

SUMMARY OF COVERAGE 2016

STANDARD BRONZE 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	\$5,000 PER PERSON, \$10,000 PER FAMILY	
Maximum yearly out-of-pocket—person/family includes deductibles, copays and/or coinsurance	\$6,350 / \$12,700	\$12,700 / \$25,400
SEEING YOUR HEALTH PROVIDERS		
Office visit with primary care provider	After deductible, \$60 copay	After deductible, 75% coinsurance
Office visit with specialist	After deductible, \$100 copay	After deductible, 75% coinsurance
X-rays	After deductible, 50% coinsurance	After deductible, 75% coinsurance
CAT, PET or MRI scan	After deductible, 50% coinsurance	After deductible, 75% coinsurance
Routine lab and pathology	After deductible, 50% coinsurance	After deductible, 75% coinsurance
Physical or occupational therapy (30 visits/year)	After deductible, \$60 copay	After deductible, 75% coinsurance
Speech therapy (30 visits/year)	After deductible, \$60 copay	After deductible, 75% coinsurance
Home health care visits	After deductible, 50% coinsurance	After deductible, 75% coinsurance
Behavioral health services (including mental health and substance abuse visits)	After deductible, \$60 copay	After deductible, 75% coinsurance
Acupuncture	Not covered	Not covered
Chiropractic	Not covered	Not covered
ADULT WELLNESS		
Adult preventive care	No cost to you	Not covered
Pregnancy and postpartum (new mother) exams	After deductible, 50% coinsurance	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
Laboratory services (preventive screenings)	No cost to you	Not covered



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MY COVERAGE	MY COST	
	In-Network	Non-Network
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	After deductible, \$20 copay	Not covered
Preferred brand	After deductible, \$80 copay	Not covered
Non-preferred brand	After deductible, 50% coinsurance	Not covered
Specialty	After deductible, 50% coinsurance	Not covered
GOING TO A HOSPITAL OR OTHER MEDICAL FACILITY		
Urgent care center visit	After deductible, \$120 copay	After deductible, 75% coinsurance
Emergency room visit (not admitted to hospital)	After deductible, 50% coinsurance	After deductible, 50% coinsurance
Ambulance to hospital	After deductible, 50% coinsurance	After deductible, 75% coinsurance
Surgery at ambulatory (outpatient) surgery center	After deductible, 50% coinsurance	After deductible, 75% coinsurance
Outpatient surgery at hospital	After deductible, 50% coinsurance	After deductible, 75% coinsurance
Inpatient hospital stay	After deductible, 50% coinsurance	After deductible, 75% coinsurance
DURABLE MEDICAL EQUIPMENT & SUPPLIES		
Tier I: Medical equipment costing up to \$799.99	After deductible, 50% coinsurance	Not covered
Tier II: Medical equipment costing \$800 or more	After deductible, 50% coinsurance	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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