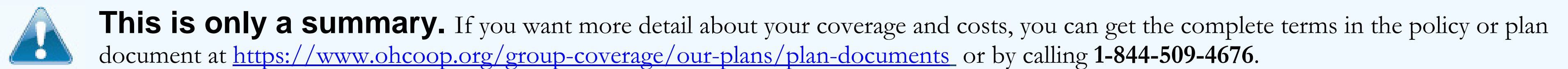
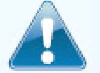


This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at https://www.ohcoop.org/group-coverage/our-plans/plan-documents or by calling **1-844-509-4676**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$6,850** person/**$13,700** family Does not apply to preventive care	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. For network providers **$6,850** person/**$13,700** family For non-network providers **$13,700** person/**$27,400** family	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, Balance billing for Non-Network providers, health care services or supplies not covered by Plan	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. See http://www.ohcoop.org/find-a-plan/our-provider-pharmacy-networks for a list of network providers or call **1-844-509-4676.**	If you use a Network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your Network doctor or hospital may use a Non-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. You don't need a referral to see a specialist.	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 4. See your policy or plan document for additional information about **excluded services**.



- **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 network **providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$40 copay/visit	75% coinsurance	——————none——————
	Specialist visit	$80 copay/visit	75% coinsurance	——————none——————
	Other practitioner office visit	$40 copay/visit	75% coinsurance	——————none——————
	Preventive care/screening/immunization	$0	Not Covered	Non-Network, not covered. Some preventive services require cost-sharing. Certain preventive services such as immunizations, mammograms, and cervical cancer screening are covered with no cost-sharing. For a complete list of preventive services covered with no cost-sharing, call 1-844-509-4676.
If you have a test	Diagnostic test (x-ray, blood work)	$150 copay/visit x-ray and $100 copay/visit labs	75% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$500 copay/visit	75% coinsurance	Preauthorization may be required

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at https://www.ohcoop.org/providers/rx-for-providers/	Generic drugs	$30 copay	Not Covered	Non-Network Exception: Up to 30 day emergency supply will be covered with preauthorization.
	Preferred brand drugs	$100 copay	Not covered	Non-Network Exception: Up to 30 day emergency supply will be covered with preauthorization.
	Non-preferred brand drugs	$200 copay	Not covered	Non-Network Exception: Up to 30 day emergency supply will be covered with preauthorization.
	Specialty drugs	50% coinsurance	Not covered	Non-Network Exception: Up to 30 day emergency supply will be covered with preauthorization.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	ASC $6,000 copay Hospital $6,300 copay	75% coinsurance	All terminations of pregnancy services provided by a licensed provider, including those for which federal funding is prohibited, are covered by this plan.
	Physician/surgeon fees	$0	75% coinsurance	——————none——————
If you need immediate medical attention	Emergency room services	$750 copay	$750 copay	——————none——————
	Emergency medical transportation	$300 copay	75% coinsurance	——————none——————
	Urgent care	$80 copay	75% coinsurance	——————none——————
If you have a hospital stay	Facility fee (e.g., hospital room)	$0, after deductible	75% coinsurance	Preauthorization required
	Physician/surgeon fee	$0	75% coinsurance	——————none——————

Common Medical Event	Services You May Need	Your Cost If You Use a Network Provider	Your Cost If You Use a Non-Network Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$40 copay	75% coinsurance	——————none——————
	Mental/Behavioral health inpatient services	$0, after deductible	75% coinsurance	Preauthorization required.
	Substance use disorder outpatient services	$40 copay	75% coinsurance	——————none——————
	Substance use disorder inpatient services	$0, after deductible	75% coinsurance	Preauthorization required
If you are pregnant	Prenatal and postnatal care	$0	100%	Non-Network not covered
	Delivery and all inpatient services	$0, after deductible	75% coinsurance	Preauthorization required
If you need help recovering or have other special health needs	Home health care	$0	75% coinsurance	Preauthorization required
	Rehabilitation services	Outpatient $40 copay Inpatient $0, after deductible	75% coinsurance	Outpatient services are limited to 30 visits/year. Preauthorization required for inpatient.
	Habilitation services	Outpatient $40 copay Inpatient $0, after deductible	75% coinsurance	Outpatient services are limited to 30 visits/year. Preauthorization required for inpatient.
	Skilled nursing care	$3,000 copay	75% coinsurance	Limited to 60 days/year. Preauthorization required.
	Durable medical equipment	Tier I $80 copay Tier II $300 copay	Not covered	Non-Network not covered. Preauthorization may be required.
	Hospice service	Home $0 Inpatient $3000 copay	75% coinsurance	Hospice limited to 30 days per lifetime. Respite in a Skilled Nursing Facility limited to 5 days per lifetime. Preauthorization required.
If your child needs dental or eye care	Eye exam	$0	Not covered	Limited to 1 visit/year
	Glasses	$0	Not covered	Limited to 1 pair/year
	Dental check-up	Not covered	Not covered	Not covered.

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.)

- Dental Care (Adult)
- Non-emergency care when traveling outside the U.S.
- Weight loss programs
- Infertility treatment
- Private-duty nursing
- Long-term care
- Routine eye care (Adult)

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
- Cosmetic Surgery, one attempt within 18 months of injury, unless there is medical necessity
- Bariatric surgery
- Hearing aids for members under 18 years; 19 to 25 years covered if in school
- Chiropractic Manipulation, ten office visits per year
- Routine foot care, only if being treated for diabetes mellitus

Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your premium. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the Plan at 1-844-509-4676. You may also contact your state insurance department at Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem OR 97301-3883. PH: 503-947-7984 or 888-877-4894. EMAIL: cp.ins@state.or.us. Through the Internet at: http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx.

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 your state insurance department at Oregon Insurance Division, Consumer

Protection Unit, 350 Winter Street NE, Salem OR 97301-3883. PH: 503-947-7984 or 888-877-4894. EMAIL: cp.ins@state.or.us. Through the Internet at: http://www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx.

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 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.**
[Insert heading and applicable tagline(s):

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 1-844-509-4676.
TTY (Oregon's Relay Services): 1-800-735-2900 or 711.
For a language other than English, please call Customer Service at any of the phone numbers above.

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** $2,370
- **Patient pays** $5,170

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	$5,000
Copays	$20
Coinsurance	$0
Limits or exclusions	$150
Total	**$5,170**

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

- **Amount owed to providers:** $5,400
- **Plan pays** $2,660
- **Patient pays** $2,740

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	$1,150
Copays	$2,120
Coinsurance	$0
Limits or exclusions	$80
Total	**$3,350**

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.