Oregon Episcopal School

# 2021 EMPLOYEE BENEFITS GUIDE - NEW HIRE

Oregon Episcopal School

# WHAT'S INSIDE

# 2021 Plan Year Highlights

Oregon Episcopal School is pleased to offer a comprehensive program of group benefits to help maintain the health and well-being of you and your eligible family members. Our benefit plan objectives are to provide you with benefits for maintaining good health and financial protection in the event of a disability or death. The ability to continue these benefit programs is a partnership between Oregon Episcopal School and our employees. With the double-digit rate of healthcare inflation, we must use our benefits wisely.

This guide is a brief overview of your benefit plans, the enrollment process and timelines. More detailed descriptions of benefits eligibility, waiting periods, and benefits are contained in your Summary Plan Descriptions (SPDs), which are your benefit booklets and group certificates. You'll find these on our benefits website and in the HR Office.

**Plan Highlights**

- Oregon Episcopal School offers three Medical Plans through Providence. See page 5 for benefit design options.
- Health Reimbursement Account (HRA) Administration is offered through Health Equity.
  - This account is paired with the Providence Personal Option In-Network plan and reimburses the last $500 of the $1,000 deductible.
- Health Savings Account (HSA) Administration is offered through Health Equity.
  - This account is paired with the Providence HSA plan option.
- Dental Plans are with Kaiser, Willamette Dental and Delta Dental for the 2021 plan year. See page 8 for benefit design options.
- The Vision Plan is offered through Vision Service Plan (VSP). See page 9 for plan details.
- Life, Voluntary Life/AD&D and Long Term Disability plans are with Sun Life. See page 10 for plan details.
- Voluntary Long Term Care is offered through Transamerica. See page 10 for additional information.
- The Flexible Spending Account administration is through Health Equity. The medical reimbursement maximum for 2021 is $2,750. Plan details available on pages 11 and 12.
- The Employee Assistance Program is offered through Cascade Centers. See page 13 for more information.
- Please note that benefits outlined in this guide are effective through December 31, 2021. Open enrollment and benefit options for the 2022 plan year will be announced in November.

## Questions?

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# Eligibility

All regular employees who work 1000 or more hours during a calendar year and faculty working at least half-time are eligible for the health insurance plans. Coverage begins on the first day of the month following the date of hire. If hired on the first of the month, the insurance benefits will be effective that day. You may elect medical, vision, and/or dental coverage for yourself and dependents including your legal spouse, domestic partner or dependent children under the age of 26.

# General Enrollment Information

- When a life-changing event occurs (marriage, divorce, birth, etc.), you can make a mid-year change to your current benefit elections without waiting for the annual open enrollment period.

- Enrollment changes can only be made within 31 days of the qualifying event and must be consistent with the change in status. After the 31-day time frame, you are only able to change your elections during the annual open enrollment period.

# Benefit Glossary

The following definitions should help you understand your benefit plans. Remember, you have access to In-Network and Out-of-Network providers. Our Medical, Dental and Vision network providers have contracted rates that can be much lower than Out-of-Network providers. Your out of pocket expense may be lower by using In-Network providers.

**Preferred Provider Organization (PPO)** - A network of providers that has agreed to contracted rates with the insurance carrier. A PPO plan pays claims from In-Network and Out-of-Network providers. Members may see reduced out of pocket costs when utilizing In-Network providers.

**Health Reimbursement Arrangement (HRA)** - A plan used to administer reimbursements on qualified medical expenses that apply towards the deductible. The reimbursements are funded by the employer.

**Health Savings Account (HSA)** - A tax-free savings account that is owned by the employee. It can be used to pay for insurance deductibles and qualified out-of-pocket medical expenses. Deposits into the HSA can be made by the employee and employer. If adult children (non-tax dependent) are enrolled on the HSA plan, they may need to set up their own HSA.

**Calendar Year Deductible (CYD**) - The amount you pay before co-insurance is paid. You only need to meet your deductible once per calendar year.

**Out-of-Pocket-Maximum** - The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. This limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your co-payments, deductibles, co-insurance payments, out-of-network payments or other expenses toward this limit.

**Co-Insurance** - The percentage of cost-sharing between what you and the insurance company must pay, after any applicable deductible has been met.

**Co-pay** - The set dollar amount that you must pay to a provider when services are rendered.

**Outpatient** - A patient who receives treatment at a hospital or outpatient facility without being admitted overnight.

**Provider** - Any facility, person, or entity recognized for payment by the insurance company.

**Usual, Customary and Reasonable (UCR)** - The determined going rate for like services in the same area. The insurance companies co-insurance percentage that they pay is taken from the UCR amount for that service. You are responsible for your co-insurance percentage plus all of the amount that exceeds UCR. UCR is used only when services are provided by an Out-of-Network provider.

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# Your 2021 Monthly Benefit Plan Costs:

| 75% TO 100% FULL-TIME EMPLOYEES | | | | |
|---|---|---|---|---|
| **Plan Selected** | **Employee** | **Employee + Spouse** | **Employee + Family** | **Employee + Child(ren)** |
| Providence Option Advantage (Open Option) | $125.32 | $803.14 | $1,230.48 | $676.22 |
| Providence Personal Option (In-Network) | $22.21 | $575.81 | $924.84 | $472.14 |
| Providence HSA Plan | $90.75 | $503.55 | $772.62 | $423.62 |
| Kaiser Dental | $3.78 | $60.52 | $117.26 | $49.17 |
| Willamette Dental | $2.42 | $36.92 | $73.18 | $38.72 |
| Delta Dental | $2.97 | $47.47 | $101.08 | $63.07 |
| VSP Vision | $0.37 | $3.72 | $9.47 | $3.90 |

| 50% TO 74% PART-TIME EMPLOYEES | | | | |
|---|---|---|---|---|
| **Plan Selected** | **Employee** | **Employee + Spouse** | **Employee + Family** | **Employee + Child(ren)** |
| Providence Option Advantage (Open Option) | $281.16 | $1,328.04 | $2,076.88 | $1,132.01 |
| Providence Personal Option (In-Network) | $168.05 | $1,090.71 | $1,672.42 | $917.93 |
| Providence HSA Plan | $245.99 | $1,041.86 | $1,543.61 | $892.82 |
| Kaiser Dental | $15.13 | $90.78 | $166.43 | $75.64 |
| Willamette Dental | $9.67 | $55.67 | $104.02 | $58.07 |
| Delta Dental | $11.87 | $71.21 | $142.68 | $92.01 |
| VSP Vision | $1.48 | $5.94 | $13.61 | $6.18 |

# Medical and Prescription Drug Coverage

For 2021, OES is offering the following medical, prescription drug, and alternative care plans through Providence.

Please see page 4 for the 2021 employee contributions. The following is a brief summary of the medical plans. For more detailed information, please refer to your Providence Handbook.

| BENEFITS | PROVIDENCE PERSONAL OPTION (IN-NETWORK) | PROVIDENCE OPTION ADVANTAGE (OPEN OPTION) | PROVIDENCE HSA^ |
|---|---|---|---|
| **Provider Network** | **Participating Providers Only** | **In Network / Out of Network** | **In Network / Out of Network** |
| Lifetime Maximum | None | None | None |
| Calendar Year Deductible | $500 Individual*<br>$1,000 Family* | $250 Individual<br>$500 Family | $1,500 Individual<br>$3,000 Family |
| Out of Pocket Maximum** (Deductible, Coinsurance and Prescription Drug out-of-pocket costs all accumulate towards the out-of-pocket maximum) | $2,000 Individual*<br>$4,000 Family* | $2,000 Individual<br>$4,000 Family | $3,000 Individual<br>$6,000 Family |
| **Doctor Office Visits** | | | |
| Primary Care/Specialist | Primary Care: $15<br>Specialist: $25 | $15 / 40% (no ded) | 20% / 40% |
| Phone and Video Visits with Primary Care Provider, or, Providence ExpressCare Retail Health Clinics | $0 | $0 / Not covered | $0 / Not covered |
| Preventive Care | $0 | $0 / 40% (no ded) | $0 / 40% |
| Maternity Care:<br>Pre-natal care<br>Delivery and post-natal<br>Inpatient hospital/facility<br>Routine newborn nursery care | $0<br>$150 delivery (no ded)<br>30%<br>30% (no ded) | $0 / 40%<br>$150 delivery (no ded) / 40%<br>20% / 40%<br>20% (no ded) / 40% | 20% / 40% |
| Inpatient Hospital Visits | 30% | 20% / 40% | 20% / 40% |
| Lab/X-Ray and Imaging | 30% (no ded) | 20% (no ded) / 40% | 20% / 40% |
| Durable Medical Equipment | 30% | 20% / 40% | 20% / 40% |
| **Hospitalization** | | | |
| Inpatient | 30% | 20% / 40% | 20% / 40% |
| Outpatient Surgery | 30% | 20% / 40% | 20% / 40% |
| Emergency Room | $250 (no ded) | $250 (no ded) / $250 (no ded) | 20% / 20% |
| Urgent Care | $15 | $15 / 40% (no ded) | 20% / 40% |
| **Prescription Drug Co-pay^^** | | | |
| Tier 1 | $0 | $0 | 20% ($0 Preventive) /<br>Not covered |
| Tier 2 | $10 | $10 | 20% / Not covered |
| Tier 3 / Tier 4 | $30 | $30 | 20% / Not covered |
| Tier 5 / Tier 6 | $30 | $30 | 50% (not to exceed $200) /<br>Not covered |
| Mail Order | 2 copays for 90 day supply | 2 copays for 90 day supply | 20% / Not covered |
| **Alternative Care** | | | |
| Spinal Manipulation, Acupuncture and Massage Therapy | $15, $1,500 Annual Maximum | $15, $1,500 Annual Maximum | $25 (after ded) to $500 max |

* Deductible and out-of-pocket maximum after qualified credit of $1,000 per member through Health Reimbursement Arrangement.

