



**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](http://www.ProvidenceHealthPlan.com) or by calling 1-800-878-4445.

Important Questions	Answers	Why this Matters:
What is the overall <u>deductible</u> ?	\$100 per person / \$200 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 <u>deductible</u> amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the <u>deductible</u> 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 <u>deductible</u> .
Are there other <u>deductibles</u> for specific services?	No.	You don't have to meet <u>deductibles</u> for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an <u>out-of-pocket limit</u> on my expenses?	Yes. \$2,200 per person / \$4,400 per family (2 or more).	The <u>out-of-pocket limit</u> 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 <u>out-of-pocket limit</u> ?	Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered.	Even though you pay these expenses, they don't count toward the <u>out-of-pocket limit</u> .
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 <i>specific</i> covered services, such as office visits.
Does this plan use a <u>network</u> of <u>providers</u> ?	Yes. For a list of participating providers see <a href="http://www.ProvidenceHealthPlan.com/providerdirectory">www.ProvidenceHealthPlan.com/providerdirectory</a> or call 1-800-878-4445.	If you use an in-network doctor or other health care <u>provider</u> , 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 <u>provider</u> for some services. Plans use the term in-network, <u>preferred</u> , or participating for <u>providers</u> in their <u>network</u> . See the chart starting on page 2 for how this plan pays different kinds of <u>providers</u> .
Do I need a referral to see a <u>specialist</u> ?	No. A referral to a specialist is not required.	You can see the <u>specialist</u> 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 <u>excluded services</u> .

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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.ccio.cms.gov](http://www.ccio.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 <u>provider's</u> office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	Not covered	Deductible does not apply. Some services such as labs and x-ray will include additional member costs.
	Specialist visit	\$20 copay/visit	Not covered	
	Other practitioner office visit	\$20 copay/visit Acupuncturist, Chiropractor or Naturopath	Not covered	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	Not covered	Deductible does not apply. Some preventive services will include additional member costs. For more information see: <a href="https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf">https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf</a> .
If you have a test	Diagnostic test (x-ray, blood work)	10% coinsurance	Not covered	Deductible does not apply.
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	Deductible does not apply. Prior authorization required.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
<p>If you need drugs to treat your illness or condition</p> <p>More information about <a href="#">prescription drug coverage</a> is contact CVS Caremark at 1 (855) 559-6433 or <a href="http://www.caremark.com">www.caremark.com</a>.</p>	Generic drugs	Retail: 50% coinsurance with a \$50 maximum per 30-day supply; Mail-Order: 50% coinsurance with a \$150 maximum per 90-supply	Not Covered	Your prescription drug coverage is administered through CVS Caremark. Providence Health Plan assumes no liability for the accuracy of your prescription drug benefits information.
	Preferred brand drugs	Retail: 50% coinsurance with a \$50 maximum per 30-day supply; Mail-Order: 50% coinsurance with a \$150 maximum per 90-day supply	Not Covered	<p>Member pays the difference in cost for brand name drugs if a generic drug is available (unless doctor indicates no substitution allowed). Your prescription drug coverage is administered through CVS Caremark. Providence Health Plan assumes no liability for the accuracy of your prescription drug benefits information.</p>
	Non-preferred brand drugs	Retail: 50% coinsurance with a \$50 maximum per 30-day supply; Mail-Order: 50% coinsurance with a \$150 maximum per 90-day supply	Not Covered	
	Specialty drugs	Same as Retail	Not Covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	
	Physician/surgeon fees	10% coinsurance	Not covered	

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# Providence Health Plan: Personal Option Plan

