

 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/Swedish. 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 ?	In-Network: \$350 per person / \$700 per family (2 or more). Out-of-Network: \$1,300 per person / \$2,600 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 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. 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 ?	In-Network: \$3,000 per person / \$6,000 per family (2 or more). Out-of-Network: \$7,300 per person / \$14,600 per family (2 or more) Pharmacy: \$1,500 per Individual / \$3,000 per family	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, services not covered, balance billing.	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/Swedish 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
		ACO Network Provider (You will pay the least)	In-Network Provider	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	\$20 copay/visit	\$35 copay/visit	40% co-insurance	Deductible does not apply in-network. Some services such as lab and x-ray may include additional member costs.
	Specialist visit	20% co-insurance \$60 max/visit	30% co-insurance \$80 max/visit	40% co-insurance	Some services such as lab and x-ray will include additional member costs. See ProvidenceHealthPlan.com/Swedish .
	Preventive care/screening/immunization	No charge	No charge	40% co-insurance	Deductible does not apply in-network. Some preventive services will include additional member costs. For more information see: ProvidenceHealthPlan.com/PreventiveCare
If you have a test	Diagnostic test (x-ray, blood work)	Facility: No charge	X-Ray facility: 40% co-insurance Lab services facility: 20% co-insurance	Facility: 50% co-insurance	Additional professional charges may apply.
	Imaging (CT/PET scans, MRIs)	Facility: \$100 copay	Facility: \$100 copay then 40% co-insurance	Facility: \$100 copay then 50% co-insurance	Additional professional charges may apply. Prior authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at ProvidenceHealthPlan.com/Swedish	Preventive drugs: Generic and Formulary	No charge	No charge	Not covered	Deductible does not apply to prescription medications. Covers up to a 30-day supply (retail); 90-day supply (mail-order). Mail order copay is 2.5 times retail. If a brand name drug is requested when a generic is available, you will pay the difference in cost, plus your copay. Prior authorization may apply. Specialty drugs are limited to 30-day supply. Specialty drugs can only be purchased at a participating specialty pharmacy. *Certain specialty drugs are subject to the Smart Rx Assist program and its rules: the list of specialty drugs subject to this program can be found at: providencehealthplan.com/swedish-caregivers
	Generic drugs	\$7.50 copay retail	\$15 copay retail	Not covered	
	Formulary brand-name drugs	\$30 copay retail	\$40 copay retail	Not covered	
	Non-formulary brand-name drugs	\$60 copay retail	\$70 copay retail	Not covered	
	Specialty drug	\$75 copay retail*	Not covered	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% co-insurance	50% co-insurance or no coverage for some facilities	Prior authorization required.
	Physician/surgeon fees	20% co-insurance	20% co-insurance	40% co-insurance	Prior authorization required. See ProvidenceHealthPlan.com/Swedish .
If you need immediate medical attention	Emergency room care	\$150 copay first visit	\$150 copay first visit	\$150 copay first visit	Second visit: \$200 copay; Third or more visit: \$250 copay. If admitted to hospital, copay not applied. All services subject to inpatient benefits.
	Emergency medical transportation	\$75 copay then 20% co-insurance	\$75 copay then 20% co-insurance	\$75 copay then 20% co-insurance	To the nearest appropriate facility.
	Urgent care	20% co-insurance \$60 max/visit	30% co-insurance \$80 max/visit	40% co-insurance	Some services will incur additional member costs. See ProvidenceHealthPlan.com/Swedish .
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay	\$200 copay then 40% co-insurance	\$200 copay then 50% co-insurance	Prior authorization required.
	Physician/surgeon fees	20% co-insurance	20% co-insurance	40% co-insurance	Prior authorization required. See ProvidenceHealthPlan.com/Swedish .
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	10% co-insurance	40% co-insurance	Additional services available through the Caregiver Assistance Program. All services, except outpatient provider visits, must be prior authorized. See your benefit summary for ABA services. See ProvidenceHealthPlan.com/Swedish .
	Inpatient services	\$200 copay	\$200 copay then 10% co-insurance	\$200 copay then 40% co-insurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you are pregnant	Office visits	No charge	No charge	40% coinsurance	Deductible does not apply in-network.
	Childbirth/delivery professional services	\$350 copay	\$350 copay	40% coinsurance	Copay applies to provider delivery charges. Deductible does not apply in-network.
	Childbirth/delivery facility services	\$200 copay	\$200 copay then 40% co-insurance	\$200 copay then 50% co-insurance	_____none_____
If you need help recovering or have other special health needs	Home health care	20% co-insurance	20% co-insurance	40% co-insurance	Limited to 40 visits per calendar year.
	Rehabilitation services	Inpatient Services: \$200 copay Outpatient Services: 20% co-insurance \$60 max/visit	Inpatient Services: \$200 copay then 40% co-insurance Outpatient Services: 30% co-insurance \$80 max/visit	Inpatient Services: \$200 copay then 50% co-insurance Outpatient Services: 40% co-insurance	Inpatient services limited to 90 visits combined with skilled nursing. Outpatient: coverage limited to 45 visits per calendar year. See ProvidenceHealthPlan.com/Swedish .
	Habilitation services	Inpatient Services: \$200 copay Outpatient Services: 20% co-insurance \$60 max/visit	Inpatient Services: \$200 copay then 40% co-insurance Outpatient Services: 30% co-insurance \$80 max/visit	Inpatient Services: \$200 copay then 50% co-insurance Outpatient Services: 40% co-insurance	
	Skilled nursing care	\$200 copay then 10% coinsurance	\$200 copay then 40% coinsurance	\$200 copay then 50% coinsurance	Prior authorization required. Limited to 90 visits per calendar year combined with inpatient rehabilitation.
	Durable medical equipment	20% co-insurance	20% co-insurance	20% co-insurance	Certain diabetes supplies are covered in full in-network.
	Hospice services	Facility: \$200 copay	Facility: \$200 copay then 40% co-insurance	Facility: \$200 copay then 50% co-insurance	Professional: 20% co-insurance with a Providence-Swedish Alliance Provider or In-network Provider. 40% co-insurance for out-of-network provider.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		ACO Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	No coverage for vision services.
	Children's glasses	Not covered	Not covered	Not covered	
	Children's dental check-up	Not covered	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
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- 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)
- Bariatric surgery (limits apply)
- Chiropractic care (limits apply)
- Hearing Aids (limits apply)
- Infertility treatment (limits apply)