** Premiums, penalties, copays or coinsurance for supplemental benefits, services not covered and fees above UCR are not included in the Out of Pocket Maximum. Even though you pay these expenses, they don't count toward the out-of-pocket limit.

^ Please note, with the exception of preventive care, all services under the HSA plan are subject to deductible.

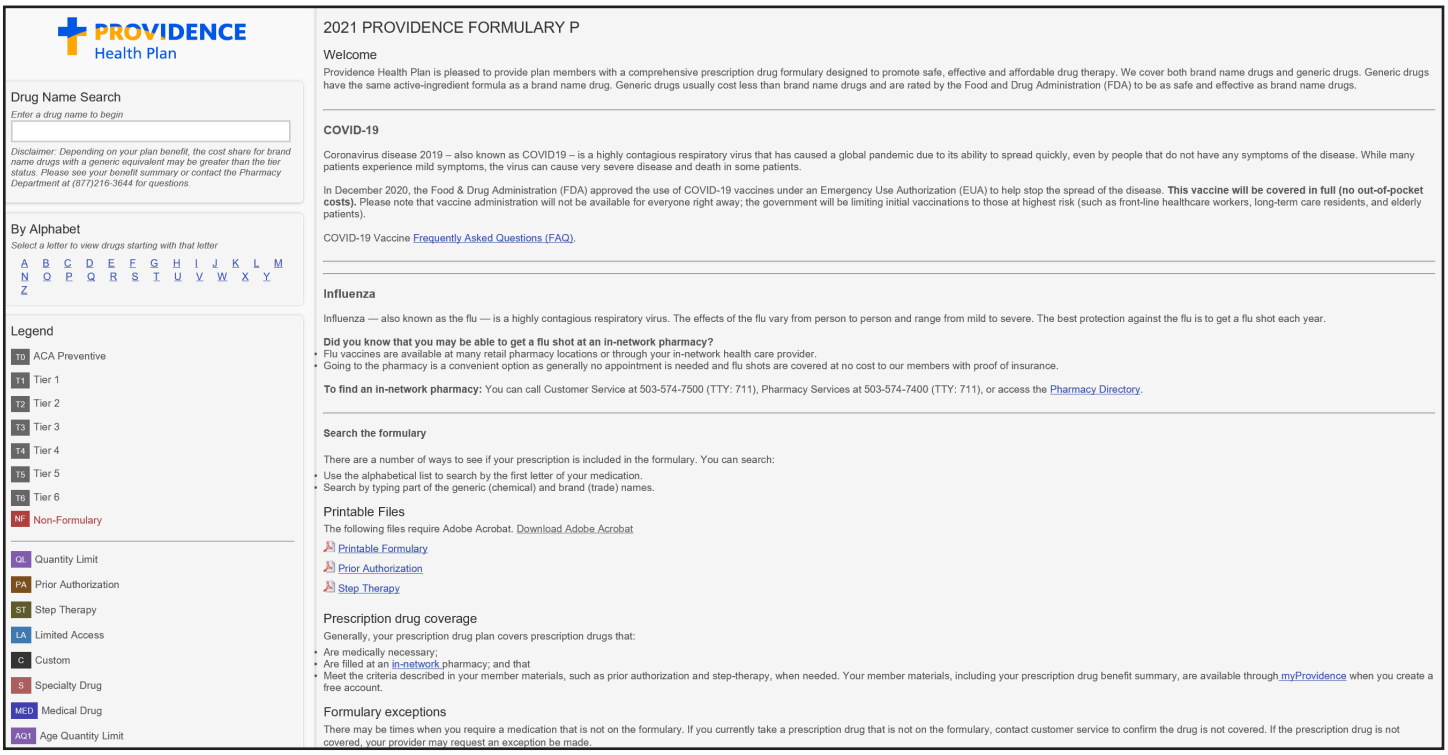
^^ To find out how a drug is covered under your plan, log into your Providence account to view the complete formulary and pharmacy information available online at https://www.providencehealthplan.com or call (503) 574-6595.

# Formulary P - Your Online Resource

Providence provides access for members to find out how a drug is covered under their plan with an online formulary tool. Be sure to select option P. The site has the following capabilities:

- Interactive formulary
- Search by medication name
- Find out if your prescription requires prior authorization or any other special considerations
- Search for alternative medications

The prescription drug formulary tool is most easily accessed through your MyProvidence online account.



PROVIDENCE Health Plan

Drug Name Search

*Enter a drug name to begin*

*Disclaimer: Depending on your plan benefit, the cost share for brand name drugs with a generic equivalent may be greater than the tier status. Please see your benefit summary or contact the Pharmacy Department at (877)216-3644 for questions.*

By Alphabet

*Select a letter to view drugs starting with that letter*

A B C D E F G H I J K L M N O P Q R S T U V W X Y Z

Legend

T0 ACA Preventive
T1 Tier 1
T2 Tier 2
T3 Tier 3
T4 Tier 4
T5 Tier 5
T6 Tier 6
NF Non-Formulary

QL Quantity Limit
PA Prior Authorization
ST Step Therapy
LA Limited Access
C Custom
S Specialty Drug
MED Medical Drug
AQT Age Quantity Limit

2021 PROVIDENCE FORMULARY P

Welcome

Providence Health Plan is pleased to provide plan members with a comprehensive prescription drug formulary designed to promote safe, effective and affordable drug therapy. We cover both brand name drugs and generic drugs. Generic drugs have the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand name drugs.

**COVID-19**

Coronavirus disease 2019 – also known as COVID19 – is a highly contagious respiratory virus that has caused a global pandemic due to its ability to spread quickly, even by people that do not have any symptoms of the disease. While many patients experience mild symptoms, the virus can cause very severe disease and death in some patients.

In December 2020, the Food & Drug Administration (FDA) approved the use of COVID-19 vaccines under an Emergency Use Authorization (EUA) to help stop the spread of the disease. **This vaccine will be covered in full (no out-of-pocket costs).** Please note that vaccine administration will not be available for everyone right away; the government will be limiting initial vaccinations to those at highest risk (such as front-line healthcare workers, long-term care residents, and elderly patients).

COVID-19 Vaccine Frequently Asked Questions (FAQ).

**Influenza**

Influenza — also known as the flu — is a highly contagious respiratory virus. The effects of the flu vary from person to person and range from mild to severe. The best protection against the flu is to get a flu shot each year.

**Did you know that you may be able to get a flu shot at an in-network pharmacy?**

- Flu vaccines are available at many retail pharmacy locations or through your in-network health care provider.
- Going to the pharmacy is a convenient option as generally no appointment is needed and flu shots are covered at no cost to our members with proof of insurance.

**To find an in-network pharmacy:** You can call Customer Service at 503-574-7500 (TTY: 711), Pharmacy Services at 503-574-7400 (TTY: 711), or access the Pharmacy Directory.

**Search the formulary**

There are a number of ways to see if your prescription is included in the formulary. You can search:

- Use the alphabetical list to search by the first letter of your medication.
- Search by typing part of the generic (chemical) and brand (trade) names.

Printable Files

The following files require Adobe Acrobat. Download Adobe Acrobat

Printable Formulary
Prior Authorization
Step Therapy

Prescription drug coverage

Generally, your prescription drug plan covers prescription drugs that:

- Are medically necessary;
- Are filled at an in-network pharmacy; and that
- Meet the criteria described in your member materials, such as prior authorization and step-therapy, when needed. Your member materials, including your prescription drug benefit summary, are available through myProvidence when you create a free account.

Formulary exceptions

There may be times when you require a medication that is not on the formulary. If you currently take a prescription drug that is not on the formulary, contact customer service to confirm the drug is not covered. If the prescription drug is not covered, your provider may request an exception be made.

## Providence Customer Service Phone Numbers

| | |
|---|---|
| Providence Resource Line | (503) 574-6595 |
| Providence Hospitals & Clinics | (503) 215-4300 |
| Providence Health Plan | (503) 574-7500 |
| myProvidence | (503) 216-6463 |
| MyChart | (833) 395-2035 |

# Health Reimbursement Arrangement (HRA) - Health Equity

## For OES employees enrolled on the Providence Personal Option In-Network plan

OES has a HRA in place to offset the deductible costs on our Providence Personal Option medical plan.

Here's how it works:

- Each employee enrolled on the Personal Option plan has an arrangement through the HRA that will reimburse up to $1,000 for each employee and up to $2,000 maximum per family.
- You are responsible for the first $500 of deductible expenses on the Personal Option plan per enrolled individual:
    - Any deductible expenses from $501 - $1,500 will be paid directly to your provider by Health Equity.

Eligible expenses include deductible expenses associated with the Personal Option medical plan. Copays and coinsurance are NOT eligible expenses.

- Funds run according to the plan year (January 1st – December 31st).
- Unused HRA dollars do not roll over from year to year.

# Health Savings Account (HSA) - Health Equity

## For OES employees enrolled on the Providence HSA Plan

Eligible employees who elect the HSA medical coverage will have a HSA automatically set up through Health Equity. A HSA can be used to pay for health care costs not covered by the Providence HSA qualified health plan. **OES will make a monthly contribution of $170** on behalf of all employees enrolled in this plan. If you currently have a HSA elsewhere, you can rollover your current HSA balance to Health Equity, if you wish. To do this please complete an HSA Rollover form and send to your previous bank as soon as possible.

