Hearing aids	Covered in full up to $1000✓	Covered in full up to $1000✓
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	40%
• Outpatient provider office visits	20%	40%
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full✓	Covered in full✓

Your guide to the words or phrases used to explain your benefits

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Deductible
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan.
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan.
- Penalties incurred if you do not follow your plan's prior authorization requirements.
- Copays and coinsurance for services that do not apply to the deductible

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered ervices from in-network providers.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Member Handbook or contract for a complete list.

Out-of-network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a plan year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

Primary Care Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Retail Health Clinic
A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

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Your Benefit Summary

Option Advantage

WA SEBB Alternate Plan 3

PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$25/$35	30% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$5,500 per person $16,500 per family (3 or more)	$11,000 per person $33,000 per family (3 or more)	$1,000 per person $3,000 per family (3 or more)	$2,000 per person $6,000 per family (3 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Option Advantage Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible(s), then you pay the following for covered services: In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits	Covered in full✓	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full✓	Not applicable
• Virtual visits to a Specialist by phone & video	$20 / visit✓	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	50%✓
• Colonoscopy (age 50 +)	Covered in full✓	50%
• Routine immunizations; shots	Covered in full✓	50%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	50%✓
• Mammograms	Covered in full✓	50%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	$25 / visit✓	50%
• Office visits to Alternative Care Provider (Includes Chiropractic manipulation, acupuncture and massage therapy.)	$25 / visit✓	50%
• Office visits to Specialists/Other Providers	$35 / visit	50%
• Hearing exam	Covered in full✓	Covered in full✓
• Allergy shots and serums	30%	50%
• Infusions and injectable medications	30%	50%
• Surgery; anesthesia in an office or facility	30%	50%
• Inpatient hospital visits	30%	50%
Diagnostic Services		
• X-ray and lab services	30%	50%
• Imaging services (such as PET, CT, MRI)	30%	50%
• Sleep studies	30%	50%

Option Advantage Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$75	$75
• Urgent care services (for non-life threatening illness/minor injury)	$35 / visit	50%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	30%	30%
Hospital Services		
• Inpatient/Observation care	$200 / day, $600 max / year	50%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	$200 / day, $600 max / year	50%
• Skilled nursing facility (Limited to 60 days per calendar year)	$200 / day, $600 max / year	50%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	30%	50%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Colonoscopy (non-preventive)	30%	50%
• Neurodevelopmental therapy	30%	50%
• Outpatient rehabilitative physical, occupational, and speech therapy (Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.)	30%	50%
• Massage therapy (limited to 30 visits per calendar year)	30%	50%
Maternity Services		
• Prenatal office visits	Covered in full✓	50%
• Delivery and postnatal services	30%	50%
• Inpatient hospital/facility services	$200 / day, $600 max / year	50%
• Routine newborn nursery care	30%	50%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	30%	50%
• Diabetes supplies (such as lancets, test strips and needles)	30%✓	50%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	30%	50%
• Hearing aids	Covered in full up to $1000✓	Covered in full up to $1000✓
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	$200 / day, $600 max / year	50%
• Day treatment, intensive outpatient and partial hospitalization services	30%	50%
• Applied behavior analysis	30%	50%
• Outpatient provider office visits	$25 / visit✓	50%
Home Health and Hospice		
• Home health care	30%	50%
• Hospice care	Covered in full✓	Covered in full✓

Your guide to the words or phrases used to explain your benefits

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Deductible
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan.
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan.
- Penalties incurred if you do not follow your plan's prior authorization requirements.
- Copays and coinsurance for services that do not apply to the deductible

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered ervices from in-network providers.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Member Handbook or contract for a complete list.

Out-of-network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a plan year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook for details

Primary Care Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Retail Health Clinic
A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

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Your Benefit Summary

HSA Qualified Plan

WA SEBB Alternative QHDP

PROVIDENCE Health Plan

What You Pay In-Network	What You Pay Out-of-Network	Calendar Year Common Out-of-Pocket Maximum	Calendar Year Common Deductible
20% coinsurance (after deductible)	40% coinsurance (after deductible; UCR applies)	$4,000 per person $8,000 per family (2 or more)	$1,500 per person $3,000 per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at www.myProvidence.com.