Summary of Benefits and Coverage: What this Plan Covers & What it Costs

Coverage Period: 01/01/2017 - 12/31/2017

Coverage for: Employee+Dependents | Plan Type: EPO

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
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 copay is not applied, all services subject to inpatient benefits.
	Emergency medical transportation	10% coinsurance	10% coinsurance	-----none-----
	Urgent care	\$20 copay/visit	Not covered	Deductible does not apply. Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	Prior authorization required.
	Physician/surgeon fee	10% coinsurance	Not covered	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	\$20 copay/ provider office visit 10% coinsurance all other services	Not covered	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	10% coinsurance	Not covered	
	Substance use disorder outpatient services	\$20 copay/ provider office visit 10% coinsurance all other services	Not covered	
	Substance use disorder inpatient services	10% coinsurance	Not covered	
If you are pregnant	Prenatal and postnatal care	Prenatal: No charge Postnatal: \$200 copay	Not covered	Deductible does not apply. Copay applies to provider delivery charges.
	Delivery and all inpatient services	10% coinsurance	Not covered	

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-Network Provider	Out-of-Network Provider	
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	<del>-----none-----</del>
	Rehabilitation services	10% coinsurance	Not covered	Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year.
	Habilitation services	10% coinsurance	Not covered	
	Skilled nursing care	10% coinsurance	Not covered	Prior authorization required. Coverage is limited to 60 days per calendar year.
	Durable medical equipment	10% coinsurance	Not covered	Deductible does not apply to diabetes supplies.
	Hospice service	No charge	Not covered	Deductible does not apply.

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Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Out-of-network Provider	
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:**

<b>Services Your Plan Does NOT Cover</b> (This isn't a complete list. Check your policy or plan document for other <a href="#">excluded services</a> .)		
<ul style="list-style-type: none"> <li>Bariatric surgery</li> <li>Cosmetic surgery (with certain exceptions)</li> <li>Dental care (Adult)</li> <li>Dental check-up (Child)</li> <li>Eye exam and glasses (Child)</li> </ul>	<ul style="list-style-type: none"> <li>Infertility treatment</li> <li>Long-term care</li> <li>Non-emergency care when traveling outside the U.S.</li> <li>Private-duty nursing</li> </ul>	<ul style="list-style-type: none"> <li>Routine eye care (Adult)</li> <li>Routine foot care (covered for diabetics)</li> <li>Voluntary termination of pregnancy</li> <li>Weight loss programs</li> </ul>

<b>Other Covered Services</b> (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
<ul style="list-style-type: none"> <li>Acupuncture (limits apply)</li> </ul>	<ul style="list-style-type: none"> <li>Chiropractic care (limits apply)</li> </ul>	<ul style="list-style-type: none"> <li>Hearing Aids (limits apply)</li> </ul>

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## 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/healthreform](http://www.dol.gov/ebsa/healthreform), or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or [www.cciio.cms.gov](http://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](http://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](mailto: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.*-----

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## 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** \$6,560
- **Patient pays** \$ \$980

**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
<b>Total</b>	<b>\$7,540</b>

**Patient pays:**

Deductibles	\$100
Copays	\$200
Coinsurance	\$510
Limits or exclusions	\$170
<b>Total</b>	<b>\$980</b>

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

- **Amount owed to providers:** \$5,400
- **Plan pays** \$ \$2,040
- **Patient pays** \$3,360

**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
<b>Total</b>	<b>\$5,400</b>

**Patient pays:**

Deductibles	\$100
Copays	\$200
Coinsurance	\$130
Limits or exclusions	\$2,930
<b>Total</b>	<b>\$3,360</b>

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## 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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## Non-Discrimination Statement:

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provide free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance  
Attn: Non-discrimination Coordinator  
PO Box 4158  
Portland, OR 97208-4158

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 711) for assistance. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>, or by mail or phone at:

U.S. Department of Health and Human Services  
200 Independence Avenue SW - Room 509F HHH Building  
Washington, DC 20201  
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

## Language Access Services:

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711)。

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

یم باشد. یا 1-800-878-4445 (TTY: 711) تماس دیری بگ. شما یبراگان یرا بصورت ی زبان لاتیتسه، دیکن یم گفتگو ی فارس زبان به اگر: توجه ف

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)