To be eligible to open and contribute to a HSA you must be:

1. Enrolled in the Providence HSA qualified plan.
2. Not covered by any other health plan or insurance except those identified by the IRS. (Possibly including military, tribal, medivac - Please check with your tax advisor if you have any questions.)
3. Not enrolled in Medicare.
4. Not claimed as a dependent on another individual's tax return.
5. Not enrolled in a "Full" Health Flexible Spending Account (FSA). This includes a spouse's traditional Flex Plan.
6. You have not received Veterans Administration (VA) benefits within the past three months.

In addition to OES' contribution to your HSA, employees may make pre-tax payroll contributions up to the IRS maximums. The funds accumulated in your HSA are owned by you and are portable should you cease to be employed by OES. If you have single HSA coverage and are under the age of 55, you may (but are not required to) contribute up to **$1,560** into your HSA for 2021. If you have family HSA coverage and are under the age of 55, you may (but are not required to) contribute up to **$5,160** into your HSA for 2021. Please note total contributions (employee plus employer) cannot exceed **$3,600** for employees under age 55 with single HSA or **$7,200** for employees under age 55 with family HSA coverage for 2021 (not counting rollover amounts). An additional catch up contribution of **$1,000** applies if you are over 55 years of age.

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# Dental Benefits

OES offers dental plans through Kaiser, Willamette Dental and Delta Dental of Oregon. The Delta Dental plan offers a choice of in- and out-of-network providers. Kaiser and Willamette Dental require that you use providers from their network in order for benefits to be covered. Please see page 4 for the 2021 employee contributions. The following is a brief summary of the dental plans. For more detailed information, please refer to your Benefit Summary.

| BENEFITS | KAISER | WILLAMETTE DENTAL | DELTA DENTAL |
|---|---|---|---|
| **Provider Network** | **Kaiser Only** | **Willamette Dental Only** | **All Dentists, except for Kaiser** |
| Annual Deductible | $50 per person<br>$150 per family | None | $50 per person<br>$150 per family |
| Annual Maximum | None | None | $1,000 per person |
| **Services** | | | |
| Office Visit Copay | $10 | $15 | None |
| **Diagnostic/Preventive Services** | | | |
| Exams, cleanings, x-ray | 100% deductible waived | 100% | 100% deductible waived* |
| **Basic/Restorative Services** | | | |
| Fillings and simple extractions | 100% after deductible | Copay varies, based on service | 80% after deductible** |
| **Major Services** | | | |
| Oral Surgery, crowns, and dentures | 80% after deductible | Copay varies, based on service | 50% after deductible** |
| **Orthodontia Coverage** | | | |
| (Lifetime Maximum)<br>No waiting period | 50% to $3,000 for subscribers under 18 years of age.<br>Member copay required | $2,700 Member Copay Required | Not covered |

*Preventive services will not accumulate towards your annual maximum of $1,000.
**UCR is set at 90th Percentile.

# VSP Vision Program

OES offers vision coverage through Vision Service Plan (VSP). This plan offers coverage for both in-network and out-of-network providers. You are automatically enrolled in VSP when you elect medical coverage; however you may elect vision coverage only. Please see page 4 for the 2021 employee contributions. The following is a brief summary of the vision plan. For more detailed information, please refer to your VSP Benefits Summary.

**Please note, no ID card is required; your name and social security number are the identification used to access benefits.**

| COVERAGE | VSP PROVIDERS | NON-VSP PROVIDERS |
|---|---|---|
| **Exam** | | |
| Once every 12 months | $10 copay, then covered in full | Reimbursed up to $43 |
| **Frames** | | |
| Every 24 months | Covered up to $140 allowance; Covered up to $160 allowance for featured frame brands | Reimbursed up to $70 |
| **Lenses (Standard uncoated plastic)** | | |
| Single Vision (every 12 months) | $25 copay, then covered in full | Reimbursed up to $30 |
| Lined Bifocal (every 12 months) | $25 copay, then covered in full | Reimbursed up to $50 |
| Lined Trifocal (every 12 months) | $25 copay, then covered in full | Reimbursed up to $65 |
| **Contact Lenses** | | |
| In lieu of frames and lenses, every 12 months | Up to $60 copay for fitting and evaluation, the covered up to $140 allowance | Reimbursed up to $105 |
| **All other Materials** | | |
| Non-Rx Sunglasses, Accessories, Etc. | Discounts available | |

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# Group Life Insurance and AD&D - Sun Life

Group Term Life Benefits: This plan pays your beneficiary a specified benefit in the event of your death. Employees are covered at 1 x your annual earnings, to a maximum of $200,000. OES pays 100% of the cost of this benefit.

AD&D Benefits: This plan pays a benefit to your specified beneficiary in the event of your death from an accidental injury or a benefit to you in the event of your dismemberment from an accidental injury. You are covered at 1 x your annual earnings to a maximum of $200,000. OES pays 100% of the cost for this benefit.

# Supplemental (Voluntary) Life Insurance and AD&D - Sun Life

Voluntary Life Insurance: This plan allows you to elect coverage for yourself and your dependent family members. You may elect up to 5 x your annual earnings to a maximum of $500,000 in $10,000 increments. If you enroll during your initial eligibility period, no medical questions will be asked until your coverage exceeds $110,000. If you enroll after your initial eligibility period, you will need to complete an application and medical questionnaire and receive approval from Sun Life for coverage requested. Likewise, your spouse or domestic partner may elect up to 100% of your amount, in $5,000 increments. No medical questions are asked until coverage exceeds $25,000 if enrolling during the employee's initial eligibility period. Dependent children are also eligible for up to $10,000 of coverage in $2,000 increments.

Voluntary AD&D: This plan allows you to elect coverage for yourself and your dependent family members. AD&D is completely stand alone to the Optional Life. The employees can elect VAD&D even if they have not elected Optional Life, or can elect a different amount of VAD&D than their Optional Life election. You may elect up to 5 x your annual earnings to a maximum of $500,000 in $10,000 increments. Likewise, your spouse or domestic partner may elect up to 100% of your amount, in $5,000 increments. Dependent children are also eligible for up to $10,000 of coverage in $2,000 increments.

# Voluntary Long Term Care (LTC) - Transamerica

Voluntary LTC: This plan allows all employees the chance to enroll during the annual enrollment period in October. If you are a new employee, you become eligible 180 days after you begin employment and will qualify for simplified underwriting. You will be able to take advantage of the simplified enrollment forms; otherwise full medical underwriting will apply. Unlike traditional health insurance, long-term care insurance is designed to cover long-term services and support, including personal and custodial care in a variety of settings such as your home, a community organization, or other facility. Long-term care insurance policies reimburse policyholders a daily amount (up to a pre-selected limit) for services to assist them with activities of daily living such as bathing, dressing, or eating. You can select a range of care options and benefits that allow you to get the services you need, where you need them. For more information on this benefit, please contact HR.

# Long Term Disability - Sun Life

If you are disabled by an injury or illness, our LTD plan provides income benefits as long as you are physician-certified as disabled, or until retirement age, whichever is earlier. A monthly benefit of 60% of monthly salary to a maximum of $3,000 is payable after a 90-day waiting period. All employees are required to pay for their own disability coverage, but the benefits will be tax-free. Employee Paid Premium is 0.265% of monthly earnings to a maximum coverage of $3,000 monthly.

Example: Salary is $3,000/month = LTD premium of $7.95/month

# Assist America - Global Travel Services

OES provides you and your dependents with Assist America's Global Travel Services. Additional information is available at www.assistamerica.com. Coverage is in effect during all personal, vacation and business travel, domestic and international, as long as you are at least 100 miles from home. Unlike most travel policies, there are no dollar limitations in place for most of the following services:

- Medical Consultation, Evaluation & Referral
- Hospital Admission Guarantee
- Emergency Medical Evacuation
- Critical Care Monitoring
- Medically Supervised Repatriation
- Prescription Assistance
- Emergency Message Transmission
- Transportation to Join a Patient
- Care for Minor Children
- Return of Mortal Remains
- Lost Luggage or Document Assistance
- Interpreter & Legal Referral
- Pre-Trip Information

# Flexible Spending Account (FSA) - Health Equity

Flexible Spending Accounts (FSAs) provide you with an important tax advantage that can help you pay health care and dependent care expenses on a pre-tax basis. By anticipating your family's health care and dependent care costs for the next plan year, you can actually lower your taxable income.

The Internal Revenue Service allows FSAs as a means to provide a tax break to employees and their dependents. As an employee, you agree to set aside a portion of your pre-tax salary in an account, and that money is deducted from your paycheck over the course of the year. The amount you contribute to the FSA is not subject to Social Security (FICA), federal, state, or local income taxes - effectively adjusting your annual taxable salary. The taxes you pay each paycheck and collectively each plan year can be reduced significantly, depending on your tax bracket. As a result of the personal tax savings you realize, your spendable income will increase.

*How do FSAs Work?*
Your premiums will automatically be deducted pre-tax unless you elect otherwise. If you decide to enroll in the Health Care FSA or Dependent Care FSA, your contributions are taken out of each paycheck - before taxes - in equal installments throughout the plan year. These dollars are placed into your FSA into separate accounts (Health Care/Dependent Care). When you have an eligible health care expense, you can use your FSA debit card to pay for these expenses. In many cases, this automatic service may eliminate the need to file claims for reimbursement.

The Health Care FSA reimburses you for the full amount of your annual election (less any reimbursement already received), at any time during the plan year, regardless of the amount actually in your account. The Dependent Care FSA only reimburses you for the amount that is in your account at the time you make a claim.