- When two or more family members are enrolled, the in-network per person annual limit on cost-sharing is $7,350.
- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate toward your common out-of-pocket maximum.
- To find if a drug is covered under your plan, check online at www.ProvidenceHealthPlan.com/pharmacy.
- Prior authorization is required for some services.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/providerdirectory.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

HSA Qualified Plan Benefit Highlights	After you pay your calendar year common deductible, then you pay the following for covered services:	
✓ No deductible needs to be met prior to receiving this benefit.	In-Network Coinsurance (after deductible, when you see an in-network provider)	Out-of-Network Coinsurance (after deductible, when you see a non-network provider)
On-Demand Provider Visits		
• Virtual visits to a Primary Care Provider by phone & video (ExpressCare Virtual) or by Web-direct Visits	Covered in full	Not covered
• Providence ExpressCare Retail Health Clinic	Covered in full	Not applicable
• Virtual visits to a Specialist by phone & video	15%	Not covered
Preventive Care		
• Periodic health exams and well-baby care	Covered in full✓	40%
• Routine immunizations; shots	Covered in full✓	40%
• Colonoscopy (age 50 +)	Covered in full✓	40%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	40%
• Mammograms	Covered in full✓	40%
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full✓	Not covered
Physician / Provider Services		
• Office visits to Primary Care Provider	20%	40%
• Office visits to Alternative Care Provider (Chiropractic manipulation, acupuncture and massage therapy are covered on a separate benefit summary. Consult your member materials for these benefits.)	20%	40%
• Office visits to Specialists/Other Providers	30%	40%
• Allergy shots and serums	20%	40%
• Infusions and injectable medications	20%	40%
• Surgery; anesthesia in an office or facility	20%	40%
• Inpatient hospital visits	20%	40%
Diagnostic Services		
• X-ray; lab services	20%	40%
• High-tech imaging services (such as PET, CT or MRI)	20%	40%
• Sleep studies	20%	40%

HSA Qualified Plan Benefit Highlights (continued)	In-Network Coinsurance	Out-of-Network Coinsurance
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share		
• ACA Preventive drugs	Covered in full✓	Not covered
• Preferred generic drugs	20%	Not covered
• Non-preferred generic drugs	20%	Not covered
• Preferred brand-name drugs	20%	Not covered
• Non-preferred brand-name drugs	20%	Not covered
• Specialty drugs (specialty drugs are limited to a 30-day supply and must be obtained through a contracted specialty pharmacy)	50%	Not covered
• Compounded drugs (compounded drugs are limited to 30-day supply and must be obtained at a retail/preferred retail pharmacy)	50%	Not covered
Emergency and Urgent Services		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%	40%
• Emergency medical transportation (air and/or ground) (Emergency medical transportation is covered under your in-network benefit, regardless of whether or not the provider is an in-network provider)	20%	20%
Hospital Services		
• Inpatient/Observation care	20%	40%
• Rehabilitative care (Limited to 30 days per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Skilled nursing facility (Limited to 60 days per calendar year)	20%	40%
• Temporomandibular joint (TMJ) services (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
Outpatient Services		
• Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)	20%	40%
• Colonoscopy (non-preventive)	20%	40%
• Temporomandibular joint (TMJ) service (Inpatient and/or outpatient services combined limit of $1,000 per calendar year/$5,000 per lifetime)	50%	Not covered
• Outpatient rehabilitative physical therapy (Limited to 30 visits combined with OT and ST per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Outpatient rehabilitative occupational and speech therapy (Limited to 30 visits combined with PT per calendar year. Limits do not apply to Mental Health Services.)	20%	40%
• Neurodevelopmental therapy	20%	40%
• Massage therapy (limited to 30 visits per calendar year)	20%	40%
Maternity Services		
• Prenatal office visits	Covered in full✓	40%
• Delivery and postnatal services	20%	40%
• Inpatient hospital/facility services	20%	40%
• Routine newborn nursery care	20%	40%
Medical Equipment, Supplies and Devices		
• Medical equipment, appliances and supplies	20%	40%
• Diabetes supplies (such as lancets, test strips and needles)	20%	40%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year)	20%	40%
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-711-4577.)		
• Inpatient and residential services	20%	40%
• Day treatment, intensive outpatient and partial hospitalization services	20%	40%
• Applied behavior analysis	20%	40%
• Outpatient provider office visits	20%	40%
Home Health and Hospice		
• Home health care	20%	40%
• Hospice care	Covered in full	Covered in full

Your guide to the words or phrases used to explain your benefits

ACA Preventive drug
Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, that are listed in our formulary as such, and are covered at no cost when received from Participating Pharmacies.
Over-the-counter preventive drugs received from Participating Pharmacies require a written prescription from your Qualified Provider to be covered in full under this benefit.

