PROVIDENCE Health Plan

2019 Open Enrollment Change Form

Individual & Family Insurance

THIS FORM IS FOR OPEN ENROLLMENT CHANGES ONLY, 11/1/2018-12/15/2018

If you are not a current Providence Health Plan Individual & Family Policyholder, do not use this form. To complete an application for new enrollment, please visit **ProvidenceHealthPlan.com**.

This form cannot be used to make changes to plans purchased through the Federal Health Insurance Marketplace. Contact the Marketplace at **HealthCare.gov** or by calling 1-800-318-2596.

See Page 5 for Change Form instructions.

Policyholder Information

Subscriber ID Number: _____ - _____

This box must be completed for all plan change and cancellation requests.
If this information is incomplete, your Change Form may be returned causing a delay.

Policyholder Last Name	**First Name**	**MI**	**Date of Birth** (MM-DD-YYYY)

Home Address (Check box if new address) No post office box or retail/business addresses	**City**	**State**	**Zip Code**	**County**
Mailing Address (Check box if new address) If different from home address	**City**	**State**	**Zip Code**	**County**

Email Address	**Home/Cell Phone Number** (required)	**Work Phone/Other Phone** (optional)

Social Security Number **Sex** (check one) Female Male

Have you used any tobacco products in the last 6 months? Yes No
Tobacco use is defined as an average of at least 4 times per week, except for religious or ceremonial purposes.

Cancel My 2018 Individual & Family Plan Coverage

This box should only be completed if you want to cancel your coverage.

I want to cancel my 2018 Individual & Family Plan coverage effective 12/31/18.
(Please note: This action will end the health insurance coverage for all enrolled members on your plan. You and your dependents will not be enrolled for the 2019 benefit plan year. To obtain new coverage outside of Open Enrollment, you must have a special enrollment qualifying event.)

Sign, date, and submit this page to complete your request to cancel your coverage effective 12/31/18:

_____ _____
Signature of Policyholder (required) **Date**

Change My 2019 Individual & Family Plan Coverage

Open Enrollment is your opportunity to make changes to your current health plan coverage. The changes you request in sections 1-3 below will be effective January 1, 2019, conditioned on PHP's receipt of your completed Change Form by December 15, 2018, and timely payment of your November and December premiums.

1. I am making the following changes to my plan selection for 2019:

(If there are no changes, do not complete this box.)

Medical Plan (Check one)	**Network**	**Service Areas**
Connect 2500 Silver	Connect	Clackamas, Hood River, Multnomah, Washington, Yamhill (Newberg zip code 97132 only)
Connect 7900 Bronze		
Providence Oregon Standard Gold- Choice	Choice	Benton, Clackamas, Clatsop, Crook, Deschutes, Douglas, Hood River, Jackson, Jefferson, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Washington, Yamhill
Providence Oregon Standard Silver- Choice		
Providence Oregon Standard Bronze- Choice		
HSA Qualified 6650 Bronze- Choice		
Providence Oregon Standard Gold- Signature	Signature	Baker, Columbia, Coos, Curry, Gilliam, Grant, Harney, Josephine, Klamath, Lake, Malheur, Morrow, Sherman, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler
Providence Oregon Standard Silver- Signature		
Providence Oregon Standard Bronze- Signature		
HSA Qualified 6650 Bronze- Signature		
Dental Plan (Check one)		
I want Providence Progressive Dental coverage for 2019	Must enroll in medical plan	All counties in Oregon
I do not want Providence Progressive Dental coverage for 2019		

To review a Summary of Benefits and Coverage (SBC) for these medical plans, visit **ProvidenceHealthPlan.com/sbc**.

If you select a Connect or Choice Network plan, you will need to choose a medical home and a primary care provider upon enrollment. To see medical homes in your area, view our provider directory at **ProvidenceHealthPlan.com/findaprovider**.

Providence Progressive Dental Plan: In order to purchase the Providence Progressive Dental Plan, you must also purchase a PHP medical plan. If you choose the Providence Progressive Dental Plan, all people on the plan will be enrolled. There is a separate premium for the dental plan which will apply to each person on the policy. For children age 18 and younger who are enrolled on the Connect plans, this coverage will be supplemental to the pediatric dental coverage already included under the medical plan.

Pediatric Dental Disclaimer: Our Standard and HSA medical plans DO NOT include pediatric dental coverage. Under the health care reform law (the Affordable Care Act or ACA), if you purchase one of these plans outside of the Marketplace, we must have reasonable assurance that you have obtained separate pediatric dental coverage through a Marketplace-certified pediatric dental plan. This requirement applies whether you obtain coverage for children or adults. Marketplace-certified pediatric dental plans can be found through the Federal Health Insurance Marketplace at **HealthCare.gov**.

For more details regarding plan information and rates, visit **ProvidenceHealthPlan.com**.