*Is an FSA Right for Me?*

FSAs are beneficial for anyone who has out-of-pocket medical, dental, vision, hearing or dependent care expenses beyond what his or her insurance plan covers. At enrollment time, you will need to determine your plan year contribution amount. Estimate the expenses that you know you will incur during the year. These include out-of-pocket expenses for yourself and anyone claimed as a dependent on your taxes. If you have $100 or more in recurring or predictable expenses, an FSA can help you stretch your dollars.

Please keep in mind, that once you have enrolled in the plan, you cannot change the amount elected. If you experience a life event change during the plan year such as marriage, divorce, birth or adoption of a child, or a spouse/domestic partner losing or gaining other coverage, you could qualify to make changes to your benefit plans. You are required to notify HR within 31 days of the date of the event to make benefit plan changes. Failure to notify HR within 31 days may disqualify you and require you to wait until the next open enrollment to make plan changes.

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## Limited Health Care FSA - For Employees Participating in the OES HSA Medical Plan

Employees enrolled in the Providence HSA medical plan and participating in the Health Savings Account are only eligible to participate in the Limited Health Care Reimbursement Plan. Employees can elect to contribute pretax amounts to pay for unreimbursed Dental and Vision expenses up to the maximum annual amount of $2,750.

## Full Health Care FSA - For Employees not Enrolled in the OES HSA Medical Plan or any other HSA Qualified Plan

This account enables you to use pre-tax dollars to pay for certain IRS-approved unreimbursed health related expenses. An example of these health related expenses are deductibles, copays and coinsurance. The maximum contribution to this account is $2,750 annually.

It is important that you carefully and conservatively determine how much to annually contribute to your FSA because:

- You must incur expenses during the plan year. The plan year for this benefit is January 1, 2021 - December 31, 2021.
- You cannot change your annual contribution amount during the plan year except for certain changes in your family status.

***$500 Carryover Provision for Limited and Full Health Care FSA***

The plan year for the Health Care FSA is January 1, 2021 - December 31, 2021. If you do have remaining funds in your FSA account on December 31st, OES **has a $500 carry over provision for our Section 125 plan. If you have any unused dollars at the end of the plan year (December 31, 2021), you will be able to carry over up to $500 to be used between January 1 - December 31, 2022.**

## Dependent Care FSA

This account enables you to use pre-tax dollars toward qualified dependent care. The annual maximum amount you may contribute to the Dependent Care FSA per plan year is $5,000 or $2,500 if married but filing taxes separately.

## Eligible expenses

If you elect to contribute to the Dependent Care FSA, you may be reimbursed for:

- The cost of a child or adult dependent care
- The cost for an individual to provide care either in or out of your house
- Nursery schools and preschools (excluding kindergarten)

For these services to be eligible, they must be for the care of a tax-dependent child under age 13 who lives with you, or a tax-dependent parent, spouse or child who lives with you and is incapable of caring for himself or herself. The care must be needed so that you and your spouse can go to work. Care must be given during normal working hours - Saturday night babysitting does not qualify - and cannot be provided by another of your dependents.

The same rules regarding changes in enrollment for the Healthcare Spending Account apply to this plan.

**Flexible Spending Debit Card:** If you enroll in either the Healthcare FSA or Dependent Care FSA, you and your spouse are eligible for a flexible spending debit card. The debit card can be used to pay for out-of-pocket costs for eligible medical, dental, and vision expenses for you and your qualifying dependents. Although using the debit card can limit the number of receipts that you may need to submit to Health Equity, Health Equity may still require submission of receipts on certain claims. It is always good to keep your receipts in a safe place.

**You must re-enroll each year in the dependent care and healthcare spending accounts. Your share of dependent medical and dental premiums will be automatically deducted pre-tax, unless you elect otherwise.**

# Employee Assistance Program (EAP) 1-800-433-2320

OES makes available to you and your family the confidential services of Cascade Centers EAP. Trained counselors will work with you or your family members on personal relationships, workplace issues, substance abuse, emotional/mental health issues, wellness concerns and other problems. OES pays 100% for these benefits, including:

- Up to five face-to-face EAP counseling sessions per issue per family unit per contract year from licensed EAP professional counselors.
- 24/7 Crisis Hot Line
- Identity Theft Services: Employees and family members receive unlimited phone consultation for identity theft recovery, support, and prevention.
- Cascade Personal Wellness Program: Wellness coaches offer support, information and referrals as needed and provide phone and email access for help in dealing with the following issues:
    - o fitness and exercise
    - o weight management
    - o stress reduction
    - o smoking cessation
    - o sports performance
    - o life balance
    - o chronic conditions.
- Wellness tip sheets and other education materials are available to support you and your family members who wish to make changes in health behaviors.
- Health Risk Assessment (HRA). This can be accessed through the following websites: **www.wellcall.com,** or, **www.cascadecenters.com**. Cascade Centers can also be reached at **(503) 639-3009**. To use this service, employees and dependents must initially create an account using the company password "OES". They will then be able to set up a user name and password of their own choosing.

# Meal Program

During the academic year, employees enjoy one free meal during the work day, courtesy of OES.

# Extension Program

Extension Program Employees with children enrolled in the Lower School and Middle School may use the Extension Program Services for their children as follows:

1. In Lower School, the first eight hours of drop-in home base per month per child is at no charge during the academic year. Please provide 24 hours of notice. Unused hours are not bankable. In the case of two parents who work at OES, this benefit is per child rather than per parent.

2. The Middle School Extension Drop-in Program is free of charge.

3. Employees receive 20% off after school classes. After school class discounts are automatically applied by the Extension Office. If the employee receives financial aid, the benefit will be increased to a 50% discount automatically applied by the Extension Office. Private lessons do not apply.

4. Employees that work during the summer receive 50% off summer classes. Employees that do not work in the summer receive 20% off summer classes. Summer class discounts should be applied by employees during the registration process by applying a waiver code at check-out. Waiver codes will be issued by contacting the Extension Office. Summer flexible tuition opportunities and procedures will be announced each year. Private lessons do not apply.

Contact the Extension Program at extension@oes.edu for more information.

# Matching Retirement Plan - AIG

OES offers a 403(b) retirement plan with a generous employer match through VALIC. The School contributes 7.5% when you contribute at least 5% of your gross monthly income to the plan and 4% when you contribute at least 2.5%.

Regular employees who have completed one hour of service and work at least 1000 hours per calendar year are eligible for enrollment in the plan.

Investment advisors Cecile Nguyen (Cecile.Nguyen@aig.com) and Thomas Grover (thomas.grover@aig.com) can help you enroll anytime online at www.VALIC.com.

Oregon Episcopal School

# Paid Leave Benefits

**Please refer to Employee Handbook for more information.**
**Bereavement Leave** – 5 working days for immediate family
**Jury Duty** – Paid time off to fulfill jury duty obligations
**Holidays** – Recognized holidays are paid if it is your scheduled work day
**Sick Leave –** Full Time Faculty: 10 days per year  Full Time Staff: 12 days per year
Sick Leave is Pro-Rated for Eligible Part-Time Employees
**Personal Days –** Two days per year (July-June)
**Vacation – Year Round Staff Only**  Full-Time 1st Year 10 days per year
Vacation is Pro-rated for Eligible Part-Time Employees
**Extended Sick Leave –** Provides 50% salary under specific conditions
**Parental Leave -** Up to 2 weeks paid leave for eligible employees

# Contacts

If you have questions, contact the appropriate entity or person listed in the following directory.

| BENEFITS CONTACT INFORMATION | | | |
|---|---|---|---|
| **Benefit** | **Provider/Contact** | **Phone** | **Email/Website** |
| **Human Resources** | Veena Iyengar | (503) 416-9482 | iyengarve@oes.edu |
| | Tammy Stotik | (503) 416-9382 | stotikt@oes.edu |
| **Health** | Providence Health | (503) 574-7500 | www.providence.org/healthplans |
| **Dental** | Willamette Dental | (503) 952-2000 | www.willamettedental.com |
| | Kaiser Permanente | (503) 813-2000 | www.kaiserpermanente.org |
| | Delta Dental | (877) 277-7280 | www.modahealth.com |
| **Vision** | VSP | (800) 877-7195 | www.vsp.com |
| **Life, AD&D, Long Term Disability** | Sun Life | (800) SUN-LIFE (786-5433) | www.sunlife.com |
| **Long Term Care** | Transamerica | (800) 338-0257 | www.transamerica.com |
| **HSA / HRA Administrator, Flexible Spending Account (FSA)** | Health Equity | (877) 694-3942 | www.healthequity.com |
| **Retirement** | Cecile Nguyen<br>Bob Davee | (503) 867-3736<br>(971) 219-0235 | Cecile.Nguyen@aig.com<br>Bob.Davee@aig.com |
| **EAP/Wellness** | Cascade Centers | (503) 639-3009 | www.cascadecenters.com |
| **Global Travel Services** | Assist America | (800) 304-4585 | www.assistamerica.com |
| **OES Benefits Website (Enrollment Forms and Documents)** | Veena Iyengar | (503) 416-9482 | www.oes.edu/contacts/employment.html |
| **Benefits Questions** | benefits@oes.edu | | |

# Special Enrollment Rights

If you are declining enrollment for yourself or your dependents due to other coverage, you may be able to enroll later if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing towards it) if you request enrollment within 31 days. If you have a new dependent as a result of marriage, birth, adoption or placement for adoption, you may also be able to enroll later if you request enrollment within 31 days of the event. To request special enrollment or obtain more information about your Special Enrollment Rights, contact HR. If you do not have a certificate, but you do have prior health coverage, we will help you obtain one from your prior plan. There are also other ways of proving you have creditable coverage. Please contact Human Resources if you need help demonstrating creditable coverage.