Annual limit on cost sharing
The maximum amount a member pays out-of-pocket per calendar year for in-network essential health benefit covered services, when two or more family members are enrolled in this plan.

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Common deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays and coinsurance for services that do not apply to the deductible

Common out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in- and out-of-network services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Member Handbook for details.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Maintenance drug
Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

Health Savings Account (HSA)
Employee-owned bank accounts where money is deposited – by employees, employers and even family members – to be used for employees' current and future health care expenses. Contributions can be deducted pre-tax from paychecks, and the money rolls over year to year and stays with the employee even with job changes and retirement.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers. balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Limitations and Exclusions
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your member handbook or contract for a complete list.

Out-of-network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory

Preferred brand-name drug / Non-preferred brand-name drug
Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Generally your out-of-pocket costs will be less for preferred brand-name drugs.

Preferred generic drug / Non-preferred generic drug
Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Generally your out-of-pocket costs will be less for Preferred generic drugs.

Prescription Drug Prior Authorization
The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses.

Primary Care Provider
A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Retail Health Clinic
A walk-in health clinic, other than an office, urgent care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Safe Harbor Preventive drugs
The Internal Revenue Code governing HSA-Qualified plans provides for a "safe harbor" for qualifying preventive medications, allowing these medications to be exempt from the deductible. Safe Harbor Preventive drugs do not include any medication used to treat an existing illness, injury or condition. Safe Harbor Preventive drugs are subject to formulary and tier status, as well as pharmacy management programs (i.e. prior authorization, step therapy, quantity limits).

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Virtual visit
Visit with a Network Provider using secure internet technology such as Providence Express Care phone and video visits or Web-direct Visits.

Web-direct Visit
A consultation with Network Provider using an online questionnaire to collect information to diagnose and treat common conditions such as cold, flu, sore throat, allergies, earaches, sinus pain or UTI.

Contact us
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 711

Have questions about your benefits and want to contact us via email? Go to our website at:
www.ProvidenceHealthPlan.com/contactus

Washington State Health Care Authority
SEBB Bid Rate Form
Instructions

Worksheet 1 - Base Rate Development

(1) Base Period

Base period experience information for the population used to develop rates. Rates are to be developed based on a single population for all plans, with plan-based variation defined separately in Worksheet 2.

(1a) Base Period Start Date: Start date for base period experience
(1b) Base Period End Date: End date for base period experience
(1c) Experience Allowed : Allowed claims incurred during the base period, completed for IBNP, excluding any other adjustments. Allowed claims are defined as claims after carrier discounts but before the deduction of member cost sharing.
(1d) Member Months : Member Months during the base period
(1e) Allowed PMPM : (1b) / (1c)

(2) Projection Factors

Standard projection adjustments between the base period and projection period (Calendar Year 2020).

(2a) Utilization Trend : Secular utilization trend between base and projection period, including impact of service mix changes
(2b) Management Adjustment : Expected change in claims costs due to changes in utilization management practices
(2c) Unit Cost Trend: Secular unit cost trend between base and projection period, inflation component only
(2d) Contracting Adjustment : Changes in claims costs due to updates to overall contracting

(3) Raw Projected PMPM: (1) * (2)

(4) PMPM Other Adjustments

Additional adjustments to projected PMPM. Please describe any additional adjustments and justify why they are necessary. HCA reserves the right to limit any adjustments (positive or negative) in the rates provided.

(4a) Covered Benefits : Adjustment from covered benefits in the experience to required benefits in the sample plans (i.e. consistent with the PEBB Uniform Medical Plan Classic benefits)
(4b) Morbidity : Placeholder - This adjustment will be made at a later time based upon a carrier specific adjustment relative to the risk pool
(4c) Other 1 (please include a description)
(4d) Other 2 (please include a description)

(5) Adjusted Projected Allowed PMPM: (**3) * (4)**

(6) Retention

Projected retention, expressed as a percentage of premium. The same percentage load will be applied to every plan in Worksheet 2.

