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, join.collectivehealth.com/pebb-php. 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.cciio.cms.gov or call (855) 284-1368 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	In-Network: $250/per person $750/per family (3 or more) Out-of-Network: $500/per person $1,500/per family (3 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 plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.
Are there services covered before you meet your deductible?	Yes. Most preventive care in-network.	This plan covers some items and services even if you haven't yet met the 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?	Yes for prescriptions. $50/person; $150/family (3 or more). Does not apply to value drugs.	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
What is the out-of-pocket limit for this plan?	In-Network: $1,900/per person $5,700/per family (3 or more) Max Cost Share $6,850/person; $13,700/family (2 or more). Out-of-Network: $4,800/per person $14,400/per family (3 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 Usual, Customary, and Reasonable (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 join.collectivehealth.com/pebb-php or call (855) 284-1368.	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 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	10% or 15% coinsurance	30% coinsurance	Deductible waived for the first four office visits in-network per calendar year. Chronic condition visits for asthma, diabetes and heart conditions are covered in full in-network.*
	Specialist visit	15% coinsurance	30% coinsurance	Chronic condition visits for asthma, diabetes and heart conditions are covered in full in-network.
	Preventive care/screening/ immunization	No charge. Deductible does not apply.	30% coinsurance	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	15% coinsurance	30% coinsurance	——————none——————
	Imaging (CT/PET scans, MRIs)	$100 copay then 15% coinsurance	$100 copay then 30% coinsurance	Copay does not apply to cancer related services or out-of-pocket maximum.
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.Providence HealthPlan.com/pebb	Value drug	No charge. Deductible does not apply.	Not covered	Must be purchased at participating pharmacies. A $1,000/person, $3,000/family. Out-of-pocket maximum applies. Covers up to a 30-day supply (retail); 90-day supply (mail order). Prior authorization may apply. If you do not obtain Prior Authorization claims for those services will be denied and you will be responsible for payment of those services. If you or your provider request a brand-name drug when a generic is available, you will pay the difference in cost, plus your copay.
	Generic drug	$10 copay retail $25 copay mail order	Not covered	
	Brand-name drugs	$30 copay retail $75 copay mail order	Not covered	
	Specialty drug	$100 copay retail	Not covered	

*For more information about limitations and exceptions, see the plan or policy document at join.collectivehealth.com/pebb-php

Common Medical Event	Services You May Need	What You Will Pay: Network Provider (You will pay the least)	What You Will Pay: Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
				Specialty drugs can only be purchased at a participating specialty pharmacy.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	15% coinsurance	$100 copay then 40% coinsurance	Out-of-network copay does not apply to the out-of-pocket maximum. Prior authorization required. If you do not obtain Prior Authorization claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	15% coinsurance	30% coinsurance	Higher copay and coinsurance amounts apply to certain specialty services.*
If you need immediate medical attention	Emergency room care	$150 copay/visit then 15% coinsurance	$150 copay/visit then 15% coinsurance	For emergency medical conditions only. In-network deductible applies both in- and out-of-network. Copay does not apply to out-of-pocket maximum. If admitted to hospital all services subject to inpatient benefits.
	Emergency medical transportation	15% coinsurance	15% coinsurance	In-network deductible applies both in- and out-of-network.
	Urgent care	15% coinsurance	15% coinsurance	In-network deductible applies both in- and out-of-network.
If you have a hospital stay	Facility fee (e.g., hospital room)	15% coinsurance	$500 copay then 40% coinsurance	Out-of-network copay does not apply to the out-of-pocket maximum. Prior authorization required. If you do not obtain Prior Authorization claims for those services will be denied and you will be responsible for payment of those services. Higher copay and coinsurance amounts apply to certain specialty services.*
	Physician/surgeon fees	15% coinsurance	30% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Mental Health : 15% coinsurance. Deductible does not apply.	30% coinsurance	

*For more information about limitations and exceptions, see the plan or policy document at join.collectivehealth.com/pebb-php