# Privacy Policy

You are entitled to receive an explanation of how your personally identifiable health information will be used and disclosed. For example, a physician or hospital is required to provide you with a Notice of Privacy Practices at your first visit. You will be required to sign an acknowledgement indicating that you received the Notice of Privacy Practices. If you have health insurance coverage, the insurance company or health plan will also provide you with a Notice of Privacy Practices immediately after you are enrolled in the plan. It is important that you read the Notice of Privacy Practices in order to understand your rights and know who to contact if you feel your privacy rights have been violated. Contact Human Resources for a copy of our health plans' Notice of Privacy Practices.

# Women's Health and Cancer Rights Act

Your plan, as required by the Women's Health and Cancer Rights Act of 1998, provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema).

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,500** per person / **$3,000** per family (**2** or more). | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met. |
| **Are there services covered before you meet your deductible?** | **Yes.** Office visits, most preventive care, emergency and urgent care services. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | **No** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$3,000** per person / **$6,000** per family (**2** or more). | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered. | Even though you pay these expenses, they don't count toward the out–of–pocket limit. |
| **Will you pay less if you use a network provider?** | **Yes.** See www.ProvidenceHealthPlan.com/providerdirectory or call 1-800-878-4445 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | **No.** | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay/visit | Not covered | Deductible does not apply. Some services such as labs and x-ray will include additional member costs. Phone and video visits are covered in full in-network. |
| | Specialist visit | $25 copay/visit | Not covered | Deductible does not apply. Some services such as labs and x-ray will include additional member costs. |
| | Preventive care/screening/ immunization | No charge | Not covered | Deductible does not apply. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | Not covered | Deductible does not apply. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | Not covered | Deductible does not apply.<br>Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.ProvidenceHealthPlan.com | Tier 1 | No charge | Not covered | ACA Preventive drugs are covered in full in-network.<br><br>Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).<br><br>Prior authorization may apply.<br><br>If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay.<br><br>Specialty drugs can only be purchased at a participating specialty pharmacy. |
| | Tier 2 | $10 copay retail<br>$20 copay mail order | Not covered | |
| | Tier 3 | $30 copay retail<br>$60 copay mail order | Not covered | |
| | Tier 4 | $30 copay retail<br>$60 copay mail order | Not covered | |
| | Tiers 5&6 - Specialty drug | $30 copay retail | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory surgery center: 20% coinsurance Hospital-based facility: 30% coinsurance | Not covered | Prior authorization required. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | |
| **If you need immediate medical attention** | Emergency room care | $250 copay | $250 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 | 30% coinsurance | 30% coinsurance | ——————none—————— |
| | Urgent care | $25 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) | 30% coinsurance | Not covered | Prior authorization required. |
| | Physician/surgeon fees | 30% coinsurance | Not covered | |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay/ provider office visit<br>30% 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. |
| | Inpatient services | 30% coinsurance | Not covered | |
| **If you are pregnant** | Office visits | No charge | Not covered | Deductible does not apply. |
| | Childbirth/delivery professional services | $150 copay | Not covered | Deductible does not apply. Copay applies to provider delivery charges. |
| | Childbirth/delivery facility services | 30% coinsurance | Not covered | ————————none———————— |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | Not covered | ————————none———————— |
| | Rehabilitation services | 30% coinsurance | Not covered | Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network to outpatient physical therapy. Limits do not apply to Mental Health Services. |
| | Habilitation services | 30% coinsurance | Not covered | Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network to outpatient physical therapy. Limits do not apply to Mental Health Services. |
| | Skilled nursing care | 30% coinsurance | Not covered | Prior authorization required. Coverage is limited to 60 days per calendar year. |
| | Durable medical equipment | 30% coinsurance | Not covered | Deductible does not apply to diabetes supplies. |
| | Hospice services | No charge | Not covered | Deductible does not apply. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Covered up to $45 | Deductible does not apply.<br>Limited to 1 exam every 12 months. |
| | Children's glasses | Not covered | Not covered | No coverage for glasses. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-up. |

## 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.)**

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- Weight loss programs

**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 (limits apply)
- Chiropractic care (limits apply)
- Hearing Aids (limits apply)
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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 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://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx
- E-mail at: cp.ins@state.or.us

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

———————————*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*———————————

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *copayment* | $25 |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $150 |
| Coinsurance | $2,850 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *copayment* | $25 |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $0 |
| Copayments | $560 |
| Coinsurance | $558 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,174** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *copayment* | $25 |
| Hospital (facility) *coinsurance* | 30% |
| Other *coinsurance* | 30% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,960** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $970 |
| Copayments | $75 |
| Coinsurance | $490 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,535** |

The plan would be responsible for the other costs of these EXAMPLE covered services

## 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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល 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).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

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)

**The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$250**/per person **$500**/per family (**2** or more). | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the policy, they have to meet their own individual deductible until the overall family deductible amount has been met. |
| **Are there services covered before you meet your deductible?** | Yes. Office visits, most preventive care, emergency and urgent care services. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | **No.** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$2,000**/per person **$4,000**/per family (**2** or more). | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered, fees above UCR. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | **Yes.** See ProvidenceHealthPlan.com/findaprovider or call 1-800-878-4445 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services. |
| **Do you need a referral to see a specialist?** | **No.** | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $15 copay/visit | 40% coinsurance | Deductible does not apply. Some services such as lab and x-ray will include additional member costs. Phone and video visits are covered in full in-network. |
| | Specialist visit | $15 copay/visit | 40% coinsurance | Deductible does not apply. Some services such as lab and x-ray will include additional member costs. |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance | Deductible does not apply. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | Deductible does not apply in-network. |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Deductible does not apply in-network. Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.ProvidenceHealthPlan.com | Tier 1 | No charge | Not covered | ACA Preventive drugs are covered in full in-network.<br><br>Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).<br><br>Prior authorization may apply.<br><br>If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay.<br><br>Specialty drugs can only be purchased at a participating specialty pharmacy. |
| | Tier 2 | $10 copay retail<br>$20 copay mail order | Not covered | |
| | Tier 3 | $30 copay retail<br>$60 copay mail order | Not covered | |
| | Tier 4 | $30 copay retail<br>$60 copay mail order | Not covered | |
| | Tiers 5&6 - Specialty drug | $30 copay retail | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory surgery center: 10% coinsurance Hospital-based facility: 20% coinsurance | 40% coinsurance | Prior authorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $250 copay | $250 copay | Deductible does not apply.<br>For emergency medical conditions only. If admitted to hospital from emergency room, copayment is waived. All services subject to inpatient benefits. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ——————none—————— |
| | Urgent care | $15 copay/visit | 40% coinsurance | Deductible does not apply.<br>Some services will include additional member costs. |

For more information about limitations and exceptions, see the plan or policy document at www.ProvidenceHealthPlan.com

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Prior authorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | $15 copay/provider office visit<br>20% coinsurance all other services | 40% coinsurance | 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. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | No charge | 40% coinsurance | Deductible does not apply in-network. |
| | Childbirth/delivery professional services | $150 copay | 40% coinsurance | Copay applies to provider delivery charges. Deductible does not apply in-network. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network. Limits do not apply to Mental Health Services. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Deductible does not apply in-network. Limits do not apply to Mental Health Services. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Prior authorization required. Coverage is limited to 60 days per calendar year. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Deductible does not apply to diabetes supplies from in-network providers. |
| | Hospice services | No charge | No charge | Deductible does not apply. |

For more information about limitations and exceptions, see the plan or policy document at www.ProvidenceHealthPlan.com

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| Children's eye exam | Children's eye exam | No charge | Covered up to $45 | Deductible does not apply.<br>Limited to 1 exam every 12 months. |
| | Children's glasses | Not covered | Not covered | No coverage for glasses. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-up. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (limits apply)
- Chiropractic care (limits apply)
- Hearing Aids (limits apply)
- Non-emergency care when traveling outside the U.S. See www.ProvidenceHealthPlan.com
- Routine eye care (Adult)

For more information about limitations and exceptions, see the plan or policy document at www.ProvidenceHealthPlan.com

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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 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://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx
- E-mail at: cp.ins@state.or.us

**Does this plan provide Minimum Essential Coverage?** **Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards?** **Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

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*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist *copayment* | $15 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $0 |
| Coinsurance | $1,750 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$2,060** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist *copayment* | $15 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $107 |
| Copayments | $540 |
| Coinsurance | $372 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$1,075** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $250 |
| Specialist *copayment* | $15 |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,960** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $250 |
| Copayments | $45 |
| Coinsurance | $326 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$621** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## 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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល 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).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

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

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| Important Questions | Answers | Why This Matters: |
|---|---|---|
| **What is the overall deductible?** | **$1,500**/per person **$3,000**/per family (**2** or more). | Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family member on the policy, the overall family deductible must be met before the plan begins to pay. |
| **Are there services covered before you meet your deductible?** | **Yes.** Most preventive care services in-network. | This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible. See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/. |
| **Are there other deductibles for specific services?** | **No** | You don't have to meet deductibles for specific services. |
| **What is the out-of-pocket limit for this plan?** | **$3,000**/per person **$6,000**/per family (**2** or more). | The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan, they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met. |
| **What is not included in the out-of-pocket limit?** | Premiums, penalties, copays or coinsurance for Supplemental Benefits, services not covered, fees above UCR. | Even though you pay these expenses, they don't count toward the out-of-pocket limit. |
| **Will you pay less if you use a network provider?** | **Yes.** See ProvidenceHealthPlan.com/findaprovider or call 1-800-878-4445 for a list of network providers. | This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Be aware your network provider might use an out-of-network provider for some services (such as lab work). Check with your providers before you get services. |
| **Do you need a referral to see a specialist?** | **No.** | You can see the specialist you choose without a referral. |