(6a) Administrative or Non-Benefit Expense (NBE): Projected administrative costs
(6b) Quality Improvements (QI): As defined in the MLR calculation requirements for the individual ACA market
(6c) Taxes and Fees
(6d) Profit /Margin

(7) Total Retention: Sum of (6a) through (6d)

(8) Base Rate Tier Mix

Subscriber month counts in each tier for the base period experience. We understand that the tier mix could potentially be significantly different in the projection period than the base period. This section should reflect the base period tier mix. We also understand that many groups use different tier structures - please adjust subscriber month counts to conform to the tier structure definitions below.

(8a) Employee Only
(8b) Employee + Spouse
(8c) Employee + Child(ren)
(8d) Employee + Family

(9) MM/AU Ratio: Calculated based on (8)

Adult Units (AU) are defined by counting the tier factor for each subscriber. For example, a population with one employee only (tier factor = 1) and one employee + child(ren) (tier factor = 1.75) has 2.75 adult units.

Worksheet 2 - Plan-Level Details

(1) CY2020 Base Allowed: WS1 (5)

(2) Actuarial Value (Federal AV): As defined by the Federal Actuarial Value Calculator for the Individual ACA market. CDHP plans should include the proposed employer HSA contribution.

(3) Plan Factors

Plan-specific variation for allowed and paid claims.

(3a) Induced Utilization: Variation in plan specific allowed claims costs based on induced demand from higher or lower cost sharing
(3b) Actuarial Value (Pricing AV) : Variation in paid to allowed ratios based on plan cost sharing. Pricing AV can vary from the Federal AV and should consider all benefits covered. CDHP plans should not include the AV impact of proposed employer HSA contributions.

(4) Other Adjustments

Additional adjustments independent of plan benefit offerings. Please describe any additional adjustments and justify why they are necessary. HCA reserves the right to limit any additional adjustments in the rates provided.

(4a) Network: Utilization or contracting impacts based on network-specific considerations that serve a plan
(4b) Morbidity: Not used at this time
(4c) Other 1 (please include a description)
(4d) Other 2 (please include a description)

(5) Plan Paid: (2) * (3) * (4)

(6) Additional Benefits

Mandatory Carve outs
(6a) Vision

Optional Carve outs
(6b-6f) Additional carveouts (please include a description)

Optional Additions
(6g-6k) Additional included benefits (please include a description)

(7) Total Paid w/Alternatives: (5) + (6)

(8) Retention: WS1 (6)

(9) PMPM Payment: (7) / (1 - (8))

(10) MM/AU Ratio: **WS1 (9)**

(11) PAUPM Payment Rate: **(9) * (10)**

(12) HSA Contributions

Proposed employer contributions for CDHP Plans

(12a) Contributions for single employees
(12b) Contributions for families

(13) Expected Member Months

This section is for informational use only. Please provide an estimate of expected member distribution by plan and enrollment tier, based on the expectation that the ratio of employee contributions will match the tier factors in Worksheet 1.

