BridgeSpan Health Company: BridgeSpan Oregon Standard Bronze Plan Value PPO

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

Summary of Benefits and Coverage: What this Plan Covers & What it Costs **Coverage for:** Individual & Eligible Family | **Plan Type: PPO**

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.bridgespanhealth.com or by calling 1 (855) 857-9943.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	In-network: **$5,000** insured **/ $10,000** family per calendar year. Out-of-network: **$10,000** insured / **$20,000** per family calendar year. Doesn't apply to in-network preventive care. **Copayments** or amounts in excess of the **allowed amount** do not count toward the **deductible**. **Deductible** and **coinsurance** waived for Native Americans receiving services from Indian Health Providers.	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. In-network: **$6,350** insured / **$12,700** family per calendar year. Out–of–network: **$12,700** insured / **$25,400** family per calendar year.	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–billed charges, and health care this plan doesn't cover.	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 www.bridgespanhealth.com or call 1 (855) 857-9943 for lists of in-network or out–of–network **providers**.	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. You don't need a referral to see a **specialist**.	You can see the **specialist** you choose without permission from this plan.

Questions: Call 1 (855) 857-9943 or visit us at www.bridgespanhealth.com.
If you aren't clear about any of the underlined terms used in this form, see the Glossary.
You can view the Glossary at www.cciio.cms.gov or call 1 (855) 857-9943 to request a copy.

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**.

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

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 visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$60 copay / visit, other services 50% coinsurance	50% coinsurance	**Copayment** applies to each in–network office visit only, whether or not the **deductible** has been met. All other services are covered at the **coinsurance** specified, after **deductible**.
	Specialist visit	$100 copay / visit, other services 50% coinsurance	50% coinsurance	
	Other practitioner office visit	Not covered	Not covered	Acupuncture and spinal manipulations are excluded.
	Preventive care/ screening/immunization	No charge	50% coinsurance	Some in-network preventive health services require cost-sharing while others do not. For a complete list of preventive services covered with no cost-sharing, visit www.bridgespanhealth.com.
If you have a test	Diagnostic test (x–ray, blood work)	50% coinsurance	50% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	50% coinsurance	50% coinsurance	——————none——————
If you need drugs to treat your illness or condition More information about **prescription drug coverage**	Generic drugs	$20 copay* / retail prescription $40 copay / mail order prescription $20 copay* for self-administrable cancer chemotherapy drugs		No coverage for prescription drugs not on the Oregon Standard Formulary. No coverage for prescription drugs from an out-of-network pharmacy. Coverage is limited to a 90–day supply retail (1 copay per 30-day supply), 90–day supply mail order or
	Preferred brand drugs	$80 copay* / retail prescription $160 copay / mail order prescription		

