



Western Grocers Employee Benefits Trust

Calculating your estimated out-of-pocket expense for common procedures

| | |
|--------------------------------|--|
| Physician Network: | Providence PPO (www.providence.org) |
| Plan Deductible: | \$100 individual (maximum \$200 family) |
| Coinsurance: | After deductible, plan pays 90% in network, 70% out of network |
| Out of pocket maximum*: | \$1000 per person annually after deductible in network. There is no maximum if your provider is out of network |

**“Out of pocket” is your 10% coinsurance up to \$1000 per person in network, after which no further coinsurance is applied and the plan pays covered services at 100% instead of 90%. Copays do not apply to out of pocket and continue to apply after out of pocket is met. The plan pays out of network services at 70% after deductible and has no maximum for your 30% coinsurance; out of network claims do not pay at 100% even if your share of coinsurance exceeds \$1000 per person.*

Your plan pays for...

- Office visits at 90% after deductible for in network providers, 70% after deductible for out of network providers
- Diagnostic radiology and imaging services at 90% after deductible for in network providers, 70% after deductible for out of network providers
(EXCEPT for procedures using a body scanner (like MRIs, CTs, bone scans, etc.), which pay at 100% after deductible and a \$200 co-pay per scan)
- Diagnostic pathology and laboratory at 90% after deductible for in network providers, 70% after deductible for out of network providers.
- Professional fees for vaginal delivery at 90% after deductible for in network providers, 70% after deductible for out of network providers.
- Immunizations at 100% after a \$15 co-pay subject to the limitations for wellness care in your plan.
- Professional fees for orthopedic and musculoskeletal surgeries 90% after deductible for in network providers, 70% after deductible for out of network providers..
- Professional fees for digestive system endoscopies at 90% after deductible for in network providers, 70% after deductible for out of network providers.

See the following pages for the estimated provider cost for common procedures.....

TABLE OF ESTIMATED COSTS

| SERVICE CODE | DESCRIPTION OF SERVICE | AVERAGE COST PPO | UCR AVERAGE |
|--|---|------------------|-------------|
| Office visits: | | | |
| 99211 | Office/outpatient visit for evaluation and management of established patient; minimal problem. | \$35.58 | \$73.96 |
| 99212 | Office/outpatient visit for evaluation and management of established patient; self-limited or minor problem. | \$73.29 | \$105.09 |
| 99213 | Office/outpatient visit for evaluation and management of established patient; low to moderate severity. | \$122.38 | \$134.28 |
| 99214 | Office/outpatient visit for evaluation and management of established patient; moderate to high severity. | \$182.86 | \$194.61 |
| 99215 | Office/outpatient visit for evaluation and management of established patient; moderate to high severity, comprehensive. | \$247.61 | \$311.38 |
| Diagnostic radiology and imaging: | | | |
| 71020 | Chest x-ray | \$59.77 | \$114.85 |
| 71020-26 | Chest x-ray, professional fee | \$22.32 | \$35.61 |
| 71020-TC | Chest x-ray, technical fee | \$38.18 | \$114.85 |
| 72193 | CT pelvis with contrast | \$616.11 | \$1,037.39 |
| 72193-26 | CT pelvis with contrast, professional fee | \$113.74 | \$186.67 |
| 72193-TC | CT pelvis with contrast, technical fee | \$502.37 | \$1,037.39 |
| 77052 | Mammography screen, CAD | \$19.21 | \$70.48 |
| 77052-26 | Mammography screen, CAD, professional fee | \$6.40 | \$11.98 |
| 77052-TC | Mammography screen, CAD, technical fee | \$12.81 | \$70.48 |
| 77057 | Mammography screen, bilateral | \$160.10 | \$199.70 |
| 77057-26 | Mammography screen, bilateral, professional fee | \$71.15 | \$83.87 |
| 77057-TC | Mammography screen, bilateral, technical fee | \$88.94 | \$199.70 |
| G0202 | Screening mammography, direct digital image, bilateral | \$256.15 | \$70.48 |
| G0202-26 | Screening mammography, direct digital image, bilateral, professional fee | \$69.02 | \$11.98 |
| G0202-TC | Screening mammography, direct digital image, bilateral, technical fee | \$187.13 | \$70.48 |
| Diagnostic pathology and lab: | | | |
| 36415 | Venipuncture | \$4.35 | \$16.72 |
| 80053 | Comprehensive metabolic panel | \$22.39 | \$48.09 |
| 80061 | Lipid panel | \$28.39 | \$54.95 |
| 85025 | Complete CBD, automated | \$16.46 | \$31.27 |
| 88305 | Level IV surgical pathology | \$207.77 | \$238.00 |
| 88305-26 | Level IV surgical pathology, professional fee | \$71.15 | \$97.60 |
| 88305-TC | Level IV surgical pathology, technical fee | \$136.61 | \$238.00 |
| Normal vaginal delivery: | | | |
| 59400 | Global obstetrical care, including vaginal delivery and antepartum and postpartum care | \$3,333.99 | \$4,273.38 |
| 59409 | Vaginal delivery only | \$1,471.63 | \$2,231.65 |
| 59410 | Vaginal delivery and postpartum care only | \$1,711.91 | \$2,469.06 |
| 59425 | Antepartum care only, 4-6 visits | \$831.36 | \$605.40 |
| 59426 | Antepartum care only, 7 or more visits | \$1,490.17 | \$1,804.32 |
| Immunizations: | | | |
| 90466 | Immunization administration under 8 years of age | \$19.46 | \$42.89 |
| 90471 | Immunization administration, one vaccine | \$43.40 | \$37.17 |
| 90472 | Immunization administration, each additional vaccine | \$20.64 | \$37.17 |
| 90658 | Influenza virus vaccine | \$16.53 | \$25.79 |
| 90715 | Tdap vaccine | \$43.81 | \$37.63 |
| Orthopedic and musculoskeletal surgery: | | | |
| 20550 | Injection, single tendon sheath or ligament | \$104.10 | \$157.94 |
| 20552 | Injection, single or multiple trigger points | \$92.63 | \$167.81 |
| 20610 | Arthrocentesis, aspiration and/or injection, major joint or bursa | \$139.75 | \$205.32 |
| 21365 | Open treatment of complicated fracture of malar area | \$1,974.30 | \$3,386.32 |
| 27447 | Arthroplasty, knee, medial and lateral compartments with or without patella resurfacing | \$2,850.57 | \$5,272.22 |