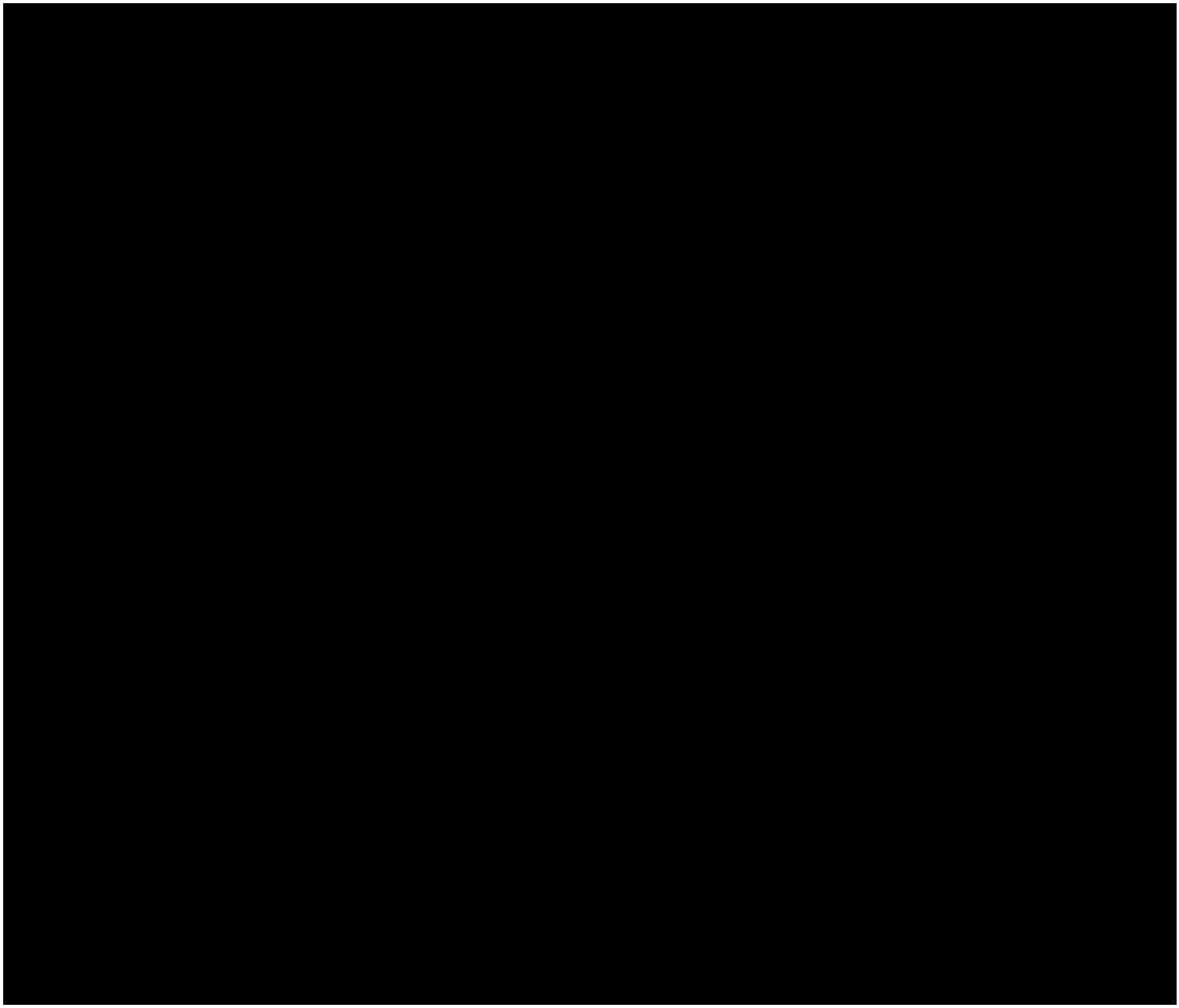
Worksheet 3 - Base Population Demographics

Member month counts by age, gender, and employee/dependent for the population used in the base period experience, consistent with the categories in the OIC K-12 Carrier Data Call. Age should be defined based on the member's age at the conclusion of the base period.

