SUMMARY OF COVERAGE 2016
SiMPLE GOLD BROAD

We offer the BROAD Network for members who would like covered medical care and services from a broad network of participating physicians, hospitals and other facilities both regionally and nationally. Members gain access to more than 19,000 statewide providers, as well as over 750,000 providers nationally. The BROAD Network may be helpful to individuals who plan to travel outside of Oregon or just want more selection and choice of providers.

See your Member Handbook or Individual Health Policy for complete benefits information.

MY COVERAGE	MY COST	
	In-Network	Non-Network
MY ANNUAL OUT-OF-POCKET COSTS		
Yearly deductible—combined in-network and non-network	NO DEDUCTIBLE	
Maximum yearly out-of-pocket—person/family includes deductibles, copays and/or coinsurance	$5,500 / $11,000	$11,000 / $22,000
SEEING YOUR HEALTH PROVIDERS		
Office visit with primary care provider	$30 copay	50% coinsurance
Office visit with specialist	$50 copay	50% coinsurance
X-rays	$30 copay	50% coinsurance
CAT, PET or MRI scan	$250 copay	50% coinsurance
Routine lab and pathology	$30 copay	50% coinsurance
Physical or occupational therapy (30 visits/year)	$30 copay	50% coinsurance
Speech therapy (30 visits/year)	$30 copay	50% coinsurance
Home health care visits	No cost to you	50% coinsurance
Behavioral health services (including mental health and substance abuse visits)	$30 copay	50% coinsurance
Acupuncture	$30 copay	50% coinsurance
Chiropractic (10 visits/year—spinal manipulation only)	$30 copay	Not covered
ADULT WELLNESS		
Adult preventive care	No cost to you	Not covered
Pregnancy and postpartum (new mother) exams	No cost to you	Not covered
Immunizations	No cost to you	Not covered
Laboratory services (preventive screenings)	No cost to you	Not covered
CHILD WELLNESS		
Well-child and newborn visits	No cost to you	Not covered
Vision	No cost to you	Not covered
Obesity-related visit	No cost to you	Not covered
Immunizations	No cost to you	Not covered

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MY COVERAGE	MY COST	
	In-Network	Non-Network
Laboratory services (preventive screenings)	No cost to you	Not covered
ADULT PREVENTIVE SCREENINGS		
Blood pressure	No cost to you	Not covered
Mammogram (age 40+)	No cost to you	Not covered
Pap test (for cervical cancer)	No cost to you	Not covered
Cholesterol	No cost to you	Not covered
Colonoscopy (for colon cancer)	No cost to you	Not covered
Type 2 diabetes	No cost to you	Not covered
HIV	No cost to you	Not covered
Hepatitis B	No cost to you	Not covered
Iron-deficiency anemia	No cost to you	Not covered
Ultrasound for aortic aneurysm	No cost to you	Not covered
PRESCRIPTION DRUGS		
Generic	$10 copay	Not covered
Preferred brand	$50 copay	Not covered
Non-preferred brand	$70 copay	Not covered
Specialty	50% coinsurance	Not covered
GOING TO A HOSPITAL OR OTHER MEDICAL FACILITY		
Urgent care center visit	$75 copay	50% coinsurance
Emergency room visit (not admitted to hospital)	$250 copay (all inclusive)	$250 copay
Ambulance to hospital	$150 copay	50% coinsurance
Surgery at ambulatory (outpatient) surgery center	$2,000 copay	50% coinsurance
Outpatient surgery at hospital	$2,500 copay	50% coinsurance
Inpatient hospital stay	$3,000 copay	50% coinsurance
DURABLE MEDICAL EQUIPMENT & SUPPLIES		
Tier I: Medical equipment costing up to $799.99	$50 copay	Not covered
Tier II: Medical equipment costing $800 or more	$100 copay	Not covered

About non-network coverage: In addition to the cost share amounts listed, members are responsible for any difference between the actual charge and Oregon's Health CO-OP allowable charge.

About copays: If the copay is higher than the actual charge for service, you'll always pay the lesser amount.

Interested? Ready to enroll? Need more information? Call toll free 1-844-509-4676 or your insurance broker.

Everyone is welcome at the CO-OP. Join us!

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