| SERVICE CODE | DESCRIPTION OF SERVICE | AVERAGE COST PPO | UCR AVERAGE |
|------------------------------------|--|------------------|-------------|
| Cont... | | | |
| Digestive system endoscopy: | | | |
| 43239 | Upper GI endoscopy with biopsy | \$640.99 | \$872.55 |
| 45378 | Colonoscopy, flexible, diagnostic | \$730.11 | \$1,042.97 |
| 45380 | Colonoscopy, flexible, diagnostic, with biopsy | \$881.27 | \$1,147.26 |
| 45384 | Colonoscopy, flexible, diagnostic, with removal of polyps by hot biopsy forceps of bipolar cautery | \$863.44 | \$1,477.53 |
| 45385 | Colonoscopy, flexible, diagnostic, with removal of polyps by snare | \$993.92 | \$1,477.53 |

Please note that:

- Providence PPO contracts with medical providers and the terms of these contracts may vary. The amounts shown in the AVERAGE COST PPO column are the average contract allowable for Providence PPO contracts.
- Confirm with your provider that they are contracted with Providence PPO or call Providence PPO at 1-800-793-9338 to confirm whether your provider is contracted or to locate a contracted provider.
- If you treat with an out of network provider you may be responsible for amounts exceeding the allowable amount listed in the UCR AVERAGE column, in addition to your 30% coinsurance.
- UCR (usual, customary and reasonable charge) is determined using MDR by Ingenix, which compares fees from providers in the same geographic region, to arrive at a usual and customary charge. Your plan is set at the 80th percentile, meaning that the maximum allowable is the amount equal to or greater than 80% of the charges used by Ingenix in its database for that CPT code/geozip combination. The information in this database is updated and published by Ingenix at scheduled times each year, and it is loaded for use upon update.
- Other services may be provided to you which are medically necessary and appropriate as part of your medical care which are not listed above and for which you may have additional financial responsibility.
- These estimates do not include costs of unanticipated procedures.
- Payment for some medical services may require that the service be preauthorized by the plan. For example, inpatient hospitalization (other than for labor and delivery) and outpatient surgical procedures (including endoscopies) require prior authorization. If services are not preauthorized, a payment penalty may apply or the service may not be covered.
- You may be responsible for the costs of procedures not covered by your plan. Please review your summary plan description to determine coverage for medical services, or call us at 503-968-2360 (or 800-777-3603) for assistance.
- You may contact us at 503-968-2360 (or 800-777-3603) for an explanation if the estimate differs from the actual cost or if you have additional questions.
- This is not a guarantee of benefits. Benefits are subject to eligibility at the time of service. Please see your summary plan description for information about what is covered by your plan. You may call our office at 503-968-2360 (or 800-777-3603) if you have questions about what your plan covers.
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