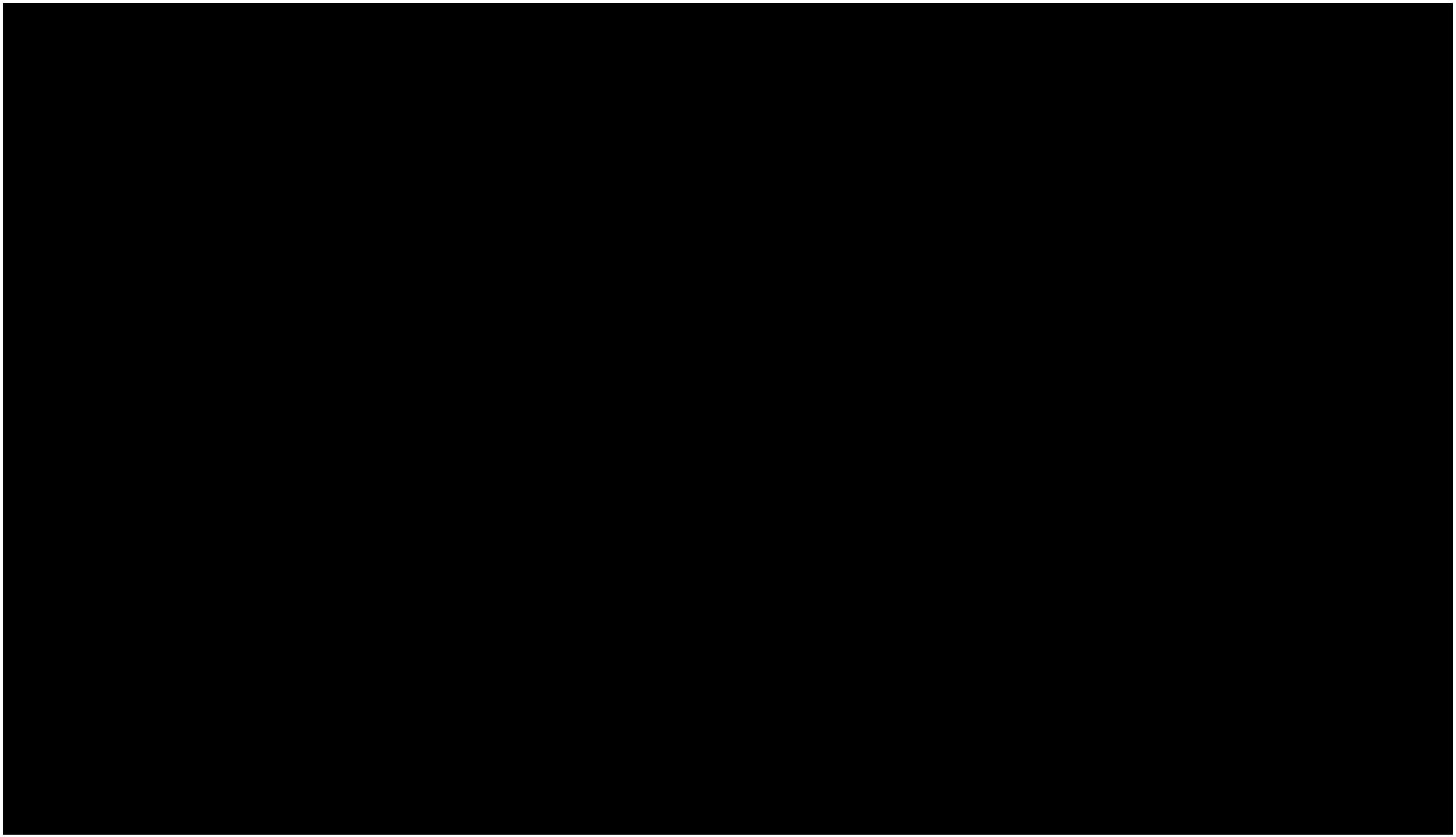
Worksheet 5 - Base Population Area Distribution

*** CONFIDENTIAL (exemption indicated on pages 2-3 of RFI Response) ***

Washington State Health Care Authority
SEBB Bid Rate Form
Worksheet 1
Base Rate Development

