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 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 (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
		Preferred 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/per in-person visit; deductible does not apply	$35 copay/visit; deductible does not apply	40% coinsurance	Some services such as lab and x-ray will include additional member costs.
	Specialist visit	20% coinsurance $60 max/visit	30% coinsurance $80 max/visit	40% coinsurance	
	Preventive care/screening/ immunization	No charge; deductible does not apply	No charge; deductible does not apply	40% coinsurance	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)	Facility: No charge	X-Ray facility: 40% coinsurance Lab services facility: 20% coinsurance	Facility: 50% coinsurance	Additional professional charges may apply.
	Imaging (CT/PET scans, MRIs)	Facility: $100 copay	Facility: $100 copay then 40% coinsurance	Facility: $100 copay then 50% coinsurance	Additional professional charges may apply. 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
		Preferred Network Provider (You will pay the least)	In-Network Provider	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 ProvidenceHealth Plan.com/Swedish	Preventive drugs: Generic and Formulary	No charge; deductible does not apply	No charge; deductible does not apply	Not covered	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 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. 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 RxAssist 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; deductible does not apply	$15 copay retail; deductible does not apply	Not covered	
	Formulary brand-name drugs	$30 copay retail; deductible does not apply	$40 copay retail; deductible does not apply	Not covered	
	Non-formulary brand-name drugs	$60 copay retail; deductible does not apply	$70 copay retail; deductible does not apply	Not covered	
	Specialty drug	$75 copay retail; deductible does not apply*	Not covered	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	40% coinsurance	50% coinsurance or no coverage for some facilities	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	20% coinsurance	20% coinsurance	40% coinsurance	
If you need immediate medical attention	Emergency room care	$150 copay first visit; deductible does not apply	$150 copay first visit; deductible does not apply	$150 copay first visit; deductible does not apply	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% coinsurance	$75 copay then 20% coinsurance	$75 copay then 20% coinsurance	To the nearest appropriate facility.
	Urgent care	20% coinsurance $60 max/visit	30% coinsurance $80 max/visit	40% coinsurance	Some services will incur additional member costs.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network Provider (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
If you have a hospital stay	Facility fee (e.g., hospital room)	$200 copay	$200 copay then 40% coinsurance	$200 copay then 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	20% coinsurance	20% coinsurance	40% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Provider visits: No charge; deductible does not apply All other services: No charge	Provider visits: No charge; deductible does not apply All other services: 10% coinsurance	40% coinsurance	Additional services available through the Caregiver Assistance Program. 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.
	Applied behavioral analysis	No charge; deductible does not apply	No charge; deductible does not apply	40% coinsurance	
	Inpatient services	$200 copay	$200 copay then 10% coinsurance	$200 copay then 40% coinsurance	
If you are pregnant	Office visits	No charge; deductible does not apply	No charge; deductible does not apply	40% coinsurance	——————none——————
	Childbirth/delivery professional services	$350 copay	$350 copay	40% coinsurance	Copay applies to provider delivery charges.
	Childbirth/delivery facility services	$200 copay	$200 copay then 40% coinsurance	$200 copay then 50% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	20% coinsurance	20% coinsurance	40% coinsurance	Limited to 40 visits per calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Preferred Network (You will pay the least)	In-Network Provider	Out-of-Network Provider (You will pay the most)	
	Rehabilitation services	Inpatient Services: $200 copay Outpatient Services: 20% coinsurance $60 max/visit	Inpatient Services: $200 copay then 40% coinsurance Outpatient Services: 30% coinsurance $80 max/visit	Inpatient Services: $200 copay then 50% coinsurance Outpatient Services: 40% coinsurance	Inpatient services limited to 90 visits combined with skilled nursing. Outpatient: coverage limited to 45 visits per calendar year. Limits do not apply to Mental Health Services.
	Habilitation services	Inpatient Services: $200 copay Outpatient Services: 20% coinsurance	Inpatient Services: $200 copay then 40% coinsurance Outpatient Services: 20% coinsurance	Inpatient Services: $200 copay then 50% coinsurance Outpatient Services: 40% coinsurance	
	Skilled nursing care	$200 copay then 10% coinsurance	$200 copay then 40% coinsurance	$200 copay then 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 90 visits per calendar year combined with inpatient rehabilitation.
	Durable medical equipment	Diabetes supplies: No charge; deductible does not apply All other medical equipment: 20% coinsurance	Diabetes supplies: No charge; deductible does not apply All other medical equipment: 20% coinsurance	Diabetes supplies: No charge; deductible does not apply; Appliances and prosthetics: 20% coinsurance; All other medical equipment: 40% coinsurance	——————none——————
	Hospice services	Facility: $200 copay	Facility: $200 copay then 40% coinsurance	Facility: $200 copay then 50% coinsurance	Professional: 20% coinsurance with a Providence-Swedish Alliance Provider or In-network Provider. 40% coinsurance for out-of-network provider.
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)
- Infertility treatments (Diagnostic testing and counseling of infertility are covered. Limits may apply.)
- Long-term care
- Private-duty nursing
- Non-emergency care when traveling outside the U.S.
- 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 (limited to 12 visits combined with chiropractic care)
- Bariatric surgery (covered only when performed at our wholly-owned facilities [Providence St Joseph Health affiliates])
- Chiropractic care (limited to 12 visits combined with acupuncture)
- Hearing Aids (limited to $1,500 every 36 months)

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 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 http://www.ProvidenceHealthPlan.com.
- 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 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, 2024. 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.

*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	$350
Specialist *coinsurance*	20%
Hospital (facility) *copayment*	$200
Other *copayment*	$350

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	**$12,800**

In this example, Peg would pay:

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

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

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**

In this example, Joe would pay:

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

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

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**

In this example, Mia would pay:

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

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

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。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711 (TTY:

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 می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با (TTY: 711) 1-800-878-4445 تماس بگیرید.

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)