All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
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| | Specialist visit | 20% coinsurance | 40% coinsurance | Some services will include additional member costs. |
| | Preventive care/screening/ immunization | No charge | 40% coinsurance | Deductible does not apply in-network. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | Imaging (CT/PET scans, MRIs) | 20% coinsurance | 40% coinsurance | Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| **If you need drugs to treat your illness or condition** More information about **prescription drug coverage** is available at www.ProvidenceHealthPlan.com | Tier 1 | 20% coinsurance retail and mail order | Not covered | Deductible does not apply to Safe Harbor drugs.<br>ACA Preventive drugs are covered in full in-network.<br>Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription).<br>Prior authorization may apply.<br>Specialty drugs can only be purchased at a participating specialty pharmacy. |
| | Tier 2 | 20% coinsurance retail and mail order | Not covered | |
| | Tier 3 | 20% coinsurance retail and mail order | Not covered | |
| | Tier 4 | 20% coinsurance retail and mail order | Not covered | |
| | Tiers 5&6 - Specialty drug | 50% coinsurance up to $200 retail | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory surgery center: 10% coinsurance Hospital-based facility: 20% coinsurance | 40% coinsurance | Prior authorization required. |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | 20%coinsurance | 20%coinsurance | For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits. |
| | Emergency medical transportation | 20% coinsurance | 20% coinsurance | ——————none—————— |
| | Urgent care | 20% coinsurance | 40% coinsurance | Some services will include additional member costs. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 20% coinsurance | 40% coinsurance | Prior authorization required. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
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| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Physician/surgeon fees | 20% coinsurance | 40% coinsurance | |
| **If you need mental health, behavioral health, or substance abuse services** | Outpatient services | 20% coinsurance | 40% coinsurance | All services except provider office visits must be prior authorized. See your benefit summary for ABA services. |
| | Inpatient services | 20% coinsurance | 40% coinsurance | |
| **If you are pregnant** | Office visits | No charge | 40% coinsurance | Deductible does not apply to in-network prenatal care. |
| | Childbirth/delivery professional services | 20% coinsurance | 40% coinsurance | Coinsurance applies to provider delivery charges. |
| | Childbirth/delivery facility services | 20% coinsurance | 40% coinsurance | ——————none—————— |
| **If you need help recovering or have other special health needs** | Home health care | 20% coinsurance | 40% coinsurance | ——————none—————— |
| | Rehabilitation services | 20% coinsurance | 40% coinsurance | Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services. |
| | Habilitation services | 20% coinsurance | 40% coinsurance | Inpatient services: coverage limited to 30 days per calendar year. Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services. |
| | Skilled nursing care | 20% coinsurance | 40% coinsurance | Prior authorization required. Coverage is limited to 60 days per calendar year. |
| | Durable medical equipment | 20% coinsurance | 40% coinsurance | Deductible does not apply to diabetes supplies from in-network providers. |

| Common Medical Event | Services You May Need | What You Will Pay | | Limitations, Exceptions, & Other Important Information |
|---|---|---|---|---|
| | | Network Provider (You will pay the least) | Out-of-Network Provider (You will pay the most) | |
| | Hospice services | No charge | No charge | ——————none—————— |
| **If your child needs dental or eye care** | Children's eye exam | No charge | Covered up to $45 | Deductible does not apply.<br>Limited to 1 exam every 12 months. |
| | Children's glasses | Not covered | Not covered | No coverage for glasses. |
| | Children's dental check-up | Not covered | Not covered | No coverage for dental check-up. |

## Excluded Services & Other Covered Services:

**Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)**

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental check-up (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- Weight loss programs

**Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)**

- Acupuncture (limits apply)
- Chiropractic care (limits apply)
- Hearing Aids (limits apply)
- Non-emergency care when traveling outside the U.S. See www.ProvidenceHealthPlan.com
- Routine eye care (Adult)

**Your Rights to Continue Coverage:** There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance Marketplace. For more information about the Marketplace, visit www.HealthCare.gov or call 1-800-318-2596.

**Your Grievance and Appeals Rights:** There are agencies that can help if you have a complaint against your plan for a denial of a claim. This complaint is called a grievance or appeal. For more information about your rights, look at the explanation of benefits you will receive for that medical claim. Your plan documents also provide complete information to submit a claim, appeal, or a grievance for any reason to your plan. For more information about your rights, this notice, or assistance, 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 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://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx
- E-mail at: cp.ins@state.or.us

**Does this plan provide Minimum Essential Coverage? Yes**

If you don't have Minimum Essential Coverage for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

**Does this plan meet the Minimum Value Standards? Yes**

If your plan doesn't meet the Minimum Value Standards, you may be eligible for a premium tax credit to help you pay for a plan through the Marketplace.

*To see examples of how this plan might cover costs for a sample medical situation, see the next section.*

## About these Coverage Examples:

**This is not a cost estimator.** Treatments shown are just examples of how this plan might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your providers charge, and many other factors. Focus on the cost sharing amounts (deductibles, copayments and coinsurance) and excluded services under the plan. Use this information to compare the portion of costs you might pay under different health plans. Please note these coverage examples are based on self-only coverage.

### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *coinsurance* | 20% |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Specialist office visits *(prenatal care)*
Childbirth/Delivery Professional Services
Childbirth/Delivery Facility Services
Diagnostic tests *(ultrasounds and blood work)*
Specialist visit *(anesthesia)*

| **Total Example Cost** | **$12,800** |
|---|---|

**In this example, Peg would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $0 |
| Coinsurance | $1,500 |
| *What isn't covered* | |
| Limits or exclusions | $60 |
| **The total Peg would pay is** | **$3,060** |

### Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *coinsurance* | 20% |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Primary care physician office visits *(including disease education)*
Diagnostic tests *(blood work)*
Prescription drugs
Durable medical equipment *(glucose meter)*

| **Total Example Cost** | **$7,400** |
|---|---|

**In this example, Joe would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $0 |
| Coinsurance | $1,437 |
| *What isn't covered* | |
| Limits or exclusions | $55 |
| **The total Joe would pay is** | **$2,992** |

### Mia's Simple Fracture
(in-network emergency room visit and follow up care)

| | |
|---|---|
| The plan's overall deductible | $1,500 |
| Specialist *coinsurance* | 20% |
| Hospital (facility) *coinsurance* | 20% |
| Other *coinsurance* | 20% |

**This EXAMPLE event includes services like:**
Emergency room care *(including medical supplies)*
Diagnostic test *(x-ray)*
Durable medical equipment *(crutches)*
Rehabilitation services *(physical therapy)*

| **Total Example Cost** | **$1,960** |
|---|---|

**In this example, Mia would pay:**

| *Cost Sharing* | |
|---|---|
| Deductibles | $1,500 |
| Copayments | $0 |
| Coinsurance | $385 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Mia would pay is** | **$1,885** |

The plan would be responsible for the other costs of these EXAMPLE covered services.

## 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៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល 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).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

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)

## Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit **www.healthcare.gov**.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or **www.insurekidsnow.gov** to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at **www.askebsa.dol.gov** or call **1-866-444-EBSA (3272)**.

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**If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2021. Contact your State for more information on eligibility –**

| **ALABAMA – Medicaid** | **COLORADO – Health First Colorado (Colorado's Medicaid Program) & Child Health Plan Plus (CHP+)** |
|---|---|
| Website: http://myalhipp.com/<br>Phone: 1-855-692-5447 | Health First Colorado Website: https://www.healthfirstcolorado.com/<br>Health First Colorado Member Contact Center: 1-800-221-3943/ State Relay 711<br>CHP+: https://www.colorado.gov/pacific/hcpf/child-health-plan-plus<br>CHP+ Customer Service: 1-800-359-1991/ State Relay 711<br>Health Insurance Buy-In Program (HIBI): https://www.colorado.gov/pacific/hcpf/health-insurance-buy-program<br>HIBI Customer Service: 1-855-692-6442 |
| **ALASKA – Medicaid** | **FLORIDA – Medicaid** |
| The AK Health Insurance Premium Payment Program<br>Website: http://myakhipp.com/<br>Phone: 1-866-251-4861<br>Email: CustomerService@MyAKHIPP.com<br>Medicaid Eligibility: http://dhss.alaska.gov/dpa/Pages/medicaid/default.aspx | Website: https://www.flmedicaidtplrecovery.com/flmedicaidtplrecovery.com/hipp/index.html<br>Phone: 1-877-357-3268 |
| **ARKANSAS – Medicaid** | **GEORGIA – Medicaid** |
| Website: http://myarhipp.com/<br>Phone: 1-855-MyARHIPP (855-692-7447) | Website: https://medicaid.georgia.gov/health-insurance-premium-payment-program-hipp<br>Phone: 678-564-1162 ext 2131 |
| **CALIFORNIA – Medicaid** | **INDIANA – Medicaid** |

| | |
|---|---|
| Website:<br>Health Insurance Premium Payment (HIPP) Program<br>http://dhcs.ca.gov/hipp<br>Phone: 916-445-8322<br>Email: hipp@dhcs.ca.gov | Healthy Indiana Plan for low-income adults 19-64<br>Website: http://www.in.gov/fssa/hip/<br>Phone: 1-877-438-4479<br>All other Medicaid<br>Website: https://www.in.gov/medicaid/<br>Phone 1-800-457-4584 |

