Providence Health Plan: Early Retirees Open Option Plan

Coverage Period: 01/01/2016 – 12/31/2016

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Employee+Dependents | **Plan Type:** EPO

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.ProvidenceHealthPlan.com or by calling **1-800-878-4445.**

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,000** per person / **$2,000** per family (**2** or more). Waived for office visits, most preventive care, emergency and urgent care services.	You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	No.	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	Yes. **$2,000** per person / **$4,000** per family (**2** or more).	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered, fees above UCR.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of participating providers see www.ProvidenceHealthPlan.com/providerdirectory or call 1-800-878-4445.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. A referral to a specialist is not required.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call **1-800-878-4445** or visit us at www.ProvidenceHealthPlan.com.

If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call 1-800-878-4445 to request a copy.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use participating **providers** by charging you lower deductibles, copayments and coinsurance amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$15 copay/visit	50% coinsurance	Deductible does not apply. Some services such as lab and x-ray will include additional member costs.
	Specialist visit	$15 copay/visit	50% coinsurance	
	Other practitioner office visit	$15 copay/visit Acupuncturist, Chiropractor or Naturopath	50% coinsurance Acupuncturist, Chiropractor or Naturopath	Deductible does not apply to office visits to alternative care providers. For costs and coverage associated with Chiropractic Manipulation and Acupuncture, please refer to your Chiropractic and Acupuncture Benefit Summary.
	Preventive care/screening/immunization	No charge	50% coinsurance	Deductible does not apply. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf.
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	50% coinsurance	Deductible does not apply in-network.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Deductible does not apply in-network. Prior authorization required.

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
You need drugs to treat your illness or condition. More information about **prescription drug coverage** is available at www.ProvidenceHealthPlan.com	Generic drugs	$10 copay retail $30 copay mail order	Not covered	Covers up to a 30-day supply (retail prescription); 90-day supply (mail-order prescription). Prior authorization may apply.
	Brand drugs	50% coinsurance retail and mail order	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Prior authorization required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room services	$100 copay	$100 copay	Deductible does not apply. For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.
	Emergency medical transportation	30% coinsurance	30% coinsurance	none
	Urgent care	$15 copay/visit	50% coinsurance	Deductible does not apply. Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Prior authorization required.
	Physician/surgeon fee	30% coinsurance	50% coinsurance	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Out-of-network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$15 copay/provider office visit 30% coinsurance all other services	50% coinsurance	All services except provider office visits must be prior authorized. Deductible does not apply to provider office visits. See your benefit summary for ABA services.
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	
	Substance use disorder outpatient services	$15 copay/provider office visit 30% coinsurance all other services	50% coinsurance	
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge Postnatal: $100 copay	50% coinsurance	Deductible does not apply in-network. Copay applies to provider delivery charges.
	Delivery and all inpatient services	30% coinsurance	50% coinsurance	none
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	none
	Rehabilitation services	30% coinsurance	50% coinsurance	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year.
	Habilitation services	Not covered	Not covered	No coverage for habilitation services.
	Skilled nursing care	30% coinsurance	50% coinsurance	Prior authorization required. Coverage is limited to 60 days per calendar year.
	Durable medical equipment	30% coinsurance	50% coinsurance	Deductible does not apply to diabetes supplies from in-network providers.
	Hospice service	No charge	No charge	Deductible does not apply.
If your child needs dental or eye care	Eye exam	Not covered	Not covered	No coverage for eye exam.
	Glasses	Not covered	Not covered	No coverage for glasses.
	Dental check-up	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Eye exam and glasses (Child)
- Habilitation services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (limits apply)
- Chiropractic care (limits apply)
- Hearing Aids (limits apply)
- Non-emergency care when traveling outside the U.S. See www.ProvidenceHealthPlan.com

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-878-4445. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact: Providence Health Plan at 1-800-878-4445, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform, or you can contact the Oregon Insurance Division by:

- Calling (503) 947-7984 or the toll free message line at (888) 877-4894
- Writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883
- Through the Internet at http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx
- E-mail at: cp.ins@state.or.us

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,390
- **Patient pays** $2,150

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$1,000
Copays	$100
Coinsurance	$900
Limits or exclusions	$150
Total	**$2,150**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $3,530
- **Patient pays** $1,870

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$1,000
Copays	$470
Coinsurance	$320
Limits or exclusions	$80
Total	**$1,870**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from **in-network providers**. If the patient had received care from **out-of-network providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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