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
is available at www.bridgespanhealth.com/web/bridgespan_individual/drug-list		$80 copay* for self-administrable cancer chemotherapy drugs		30-day supply injectable, self-administrable cancer chemotherapy and specialty drugs. **Deductible** does not apply to certain preventive drugs, women's contraceptives and immunizations at a participating pharmacy. The first fill for specialty drugs may be provided at a retail pharmacy, additional refills and any fills for specialty self-administrable cancer chemotherapy drugs must be provided at a specialty pharmacy. *$5 discount when filled at a preferred pharmacy. **5% discount when filled at a preferred pharmacy.
	Non-preferred brand drugs	50% coinsurance** / retail prescription 40% coinsurance / mail order prescription 50% coinsurance** for self–administrable cancer chemotherapy drugs		
	Specialty drugs	50% coinsurance / specialty drugs 50% coinsurance / self–administrable cancer chemotherapy drugs		
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	50% coinsurance	50% coinsurance	———none———
	Physician/surgeon fees	50% coinsurance	50% coinsurance	———none———
If you need immediate medical attention	Emergency room services	50% coinsurance	50% coinsurance	———none———
	Emergency medical transportation	50% coinsurance	50% coinsurance	———none———
	Urgent care	$120 copay / visit, other services 50% coinsurance	50% coinsurance	**Copayment** applies to each in-network urgent care visit only, whether or not the **deductible** has been met. All other services are covered at the **coinsurance** specified, after **deductible**.
If you have a hospital stay	Facility fee (e.g., hospital room)	50% coinsurance	50% coinsurance	———none———
	Physician/surgeon fee	50% coinsurance	50% coinsurance	———none———
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$60 copay / visit	50% coinsurance	**Copayment** applies to each in-network outpatient therapy visit only, whether or not the **deductible** has been met.
	Mental/Behavioral health inpatient services	50% coinsurance	50% coinsurance	
	Substance use disorder outpatient services	$60 copay / visit	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
	Substance use disorder inpatient services	50% coinsurance	50% coinsurance	
If you are pregnant	Prenatal and postnatal care	50% coinsurance	50% coinsurance	Coverage includes termination of pregnancy. Laws prohibit public funding of certain covered terminations of pregnancy. **Premium** payments are segregated to ensure compliance.
	Delivery and all inpatient services	50% coinsurance	50% coinsurance	
If you need help recovering or have other special health needs	Home health care	50% coinsurance	50% coinsurance	––––––––––––none––––––––––––
	Rehabilitation services	50% coinsurance for inpatient services, $60 copay / outpatient visit	50% coinsurance	Coverage is limited to 30 inpatient days and 30 outpatient visits each for rehabilitation and habilitation services / year. **Copayment** applies to each in–network outpatient visit only, whether or not the **deductible** has been met.
	Habilitation services	50% coinsurance for inpatient services, $60 copay / outpatient visit	50% coinsurance	
	Skilled nursing care	50% coinsurance	50% coinsurance	Coverage is limited to 60 inpatient days / year.
	Durable medical equipment	50% coinsurance	50% coinsurance	Coverage is limited to 1 pair of glasses or contacts / year due to severe medical or surgical problems other than refractive procedures.
	Hospice service	50% coinsurance	50% coinsurance	Coverage is limited to 30 inpatient or outpatient respite days / lifetime (limited to a maximum of five consecutive respite days at a time).
If your child needs dental or eye care	Eye exam	No charge	No charge	Coverage is limited to 1 routine exam / year for insureds up to age 19.
	Glasses	50% coinsurance	50% coinsurance	Coverage is limited to 1 pair of lenses (2 lenses) and 1 standard frame / year for insureds up to age 19, **deductible** waived.
	Dental check–up	Not covered	Not covered	Pediatric dental is excluded.

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care, including spinal manipulations
- Cosmetic surgery, except for certain situations
- Dental care (Adult and Pediatric)
- Infertility treatment
- Long–term care
- Non–emergency care when traveling outside the U.S.
- Private–duty nursing
- Routine eye care, including vision hardware (Adult)
- Routine foot care, except for diabetic patients
- Weight loss programs, except for nutritional counseling

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.)

- Hearing aids for insureds 18 years of age or younger or for enrolled children 19 years of age or older and enrolled in a secondary school or an accredited educational institution

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 of the coverage area

For more information on your rights to continue coverage, contact the insurer at 1 (855) 857-9943. You may also contact your state insurance department at (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883; through the Internet at:
www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by E-mail at: cp.ins@state.or.us.

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: the Oregon Insurance Division at (503) 947-7984 or the toll free message line at 1 (888) 877-4894; by writing to the Oregon Insurance Division, Consumer Advocacy Unit, P.O. Box 14480, Salem, OR 97309-0405; through the Internet at: www.oregon.gov/DCBS/insurance/gethelp/Pages/fileacomplaint.aspx; or by 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?

In order for certain types of health coverage (for example, individually purchased insurance or job-based coverage) to qualify as minimum essential coverage, the plan must pay, on average, at least 60 percent of allowed charges for covered services. This is called the "minimum value standard." **This health coverage does meet the minimum value standard for the benefits it provides.**

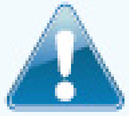
Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1 (855) 857-9943.

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:** $1,240
- **Patient pays:** $6,300

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	$1,130
Limits or exclusions	$150
Total	**$6,300**

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

- **Amount owed to providers:** $5,400
- **Plan pays:** $1,980
- **Patient pays:** $3,420

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	$420
Copays	$2,960
Coinsurance	$0
Limits or exclusions	$40
Total	**$3,420**

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.