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, https://join.collectivehealth.com/saif-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.healthcare.gov/sbc-glossary or call 1-844-945-4148 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	**$400** individual / **$800** family for In-Network providers **$800** individual / **$1600** family for Out-of-Network providers	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. Preventive care and primary care services are covered before you meet your deductible.	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?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	**$2350** individual / **$4700** family for In-Network providers **$4700** individual / **$9400** family for Out-of-Network providers	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-billed charges, and health care this plan does not cover.	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 **https://join.collectivehealth.com/saif-php** or call **1-844-945-4148** for a list of participating 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.

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
		In-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 in-person visits $5; deductible does not apply then cost share applies $25 copay/visit	40% coinsurance;	Deductible does not apply. Out-of-network: Subject to balance billing.
	Specialist visit	$35/visit	40% coinsurance	Deductible does not apply. Out-of-network: Subject to balance billing.
	Preventive care/screening/immunization	$0/visit	40% coinsurance	Deductible does not apply. Out-of-network: Subject to balance billing. 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)	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
	Imaging (CT/PET scans, MRIs)	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
If you need drugs to treat your illness or condition **More information about prescription drug coverage is available at ProvidenceHealthPlan.com**	Generic drugs	Retail (30-day): $10 copay Mail Order (90-day): $20 copay	Not covered	If you or your provider choose a brand-name medication when a generic version is available, you will have to pay the generic cost sharing and the difference in cost when you fill this medication. Your plan will require you to obtain specialty medications through a participating specialty pharmacy or you will owe the full cost of the drug when you fill this medication. Certain specialty drugs are subject to the Smart RxAssist program and its rules: visit ProvidenceHealthPlan.com/saif-members for more info.
	Preferred brand drugs	Retail (30-day): $30 copay Mail Order (90-day): $60 copay	Not covered	
	Non-preferred brand drugs	Retail (30-day): 50% coinsurance (Maximum payment of $100) Mail Order (90-day): 50% coinsurance (Maximum payment of $200)	Not covered	
	Specialty drugs	Retail (30-day): 50% coinsurance (Maximum payment of $100)	Not covered	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
	Physician/surgeon fees	Physician: $25 copay/visit Surgeon: $100 copay	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
If you need immediate medical attention	Emergency room care	$150/visit	$150/visit In-network deductible applies	Subject to deductible. Out-of-network: Subject to balance billing. Copay waived if admitted
	Emergency medical transportation	$150/visit	$150/visit In-network deductible applies	Subject to deductible. Out-of-network: Subject to balance billing.
	Urgent care	$35/visit	$35/visit	Deductible does not apply. Out-of-network: Subject to balance billing.
If you have a hospital stay	Facility fee (e.g., hospital room)	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
	Physician/surgeon fee	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Provider office visits: First 3 in-person visits $5; deductible does not apply then cost share applies $25 copay/visit; deductible does not apply. All other services: 20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
	Inpatient services	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
If you are pregnant	Office visits	No Charge	40% coinsurance	In-network: Deductible does not apply. Out-of-network: Subject to deductible and balance billing.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				Maternity care may include tests and services described elsewhere in the SBC (i.e. ultrasound).
	Childbirth/delivery professional services	$250 copay; deductible does not apply	40% coinsurance	Copay applies to provider delivery charges. Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
	Childbirth/delivery facility services	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. May require prior authorization.
If you need help recovering or have other special health needs	Home health care	$0/visit	40% coinsurance	In-network: Deductible does not apply. Out-of-network: Subject to deductible and balance billing. May require prior authorization.
	Rehabilitation services	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. 30 session every year, combined with Physical Therapy, Occupational Therapy, Speech Therapy, & Habilitation
	Habilitation services	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. 30 session every year, combined with Physical Therapy, Occupational Therapy, & Speech Therapy
	Skilled nursing care	20% coinsurance	40% coinsurance	Subject to deductible. Out-of-network: Subject to balance billing. 60 day limit every year May require prior authorization.
	Durable medical equipment	20% coinsurance	40% coinsurance	In-network: Deductible does not apply. Out-of-network: Subject to deductible and balance billing. May require prior authorization.
	Hospice services	$0/visit	$0/visit	Deductible does not apply. Out-of-network: Subject to balance billing.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		In-Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
				May require prior authorization.
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered.
	Children's glasses	Not covered	Not covered	Not covered.
	Children's dental check-up	Not covered	Not covered	Not covered.

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
- Dental Care (Child & Adult)
- Glasses (Child)
- Long Term Care
- Private-duty Nursing(except for in-home)
- Routine Eye Care (Adult)
- Routine Foot Care
- 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 (24 sessions every year)
- Bariatric Surgery
- Chiropractic Care (30 sessions every year)
- Hearing Aids (1 device per ear, every 3 years)
- Infertility Treatment
- Non-Emergency Care When Traveling Outside the U.S. See 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: Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform. 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 the plan at 1-844-945-4148. You may also contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

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 find the appropriate CLAS County Data (and which languages meet the 10% threshold), click here: County Data for Culturally and Linguistically Appropriate Services (CLAS County Data) (dol.gov)

Language Access Services:

Spanish (Español): Para obtener asistencia en Español, llame al 844-945-4148.
Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 844-945-4148.
Pennsylvania Dutch (Deitsch): Fer Hilf griege in Deitsch, ruf 844-945-4148 uff.
Samoan (Gagana Samoa): Mo se fesoasoani i le Gagana Samoa, vala'au mai i le numera telefoni 844-945-4148.
Carolinian (Kapasal Falawasch): ngere aukke ghut alillis reel kapasal Falawasch au fafaingi tilifon ye 844-945-4148.
Chamorro (Chamoru): Para un ma ayuda gi finu Chamoru, å'gang 844-945-4148.
Navajo (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 844-945-4148.

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	$400
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$12,700**
In this example, Peg would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$300
Coinsurance	$1700
What isn't covered	
Limits or exclusions	$60
The total Peg would pay is	**$2460**

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

The plan's overall deductible	$400
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$5,600**
In this example, Joe would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$500
Coinsurance	$300
What isn't covered	
Limits or exclusions	$20
The total Joe would pay is	**$1220**

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

The plan's overall deductible	$400
Specialist *[cost sharing]*	$35
Hospital (facility) *[cost sharing]*	20%
Other *[cost sharing]*	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	**$2,800**
In this example, Mia would pay:	
Cost Sharing	
Deductibles	$400
Copayments	$500
Coinsurance	$200
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$1100**