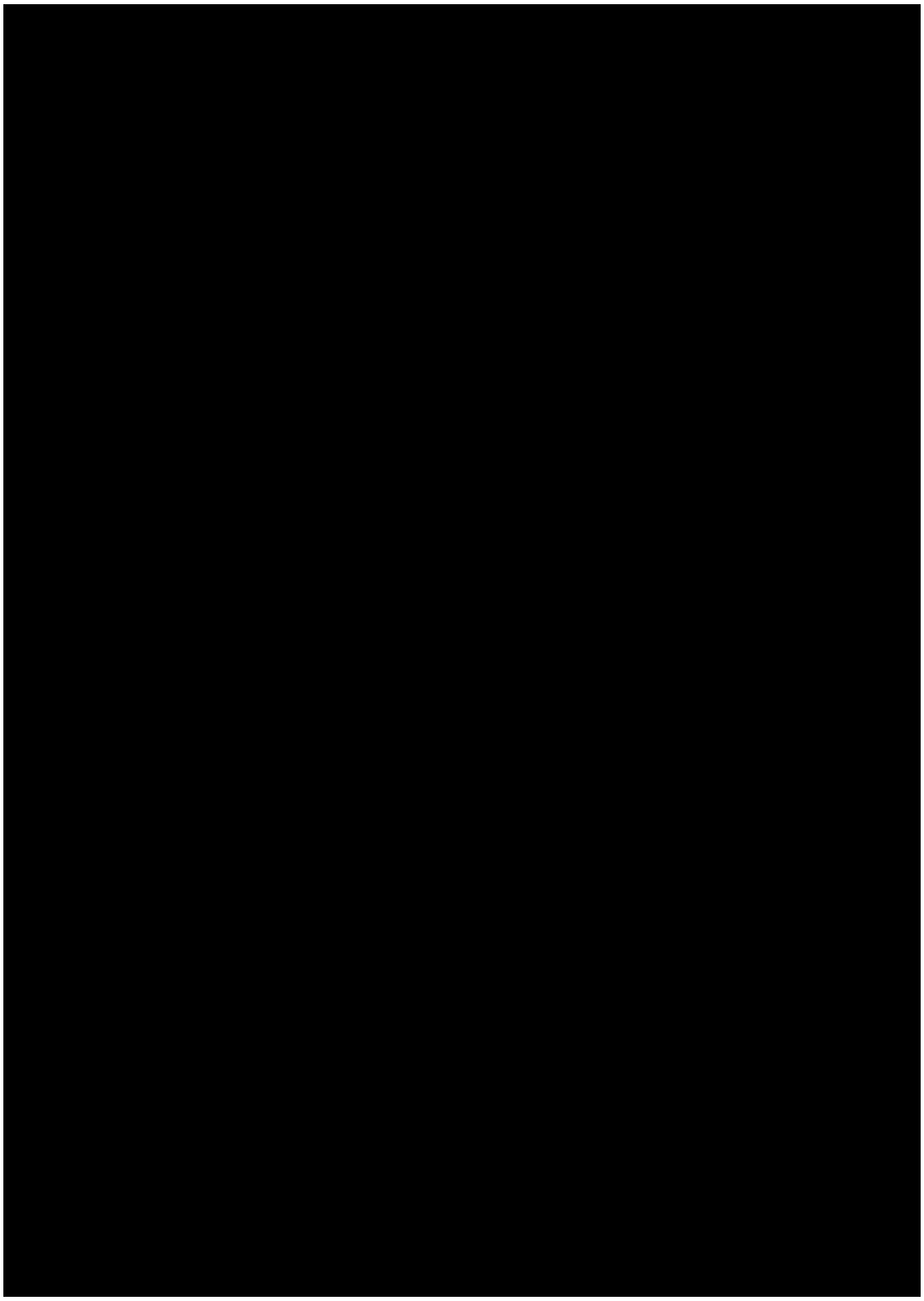


Washington State Health Care Authority
SEBB Bid Rate Form
Worksheet 2
Plan-Level Details



*** CONFIDENTIAL (exemption indicated on pages 2-3 of RFI Response) ***

Washington State Health Care Authority
SEBB Bid Rate Form
Worksheet 3
Base Population Demographics



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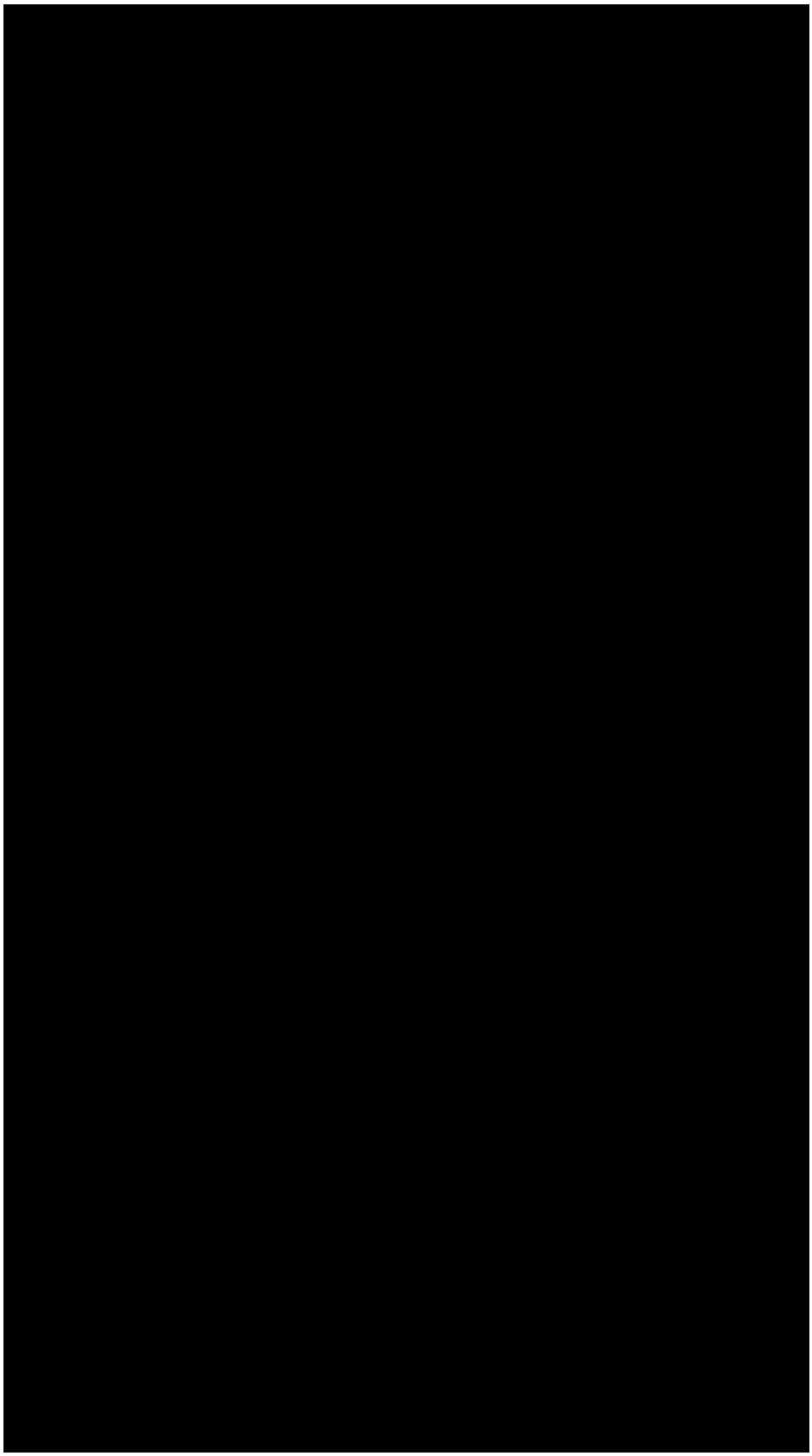
Washington State Health Care Authority
SEBB Bid Rate Form
Worksheet 4



