**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, ProvidenceHealthPlan.com. For 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 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?** | In-Network: $7,500 person / $15,000 family (2 or more). Out-of-Network: $15,000 person / $30,000 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 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 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?** | In-Network: $10,150 person / $20,300 family (2 or more). Out-of-Network: $20,300 person / $40,600 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, balance billing, penalties, copays for adult vision services, chiropractic manipulation, acupuncture, 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 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 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. |

(DT - OMB control number: 1545-0047/Expiration Date: 12/31/2019)(DOL - OMB control number: 1210-0147/Expiration date: 5/31/2022)
(HHS - OMB control number: 0938-1146/Expiration date: 10/31/2022)

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 | First 3 visits $5 copay/per visit; deductible does not apply then $60 copay/per in-person visit; deductible does not apply or $10 copay/per virtual visit; deductible does not apply | 50% coinsurance | Some services such as lab and x-ray will include additional member costs. Providence ExpressCare phone and video visits are covered in full in-network. |
| | Specialist visit | $100 copay/per visit; deductible does not apply | 50% coinsurance | Some services such as lab and x-ray will include additional member costs. |
| | Preventive care/screening/ immunization | No charge; deductible does not apply | 50% coinsurance | Not all preventive services are required to be covered in full by the ACA. For more information on preventive services that are covered in full see: ProvidenceHealthPlan.com/PreventiveCare. 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) | 50% coinsurance; deductible does not apply | 50% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 50% coinsurance | 50% 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. |

| 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 ProvidenceHealthPlan.com | Tier 1 drugs | No charge retail; deductible does not apply | Not covered | ACA Preventive drugs are covered in full in-network. Covers up to a 30-day supply (retail); 90-day mail-order supply covered at 2 times the retail copay or 5% less than the retail coinsurance. 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 a brand-name drug is requested when a generic is available, you will pay for the cost difference between the brand-name and generic drug, plus your cost-share for the brand-name drug. Specialty drugs (typically listed in Tier 5 and Tier 6 on your formulary) can only be purchased at a participating specialty pharmacy (limited to 30 days). |
| | Tier 2 drugs | $50 copay/per 30 day supply retail; deductible does not apply | Not covered | |
| | Tier 3 drugs | $100 copay/per 30 day supply retail; deductible does not apply | Not covered | |
| | Tier 4 drugs | 50% coinsurance up to $200 retail; deductible does not apply | Not covered | |
| | Tier 5 drugs | 50% coinsurance up to $300 retail | Not covered | |
| | Tier 6 drugs | 50% coinsurance retail | Not covered | |
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | Ambulatory surgery center: 40% coinsurance Hospital-based facility: 50% coinsurance | 50% 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. |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room care | $250 copay/per visit then 50% coinsurance | $250 copay/per visit then 50% coinsurance | For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits. |
| | Emergency medical transportation | 50% coinsurance | 50% coinsurance | None |
| | Urgent care | $100 copay/per visit; deductible does not apply | 50% coinsurance | Some services will include additional member costs. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 50% coinsurance | 50% 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. |
| | Physician/surgeon fees | 50% coinsurance | 50% coinsurance | |

| 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 | Office visit: First 3 visits $5 copay/per visit; deductible does not apply then $60 copay/per in-person visit; deductible does not apply or $10 copay/per virtual visit; deductible does not apply All other services: 50% coinsurance | 50% coinsurance | All services except provider office visits must be prior authorized. If you do not obtain Prior authorization claims for those services will be denied and you will be responsible for payment of those services. See your benefit summary for Applied Behavioral Analysis (ABA) services. |
| | Inpatient services | 50% coinsurance | 50% coinsurance | |
| **If you are pregnant** | Office visits | No charge; deductible does not apply | 50% coinsurance | None |
| | Childbirth/delivery professional services | 50% coinsurance | 50% coinsurance | Coinsurance applies to provider delivery charges. |
| | Childbirth/delivery facility services | 50% coinsurance | 50% coinsurance | None |
| **If you need help recovering or have other special health needs** | Home health care | 50% coinsurance | 50% 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. |
| | Rehabilitation services | Inpatient: 50% coinsurance Outpatient - Physical Therapy: 50% coinsurance; deductible does not apply Outpatient - Occupational & Speech Therapy: 50% coinsurance; deductible does not apply | 50% coinsurance | Inpatient services: Limited to 30 days per calendar year. Limited to 60 days per calendar year for head/spinal injuries. 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. Outpatient services: Limited to 30 visits per calendar year. Additional visits per specified condition: Limited to 30 visits per calendar year. Limits do not apply to Mental Health and Substance Use Disorder Services. |

| 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) | |
| | Habilitation services | Inpatient: 50% coinsurance<br>Outpatient: 50% coinsurance ; deductible does not apply | 50% coinsurance | Inpatient services: Limited to 30 days per calendar year. Limited to 60 days per calendar year for head/spinal injuries. 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. Outpatient services: Limited to 30 visits per calendar year. Limits do not apply to Mental Health and Substance Use Disorder Services. |
| | Skilled nursing care | 50% coinsurance | 50% 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. Limited to 60 days per calendar year. |
| | Durable medical equipment | Diabetic Supplies: 50% coinsurance; deductible does not apply<br>All other equipment: 50% coinsurance | 50% coinsurance | None |
| | Hospice services | Hospice: No charge; deductible does not apply<br>Respite care: 50% coinsurance | Hospice: No charge; deductible does not apply<br>Respite care: 50% 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. Respite care: Limited to 5 days, up to 30 days per lifetime. |
| **If your child needs dental or eye care** | Children's eye exam | No charge; deductible does not apply | Covered up to: $45; deductible does not apply | Limited to 1 exam per calendar year. |
| | Children's glasses | No charge; deductible does not apply | Covered up to: $170; deductible does not apply | Limited to 1 pair per calendar year. Coverage maximum depends on lens type. |
| | Children's dental check-up | No charge; deductible does not apply | No charge; deductible does not apply | Limited to 2 services per every calendar year. |