| **IOWA – Medicaid and CHIP (Hawki)** | **MONTANA – Medicaid** |
|---|---|
| Medicaid Website:<br>https://dhs.iowa.gov/ime/members<br>Medicaid Phone: 1-800-338-8366<br>Hawki Website:<br>http://dhs.iowa.gov/Hawki<br>Hawki Phone: 1-800-257-8563<br>HIPP Website:<br>https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hipp<br>HIPP Phone: 1-888-346-9562 | Website:<br>http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP<br>Phone: 1-800-694-3084 |
| **KANSAS – Medicaid** | **NEBRASKA – Medicaid** |
| Website: https://www.kancare.ks.gov/<br>Phone: 1-800-792-4884 | Website: http://www.ACCESSNebraska.ne.gov<br>Phone: 1-855-632-7633<br>Lincoln: 402-473-7000<br>Omaha: 402-595-1178 |
| **KENTUCKY – Medicaid** | **NEVADA – Medicaid** |
| Kentucky Integrated Health Insurance Premium Payment Program (KI-HIPP) Website:<br>https://chfs.ky.gov/agencies/dms/member/Pages/kihipp.aspx<br>Phone: 1-855-459-6328<br>Email: KIHIPP.PROGRAM@ky.gov<br><br>KCHIP Website:<br>https://kidshealth.ky.gov/Pages/index.aspx<br>Phone: 1-877-524-4718<br><br>Kentucky Medicaid Website: https://chfs.ky.gov | Medicaid Website: http://dhcfp.nv.gov<br>Medicaid Phone: 1-800-992-0900 |
| **LOUISIANA – Medicaid** | **NEW HAMPSHIRE – Medicaid** |
| Website: www.medicaid.la.gov or www.ldh.la.gov/lahipp<br>Phone: 1-888-342-6207 (Medicaid hotline) or 1-855-618-5488 (LaHIPP) | Website: https://www.dhhs.nh.gov/oii/hipp.htm<br>Phone: 603-271-5218<br>Toll free number for the HIPP program: 1-800-852-3345, ext 5218 |
| **MAINE – Medicaid** | **NEW JERSEY – Medicaid and CHIP** |
| Enrollment Website:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: 1-800-442-6003<br>TTY: Maine relay 711<br><br>Private Health Insurance Premium Webpage:<br>https://www.maine.gov/dhhs/ofi/applications-forms<br>Phone: -800-977-6740.<br>TTY: Maine relay 711 | Medicaid Website:<br>http://www.state.nj.us/humanservices/dmahs/clients/medicaid/<br>Medicaid Phone: 609-631-2392<br>CHIP Website: http://www.njfamilycare.org/index.html<br>CHIP Phone: 1-800-701-0710 |
| **MASSACHUSETTS – Medicaid and CHIP** | **NEW YORK – Medicaid** |
| Website: https://www.mass.gov/info-details/masshealth-premium-assistance-pa<br><br>Phone: 1-800-862-4840 | Website:<br>https://www.health.ny.gov/health_care/medicaid/<br>Phone: 1-800-541-2831 |
| **MINNESOTA – Medicaid** | **NORTH CAROLINA – Medicaid** |

| | |
|---|---|
| Website:<br>https://mn.gov/dhs/people-we-serve/children-and-families/health-care/health-care-programs/programs-and-services/other-insurance.jsp<br>Phone: 1-800-657-3739 | Website: https://medicaid.ncdhhs.gov/<br>Phone: 919-855-4100 |
| **MISSOURI – Medicaid** | **NORTH DAKOTA – Medicaid** |
| Website:<br>http://www.dss.mo.gov/mhd/participants/pages/hipp.htm<br>Phone: 573-751-2005 | Website:<br>http://www.nd.gov/dhs/services/medicalserv/medicaid/<br>Phone: 1-844-854-4825 |
| **OKLAHOMA – Medicaid and CHIP** | **UTAH – Medicaid and CHIP** |
| Website: http://www.insureoklahoma.org<br>Phone: 1-888-365-3742 | Medicaid Website: https://medicaid.utah.gov/<br>CHIP Website: http://health.utah.gov/chip<br>Phone: 1-877-543-7669 |
| **OREGON – Medicaid** | **VERMONT– Medicaid** |
| Website:<br>http://healthcare.oregon.gov/Pages/index.aspx<br>http://www.oregonhealthcare.gov/index-es.html<br>Phone: 1-800-699-9075 | Website: http://www.greenmountaincare.org/<br>Phone: 1-800-250-8427 |
| **PENNSYLVANIA – Medicaid** | **VIRGINIA – Medicaid and CHIP** |
| Website:<br>https://www.dhs.pa.gov/providers/Providers/Pages/Medical/HIPP-Program.aspx<br>Phone: 1-800-692-7462 | Website: https://www.coverva.org/hipp/<br>Medicaid Phone: 1-800-432-5924<br>CHIP Phone: 1-855-242-8282 |
| **RHODE ISLAND – Medicaid and CHIP** | **WASHINGTON – Medicaid** |
| Website: http://www.eohhs.ri.gov/<br>Phone: 1-855-697-4347, or 401-462-0311 (Direct RIte Share Line) | Website: https://www.hca.wa.gov/<br>Phone: 1-800-562-3022 |
| **SOUTH CAROLINA – Medicaid** | **WEST VIRGINIA – Medicaid** |
| Website: https://www.scdhhs.gov<br>Phone: 1-888-549-0820 | Website: http://mywvhipp.com/<br>Toll-free phone: 1-855-MyWVHIPP (1-855-699-8447) |
| **SOUTH DAKOTA - Medicaid** | **WISCONSIN – Medicaid and CHIP** |
| Website: http://dss.sd.gov<br>Phone: 1-888-828-0059 | Website:<br>https://www.dhs.wisconsin.gov/badgercareplus/p-10095.htm<br>Phone: 1-800-362-3002 |
| **TEXAS – Medicaid** | **WYOMING – Medicaid** |
| Website: http://gethipptexas.com/<br>Phone: 1-800-440-0493 | Website:<br>https://health.wyo.gov/healthcarefin/medicaid/programs-and-eligibility/<br>Phone: 1-800-251-1269 |

To see if any other states have added a premium assistance program since January 31, 2021, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
**www.dol.gov/agencies/ebsa**
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
**www.cms.hhs.gov**
1-877-267-2323, Menu Option 4, Ext. 61565

**Paperwork Reduction Act Statement**

According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The Department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

The public reporting burden for this collection of information is estimated to average approximately seven minutes per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Employee Benefits Security Administration, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 1210-0137.

OMB Control Number 1210-0137 (expires 1/31/2023)

# Important Notice from Oregon Episcopal School Group Health Plan About Your Prescription Drug Coverage and Medicare

**Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with Oregon Episcopal School Group Health Plan and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.**

**There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:**

1. **Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.**

2. **Oregon Episcopal School Group Health Plan has determined that the prescription drug coverage offered is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.**

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## When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from October 15 to December 7.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

## What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current Oregon Episcopal School Group Health Plan coverage may or may not be affected.

If you do decide to join a Medicare drug plan and drop your current Oregon Episcopal School Group Health Plan coverage, be aware that you and your dependents may or may not be able to get this coverage back.

## When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with Oregon Episcopal School and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

## For More Information About This Notice Or Your Current Prescription Drug Coverage…

Contact the person listed below for further information. **NOTE:** You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through Oregon Episcopal School Group Health Plan changes. You also may request a copy of this notice at any time.

# For More Information About Your Options Under Medicare Prescription Drug Coverage…

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

**Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).**

| | |
|---|---|
| Date: | October 1, 2020 |
| Name of Entity/Sender: | Oregon Episcopal School / Human Resources |
| Address: | 6300 SW Nicol Road, Portland, OR 97223 |
| Phone Number: | 503-416-9382 |



According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0990. The time required to complete this information collection is estimated to average 8 hours per response initially, including the time to review instructions, search existing data resources, gather the data needed, and complete and review the information collection. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

# NOTICE OF PRIVACY PRACTICES

**Oregon Episcopal School**
**6300 SW Nicol Road**
**Portland, OR 97223**

***THIS NOTICE OF PRIVACY PRACTICES DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.***

This Notice of Privacy Practices (the "Notice) describes the legal obligations of Oregon Episcopal School (the "Plan") and your legal rights regarding your protected health information held by the Plan under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH Act). Among other things, this Notice describes how your protected health information may be used or disclosed to carry out treatment, payment, or health care operations, or for any other purposes that are permitted or required by law.

We are required to provide this Notice of Privacy Practices to you pursuant to HIPAA.

The HIPAA Privacy Rule protects only certain medical information known as "Protected Health Information". Generally, PHI is health information is health information, including demographic information, collected from you or created or received by a health care provider, a health care clearing house, a health plan, your employer on behalf of the group health plan from which it is possible to individually identify you and that relates to

- (i) your past, present, or future physical or mental health or condition;
- (ii) the provision of health care to you; or
- (iii) the past, present, or future payment for the provision of health care to you.

If you have any questions about this Notice or about our privacy practices, please see the contact information at the bottom of this notice.

## EFFECTIVE DATE

This Notice is effective October 1, 2020.

## OUR RESPONSIBILITIES

We are required by law to:

- maintain the privacy of your protected health information;
- provide you with certain rights with respect to protected health information;
- provide you with a copy of this Notice of our legal duties and privacy practices with respect to your protected health information; and
- follow the terms of the Notice that is currently in effect.

We reserve the right to change the terms of this Notice and make the new provisions regarding your protected health information that we maintain, as allowed or required by law. If we make a material change to this Notice, we will provide you with a copy of our revised Notice of Practices.

## HOW WE MAY USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

**PRIMARY USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION**

Under the law, we may use or disclose your protected health information under certain circumstances without your permission. The following categories describe the different ways that we may use and disclose your protected health information. For each category of uses or disclosures we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- ***For Treatment***

  We may use or disclose your protected health information to facilitate medical treatment or services by providers. We may disclose medical information about you to providers, including doctors, nurses, technicians, medical students, or other hospital personnel who are involved in taking care of you. For example, we might disclose information about your prior prescriptions to a pharmacist to determine if prior prescriptions contraindicate a pending prescription.