2A. I am making the following changes to my dependent information for 2019:

(If there are no changes, do not complete this box.)

Please include full, legal names. For a child-only plan, children must be age 20 and younger as of their effective date. For all other plans, children must be age 25 and younger as of their effective date of coverage.

Note: If any dependents do not reside at the Policyholder's home address, you must complete section 2B below.

(Check one)	Last Name	First Name, MI	Relationship to Subscriber	Sex	Date of Birth
Add Remove Update				F M	
	Does this dependent live at the Policyholder's home address? Yes No Does this dependent use tobacco products?* Yes No		SSN:		

(Check one)	Last Name	First Name, MI	Relationship to Subscriber	Sex	Date of Birth
Add Remove Update				F M	
	Does this dependent live at the Policyholder's home address? Yes No Does this dependent use tobacco products?* Yes No		SSN:		

(Check one)	Last Name	First Name, MI	Relationship to Subscriber	Sex	Date of Birth
Add Remove Update				F M	
	Does this dependent live at the Policyholder's home address? Yes No Does this dependent use tobacco products?* Yes No		SSN:		

If you have additional changes regarding your dependents, please include them on a separate sheet.

*Tobacco use is defined as an average of at least 4 times per week, except for religious or ceremonial purposes.

2B. Dependent home address(es) if different from the Policyholder:

Dependent's Name

Dependent's Home Address | City | State | Zip Code | County

Dependent's Name

Dependent's Home Address | City | State | Zip Code | County

3. Read, Sign & Submit

Certification of Completion and Correctness

I affirm that I am requesting a change in coverage for myself and/or my enrolled family dependents and that the answers given in this Change Form are complete and correct. I am providing these answers as part of the procedure required by Providence Health Plan (PHP) to request a change in my insurance coverage. I understand and agree that no change in coverage shall be in force until the effective date determined by PHP and that PHP may contact me to clarify this request. As a member, I understand I have the right to inspect the information in my file. I understand that I can visit ProvidenceHealthPlan.com to educate myself about PHP's privacy practices. I understand that I can get a copy of PHP's Notice of Privacy Practices by going to ProvidenceHealthPlan.com and selecting "Notice of Privacy Practice" or by calling Customer Service at 503-574-7500.

Signature

1. I understand that this is an individual health insurance contract and I verify that neither my employer nor any third party will be paying the premium on this policy except as permitted by state or federal regulation.
2. I am the parent or legal guardian of all dependent children listed on this Change Form.
3. I verify that the home address(es) I provided on this Change Form for myself and my dependents are accurate.
4. I understand that I must update my information with Providence Health Plan if anything changes.
5. I affirm that if I choose a medical plan without pediatric dental coverage, I will obtain pediatric dental coverage through a separate Marketplace-certified pediatric dental plan, and that I will notify Providence Health Plan if I do not obtain coverage.

_____ _____

Signature of Policyholder (required) **Date**

Open Enrollment Change Form Instructions

You may complete this paper form or make changes online by visiting **ProvidenceHealthPlan.com** during Open Enrollment, November 1, 2018 – December 15, 2018.

Who can make changes?	Use this form to make changes to your 2019 Providence Health Plan Individual & Family coverage. **Changes to your Providence Health Plan coverage can only be requested by the Policyholder.**
Changes and effective dates 	This form may be used to: • Update Policyholder information. • Cancel your 2018 medical plan. The last date of coverage will be December 31, 2018. • Change your medical plan. • Add or cancel your Providence Progressive Dental Plan. • Add, remove or update dependent information. Changes received during Open Enrollment will be effective January 1, 2019. Change forms received after December 15, 2018 will not be processed.
How to Submit? 	Submit your completed Change Form to: Providence Health Plan P.O. Box 4649 Portland, OR 97208-4649 -OR- Email to: phpindividualforms@providence.org • Change Forms that are incomplete for any reason, such as missing signature, signature date, or any other required information may cause a delay or invalidate your requested change(s). • Submit page 1 to cancel your 2018 coverage effective December 31, 2018. • Submit all pages to request other renewal changes.
What's Next? 	• If applicable, Providence Health Plan will send you an invoice with your updated premium rate after your renewal changes have been processed. • Providence Health Plan recommends you keep a copy of your completed Change Form for your records.
Need help? 	• For plan and rate information, visit **ProvidenceHealthPlan.com**. • For a glossary of terms, visit **ProvidenceHealthPlan.com/glossary** for a listing of health insurance terms and definitions. • For more information or for assistance completing this Change Form, contact Membership Accounting at 503-574-5791 or 1-888-816-1300, TTY: 711 or your insurance producer.

DO NOT RETURN THIS PAGE TO PROVIDENCE HEALTH PLAN

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 Information

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 می‌کنید، تسهیلات زبانی بصورت رایگان برای شما میباشد. با تماس 1-800-878-4445 (TTY: 711) می‌باشد.

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)