Common Medical Event	Services You May Need	What You Will Pay Network Provider (You will pay the least)	What You Will Pay Out-of-Network Provider (You will pay the most)	Limitations, Exceptions, & Other Important Information
		Substance Abuse: No charge. Deductible does not apply.		For all services except outpatient provider visits and applied behavior analysis, Providence Health Plan must be notified as soon as reasonably possible following the onset of treatment for coverage to continue. See your benefit summary for Applied Behavioral Analysis (ABA) services. Out-of-network copay does not apply to the out-of-pocket maximum.
	Inpatient services	Mental Health : 15% coinsurance Substance Abuse: No charge. Deductible does not apply.	$500 copay then 30% coinsurance	
If you are pregnant	Office visits	No charge. Deductible does not apply.	30% coinsurance	——————none——————
	Childbirth/delivery professional services	15% coinsurance	30% coinsurance	——————none——————
	Childbirth/delivery facility services	15% coinsurance	$500 copay then 40% coinsurance	Out-of-network copay does not apply to the out-of-pocket maximum.
If you need help recovering or have other special health needs	Home health care	15% coinsurance	30% coinsurance	Limited to 180 visits per calendar year.
	Rehabilitation services	15% coinsurance	Inpatient Services: $500 copay then 40% coinsurance Outpatient Services: 30% coinsurance	Inpatient services: coverage limited to 30 days per calendar year; 60 days head or spinal cord injuries. Outpatient services: coverage limited to 60 visits per calendar year. Limits do not apply to Mental Health Services. Out-of-network copay does not apply to the out-of-pocket maximum.
	Habilitation services	15% coinsurance	Inpatient Services: $500 copay then 40% coinsurance Outpatient Services: 30% coinsurance	Inpatient services: coverage limited to 30 days per calendar year; 60 days head or spinal cord injuries. Outpatient services: coverage limited to 60 visits per calendar year. Limits do not apply to Mental Health Services. Out-of-network copay does not apply to the out-of-pocket maximum.

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)	
	Skilled nursing care	15% coinsurance	$500 copay then 30% coinsurance	Prior authorization required. If you do not obtain Prior Authorization claims for those services will be denied and you will be responsible for payment of those services. Coverage is limited to 180 visits per calendar year. Out-of-network copay does not apply to the out-of-pocket maximum.
	Durable medical equipment	15% coinsurance	30% coinsurance	Diabetic supplies are covered in full. Prior authorization required for some durable medical equipment. For more details see ProvidenceHealthPlan.com/PEBBPriorAuthorization. If you do not obtain Prior Authorization claims for those services will be denied and you will be responsible for payment of those services.
	Hospice services	No charge. Deductible does not apply.	No charge. Deductible does not apply.	Prior authorization required for out-of-network services. If you do not obtain Prior Authorization claims for those services will be denied and you will be responsible for payment of those services.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Coverage provided by separate carrier. See VSP plan.
	Children's glasses	Not covered	Not covered	
	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.)		
• Cosmetic surgery (with certain exceptions) • Dental care (Adult) • Dental check-up (Child)	• Eye exam and glasses (Child) • Long-term care • Private-duty nursing	• Routine eye care (Adult) • Routine foot care (covered for diabetics)

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
• Acupuncture (limited to 60 visits per year combined with chiropractic care) • Bariatric surgery	• Chiropractic care (limited to 60 visits per year combined with acupuncture) • Hearing aids (one per ear every 3 calencar years) • Infertility treatment	• Non-emergency care when traveling outside the U.S. See join.collectivehealth.com/pebb-php • Weight loss programs

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:

- PEBB COBRA Adminstrator at BenefitHelp Solutions (877) 433-6079 or (503) 765-3581
- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Oregon Division of Financial Regulation at (888) 877-4894 or https://dfr.oregon.gov/Pages/index.aspx regarding their possible rights to continuation coverage under State law.

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 on how 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 (855) 284-1368 at join.collectivehealth.com/pebb-php
- PEBB Benefit Manager 503-373-1102
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free), or https://dfr.oregon.gov

Does this plan provide Minimum Essential Coverage? Yes

Minimum Essential Coverage generally includes plans, health insurance available through the Marketplace or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of Minimum Essential Coverage, you may not be eligible for the premium tax credit.

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	**$250**
Specialist coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	**$12,700**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$250
Copayments	$0
Coinsurance	$1,700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2,010**

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 coinsurance	**15%**
Hospital (facility) coinsurance	**15%**
Other coinsurance	**15%**

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	**$5,600**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$100
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$720**

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

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

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	**$2,800**

In this example, Mia would pay:

Cost Sharing	
Deductibles	$300
Copayments	$300
Coinsurance	$300
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$900**

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 (855) 284-1368. 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 (855) 284-1368. (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 (855) 284-1368 (TTY: 711).

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al (855) 284-1368 (TTY: 711).

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số (855) 284-1368 (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 (855) 284-1368 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (855) 284-1368 (телетайп: 711).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. (855) 284-1368 (TTY: 711) 번으로 전화해 주십시오

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером (855) 284-1368 (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。(855) 284-1368 (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 (855) 284-1368 (رقم هاتف الصم والبكم: (TTY: 711).

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la (855) 284-1368 (TTY: 711).

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ (855) 284-1368 (TTY: 711)។

XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa (855) 284-1368 (TTY: 711).

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: (855) 284-1368 (TTY: 711).

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. بگیرید تماس (855 (284-1368 (TTY: 711) باشد می ف .با

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le (855) 284-1368 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (855) 284-1368 (TTY: 711