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. Additionally, if your plan is governed by ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>.

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](#).

This Summary of Benefits and Coverage required by the Affordable Care Act summarizes the benefit options available to eligible employees as of January 1, 2022. The official plan document and summary plan description will provide more complete details regarding the terms of the Plan. If there is any conflict between the statements in this Summary and the official plan documents, the terms of the plan documents will govern all rights and obligations of participants, beneficiaries, plan fiduciaries and the Company. Swedish Health Services reserves the right to amend or terminate these benefits or change the cost of coverage, for any reason, at any time.

Benefits information described here will be relevant for the majority of Swedish caregivers. Some caregivers covered by collective bargaining agreements may have differences. Swedish will share relevant requested information with labor representatives and will work to ensure we comply with our contracts and our obligation to bargain in good faith.

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)	Managing Joe's type 2 Diabetes (a year of routine in-network care of a well-controlled condition)	Mia's Simple Fracture (in-network emergency room visit and follow up care)
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- The [plan's](#) overall [deductible](#) \$350
- [Specialist coinsurance](#) 20%
- Hospital (facility) [copayment](#) \$200
- Other [copayment](#) \$350

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
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$2,650
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$3,060

- The [plan's](#) overall [deductible](#) \$350
- [Specialist coinsurance](#) 20%
- Hospital (facility) [copayment](#) \$200
- Other [copayment](#) \$200

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
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$780
Coinsurance	\$50
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,240

- The [plan's](#) overall [deductible](#) \$350
- [Specialist coinsurance](#) 20%
- Hospital (facility) [copayment](#) \$200
- Other [copayment](#) \$200

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
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$350
Copayments	\$430
Coinsurance	\$220
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$1,000

Non-Discrimination Statement:

Providence Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan:

- Provides 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)
- Provides 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 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
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。

(TTY: ملحوظة: إذا لم نتحدث اذكرك اللغة، فإن خدمات المساعدة اللغوية متوفرة لك بالمجان. اتصل برقم 1-800-878-4445 رقم هاتف الصم والبكم: 711)

ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la 1-800-878-4445 (TTY: 711).

ប្រយ័ត្ន៖ ប្រសិនបើអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយខុននកភាសា គឺអាចមានសំ ឬ សក្យ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។
ພິສິດຊຸມ

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).

ف جي ب اشد ب ا 1-800-878-4445 (TTY: 711) ن ماس ب ك بر د. شط ب راي راي گان ب صورت زب ان ي ن س ه بالت ك ن يد، جي ك ن ن كون ا ر س ي زب ان ب هاك ر ب وج ه

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

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