## 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.)**

- Abortion
- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine foot care (covered for diabetes)
- Weight loss programs

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

- Acupuncture (12 visits)
- Chiropractic care (20 visits)
- Hearing aids (one per ear every 3 calendar years)
- Non-emergency care when traveling outside the U.S. See 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:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or ProvidenceHealthPlan.com.
- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or 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 ciio.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 503-947-7984/1-888-877-4894 (toll-free) or dfr.oregon.gov 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 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 503-574-8757/1-800-878-4445 (toll-free) or ProvidenceHealthPlan.com.
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or 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 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.

## Language Access Services:

Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-878-4445 (TTY: 711).

Chinese (**中文**): **如果需要中文的帮助，** 请拨**打**这**个号**码1-800-878-4445 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-878-4445 (TTY: 711).

Spanish (Español): Para obtener asistencia en Español, llame al 1-800-878-4445 (TTY: 711).

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

**PRA Disclosure 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 one minute 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, 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 12100123.

## 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 | $7,500 |
| Specialist copayment | $100 |
| Hospital (facility) coinsurance | 50% |
| Other coinsurance | 50% |

**This EXAMPLE event includes services like:**
Specialist office visits *(pre-natal 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 | $7,500 |
| Copayments | $10 |
| Coinsurance | $2,500 |
| *What isn't covered* | |
| Limits or exclusions | $20 |
| **The total Peg would pay is** | **$10,030** |

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

| | |
|---|---|
| The plan's overall deductible | $7,500 |
| Specialist copayment | $100 |
| Hospital (facility) coinsurance | 50% |
| Other coinsurance | 50% |

**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* | $10 |
| Copayments | $1,700 |
| Coinsurance | $400 |
| *What isn't covered* | |
| Limits or exclusions | $0 |
| **The total Joe would pay is** | **$2,110** |

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

| | |
|---|---|
| The plan's overall deductible | $7,500 |
| Specialist copayment | $100 |
| Hospital (facility) coinsurance | 50% |
| Other coinsurance | 50% |

**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* | $2,000 |
| Copayments | $200 |
| Coinsurance | $60 |
| *What isn't covered* | |
| Limits or exclusions | $400 |
| **The total Mia would pay is** | **$2,660** |

*Note: This plan has other deductibles for specific services included in this coverage example. See "Are there other deductibles for specific services?" row above.

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

## Non-Discrimination Statement

Discrimination is against the law. Providence Health Plan ("PHP") does not discriminate or treat people unfairly based on:

- Age
- Color
- Disability
- National origin
- Gender identity
- Language proficiency
- Race
- Sexual Orientation
- Religion
- Sex
- Pregnancy

**You have the following rights:**

- To get free help from a qualified language interpreter.
- To get written information in the language you speak.
- To get information in a way you understand, including:
  - free help from a qualified sign language interpreter,
  - written information in large print, audio, Braille, or other formats, or
  - other reasonable modifications

**Contact the Civil Rights Coordinator at PHP if you:**

- Need reasonable modifications, appropriate auxiliary aids and services, or language assistance services,
- Believe PHP failed to provide services and discriminated against you, or
- Want to file a grievance.

**Please contact our Civil Rights Coordinator in one of these ways:**

1) **You can call us.**
   **Toll-free: 1-800-878-4445** **Oregon: 1-503-574-7500**
   Hearing impaired members may call our TTY line at 711.
2) **You can mail or email us.**
   Providence Health Plan Attn: Civil Rights Coordinator
   PO Box 4158 Portland, OR 97208-4158
   Email: PHPAppealsandGrievances@providence.org
3) **You also have a right to file a complaint with the following:**
   U.S. Department of Health and Human Services, Office for Civil Rights
   Web portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsfWA
   Email: OCRComplaint@hhs.gov
   Phone: 1-800-369-1019, 1-800-537-7697
   Mail: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Bldg., Washington, DC 20201

   Oregon Division of Financial Regulation
   Web: https://dfr.oregon.gov/Pages/index.aspx
   Email: DFR.InsuranceHelp@dcbs.oregon.gov
   Phone: 1-888-877-4894

## 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: N ế u bạn nói Ti ế ng 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៖ បើសិនអ្នកនិយ ាយ ខ្ម រ, សេវ ជំនួយផ្ន ក ភ្ន ក ងមិនគិតឈ ល គឺមនសំ ប់បំ រ អ្ក ជូ ទូរស័ព 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 هب زبان فارسی گفتگو می کنید، تسهیالت زبانی بصورت رایگان برای شما دیریگب. اس 1-800-878-4445 (TTY: 711) اب. اب دشاب می ف

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)