* CONFIDENTIAL (exemption indicated on page 4-5 of RFI Response) *

Exhibit 5 - County Coverage

a. State	b. County	c. # of HMO Plans Currently Available	d. # of PPO Plans Currently Available	e. # of Other Plan Types Currently Available	f. # of HMO Plans Anticipated for	g. # of PPO Plans Anticipated for	h. # of Other Plan Types Anticipated
WA	Adams	0	2		[redacted]		
WA	Asotin	0	2				
WA	Benton	0	2				
WA	Chelan	0	2				
WA	Clallam	0	2				
WA	Clark	0	2				
WA	Columbia	0	2				
WA	Cowlitz	0	2				
WA	Douglas	0	2				
WA	Ferry	0	2				
WA	Franklin	0	2				
WA	Garfield	0	2				
WA	Grant	0	2				
WA	Grays Harbor	0	2				
WA	Island	0	2				
WA	Jefferson	0	2				
WA	King	0	2				
WA	Kitsap	0	2				
WA	Kittitas	0	2				
WA	Klickitat	0	2				
WA	Lewis	0	2				
WA	Lincoln	0	2				
WA	Mason	0	2				
WA	Okanogan	0	2				
WA	Pacific	0	2				
WA	Pend Oreille	0	2				
WA	Pierce	0	2				
WA	San Juan	0	2				
WA	Skagit	0	2				
WA	Skamania	0	2				
WA	Snohomish	0	2				
WA	Spokane	0	2				
WA	Stevens	0	2				
WA	Thurston	0	2				
WA	Wahkiakum	0	2				
WA	Walla Walla	0	2				
WA	Whatcom	0	2				
WA	Whitman	0	2				
WA	Yakima	0	2				
OR	Clackamas	0	2				
OR	Clatsop	0	2				
OR	Columbia	0	2				
OR	Gilliam	0	2				
OR	Hood River	0	2				
OR	Morrow	0	2				
OR	Multnomah	0	2				
OR	Sherman	0	2				
OR	Umatilla	0	2				
OR	Union	0	2				
OR	Wallowa	0	2				
OR	Wasco	0	2				
OR	Washington	0	2				
ID	Adams	0	2				
ID	Benewah	0	2				
ID	Bonner	0	2				
ID	Boundary	0	2				
ID	Idaho	0	2				
ID	Kootenai	0	2				
ID	Latah	0	2				
ID	Lewis	0	2				
ID	Nez Perce	0	2				

Providence Health Plan (PHP) Comments