- ***Payment***

  We may use or disclose your protected health information to determine your eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. For example, we may tell your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary, or to determine whether the Plan will cover the treatment. We may also share your protected health information with a utilization review or precertification service provider. Likewise, we may share your protected health information with another entity to assist with the adjudication or subrogation of health claims or to another health plan to coordinate benefit payments.

- ***For Health Care Operations***

  We may use and disclose your protected health information for other Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess-loss) coverage; conducting or arranging for medical review, legal services audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities. However, we will not use your genetic information for underwriting purposes.

- ***Treatment Alternatives or Health-Related Benefits and Services***

  We may use and disclose your protected health information to send you information about treatment alternatives or other health-related benefits and services that might be of interest to you.

- ***To Business Associates***

  We may contract with individuals and entities known as Business Associates to perform various functions on our behalf or to provide certain types of services. In order to perform these functions or to provide the services, our Business Associates will receive, create, maintain, transmit, use, and/or disclose protected health information, but only after they agree in writing with us to implement appropriate safeguards regarding your protected health information. For example, we may disclose your protected health information to a Business Associate to process your claims for Plan benefits or to provide support services, such as utilization management, subrogation, or pharmacy benefit management, but only after the Business Associate enters into a Business Associate contract with us.

As Required by Law. We will disclose your protected health information when required to do so by federal, state, or local law. For example, we may disclose your protected health information when required by national security laws or public health disclosure laws.

- ***To Avert a Serious Threat to Health or Safety***

  We may use and disclose your protected health information when necessary to prevent a serious threat to your health and safety, or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat. For example, we may disclose your protected health information in a proceeding regarding the licensure of a physician.

- ***To Plan Sponsors***

  For the purpose of administering the plan, we may disclose to certain employees of the Employer protected health information. However, those employees will only use or disclose that information as necessary to perform plan administration functions or as otherwise required by HIPAA, unless you have authorized further disclosures. Your protected health information cannot be used for employment purposes without your specific authorization.

**SPECIAL SITUATIONS**

In addition to the above, the following categories describe other possible ways that we may use and disclose your protected health information without your specific authorization. For each category of uses or disclosures, we will explain what we mean and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

- ***Organ and Tissue Donation***

  If you are an organ donor, we may release your protected health information after your death to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

- ***Military***

  If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

- ***Workers' Compensation***

  We may release your protected health information for workers' compensation or similar programs, but only as authorized by, and to the extent necessary to comply with, laws relating to workers' compensation and similar programs that provide benefits for work-related injuries or illness.

- ***Public Health Activities***

  We may disclose your protected health information for public health activities. These activities generally include the following:

  - to prevent or control disease, injury, or disability;
  - to report births and deaths;
  - to report child abuse or neglect;
  - to report reactions to medications or problems with products;
  - to notify people of recalls of products they may be using;
  - to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
  - to notify the appropriate government authority if we believe that a patient has been the victim of abuse, neglect, or domestic violence. We will only make this disclosure if you agree, or when required or authorized by law.

- ***Health Oversight Activities***

  We may disclose your protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

- ***Lawsuits and Disputes***

  If you are involved in a lawsuit or a dispute, we may disclose your protected health information in response to a court or administrative order. We may also disclose your protected health information in response to a subpoena, discovery request, or other lawful process by someone involved in a legal dispute, but only if efforts have been made to tell you about the request or to obtain a court or administrative order protecting the information requested.

- ***Law Enforcement***

  We may disclose your protected health information if asked to do so by a law enforcement official.
  - in response to a court order, subpoena, warrant, summons, or similar process;
  - to identify or locate a suspect, fugitive, material witness, or missing person;
  - about the victim of a crime if, under certain limited circumstance, we are unable to obtain the victim's agreement;
  - about a death that we believe may be the result of criminal conduct; and
  - about criminal conduct;

- ***Coroners, Medical Examiners and Funeral Directors***

  We may release protected health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release medical information about patients to funeral directors, as necessary to carry out their duties.

- ***National Security and Intelligence Activities***

  We may release your protected health information to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

- ***Inmates***

  If you are an inmate of a correctional institution or are in the custody of law enforcement official, we may disclose your protected health information to the correctional institution or law-enforcement official if necessary (1) for the institution to provide you health care; (2) to protect your health and safety and the health and safety of others; or (3) for the safety and security of the correctional institution.

- ***Research***

  We may disclose your protected health information to researchers when:
  - the individual identifiers have been removed; or
  - when an institutional review board or privacy board has reviewed the research proposal and established protocols to ensure the privacy of the requested information, and approves the research.

**REQUIRED DISCLOSURES**

The following is a description of disclosures of your protected health information we are required to make.

- ***Government Audits***

  We are required to disclose your protected health information to the Secretary of the U.S. Department of Health and Human Services when the Secretary is investigating or determining our compliance with the HIPAA Privacy Rule.

- ***Disclosures to You***

  When you request, we are required to disclose to you the portion of your protected health information that contains medical records, billing records, and any other records used to make decisions regarding your health care benefits. We also are required to provide, upon your request, an accounting of most disclosures of your protected health information that are for reasons other than payment, treatment, or health care operations, and if the protected health information was not disclosed pursuant to your individual authorization.

- ***Personal Representatives***

  We will disclose your protected health information to individuals authorized by your, or to an individual designated as your personal representative, attorney-in-fact, etc., so long as you provide us with a written notice/authorization and any supporting documents (i.e., power of attorney). Note: Under the HIPAA privacy rule, we do not have to disclose information to a personal representative if we have a reasonable belief that:

  - (1) you have been, or may be, subjected to domestic violence, abuse, or neglect by such person; or
  - (2) treating such person as your personal representative could endanger you; and
  - (3) in the exercise of professional judgment, it is not in your best interest to treat the person as your personal representative.

**YOUR RIGHTS**

You have the following rights with respect to your protected health information:

- ***Right to Inspect and Copy***

  You have the right to inspect and copy certain protected health information that may be used to make decisions about your Plan benefits. If the information you request is maintained electronically, and you request an electronic copy, we will provide a copy in the electronic form and format you request, if the information can be readily produced in that form and format; if the information cannot be readily produced in that form and format, we will work with you to come to an agreement on form and format. If we cannot agree on an electronic form and format, we will provide you with a paper copy.

  To inspect and copy your protected health information, you must submit your request in writing to please see the contact information at the bottom of this notice. If you request a copy of the information, we may charge a reasonable fee for the costs of copying, mailing, or other supplies associated with your request.

  We may deny your request to inspect and copy in certain very limited circumstances. If you are denied access to your medical information, you may request that the denial be reviewed by submitting a written request to the contact located at the bottom of this notice.

- ***Right to Amend***

  If you feel that the protected health information we have about you is incorrect or incomplete, you may ask us to amend your information. You have the right to request an amendment for as long as the information is kept by or for the Plan.

  To request an amendment, your request must be made in writing and submitted to the contact at the bottom of this notice. In addition, you must provide a reason that supports your request.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- is not part of the medical information kept by or for the Plan;
- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the information that you would be permitted to inspect and copy; or
- is already accurate and complete.

If we deny your request, you have the right to file a statement of disagreement with us and any future disclosures of the disputed information will include your statement.

- ***Right to an Accounting of Disclosures***

You have a right to an "accounting" of certain disclosures of your protected health information. The accounting will not include (1) disclosures for purposed of treatment, payment, or health care operations; (2) disclosures made to you; (3) disclosures made pursuant to your authorization; (4) disclosures made to friends or family in your presence or because of an emergency; (5) disclosures for national security purposes; and (6) disclosures incidental to otherwise permissible disclosures.

To request this list or accounting of disclosures, you must submit your request in writing to the contact at the bottom of this notice. Your request must state the time period you want the accounting to cover, which may not be longer than six years before the date of the request. Your request should indicate in what form you want the list (for example, paper or electronic). The first list you request within a 12-month period will be provided free of charge. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at the time before any costs are incurred.

- ***Right to Request Restrictions***

You have the right to request a restriction or limitation on your protected health information that we use or disclose for treatment, payment, or health care operations. You also have the right to request a limit on your protected health information that we disclose to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you could ask that we not use or disclose information about a surgery that you had.

Except as provided in the next paragraph, we are not required to agree to your request. However, if we do agree to the request, we will honor the restriction until you revoke it or we notify you.

We will comply with any restriction request if (1) except as otherwise required by law, the disclosure is to a health plan for purposes or carrying out payment or health care operations (and is not for purposes of carrying out treatment); and (2) the protected health information pertains solely to a health care item or service for which the health care provider involved has been paid in full by you or another person.

To request restrictions, you must make your request in writing to the contact at the bottom of this notice. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or booth; and (3) to whom you want the limits to apply – for example, disclosures to your spouse.

- ***Right to Request Confidential Communications***

You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail.

To request confidential communications, you must make your request in writing to the contact at the bottom of this notice. We will not ask you the reason for our request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

- ***Right to Be Notified of a Breach***

  You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

- ***Right to Receive a Paper Copy of This Notice***

  You have the right to a paper copy of this Notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

  To obtain a paper copy of this notice please see the contact information at the bottom of this notice.

**COMPLAINTS**

If you believe that your privacy rights have been violated, you may file a complaint with the Plan or with the Office for Civil Rights of the United States Department of Health and Human Services. To file a complaint with the Plan, contact.

**Oregon Episcopal School**
**Attn: Human Resources Department**
**6300 SW Nicol Road**
**Portland, OR 97223**
**503-416-9382**

All complaints must be submitted in writing.

You will not be penalized, or in any other way retaliated against, for filing a complaint with the Office for Civil Rights or with us.