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 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?	$0 at Indian Health Care Provider (IHCP) or with IHCP referral at non-IHCP; In-Network: $8,700 person / $17,400 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. Services received at an IHCP or with an IHCP referral are covered at no charge.	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: $8,700 person / $17,400 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, chiropractic manipulation, acupuncture, services not covered, fees above 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. Services received from Indian Health Services (IHS) providers are covered in full.	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
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	No charge	$50 copay/per in-person visit; deductible does not apply or $50 copay/per virtual visit; deductible does not apply	Not covered	Some services such as lab and x-ray will include additional member costs. Phone and video visits are covered in full in-network.
	Specialist visit	No charge	$100 copay/per visit; deductible does not apply	Not covered	Some services such as lab and x-ray will include additional member costs.
	Preventive care/screening/ immunization	No charge	No charge; deductible does not apply	Not covered	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)	No charge	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	No charge	Not covered	Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP 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	$20 copay/per 30 day supply 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 a brand-name drug is requested when a generic is available, you will pay the difference in cost, plus your Tier 4 or Tier 6 cost-share. Specialty drugs (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	No charge retail	$20 copay/per 30 day supply retail; deductible does not apply	Not covered	
	Tier 3 drugs	No charge retail	No charge retail	Not covered	
	Tier 4 drugs	No charge retail	No charge retail	Not covered	
	Tier 5 drugs	No charge retail	No charge retail	Not covered	
	Tier 6 drugs	No charge retail	No charge retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	No charge	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	No charge	Not covered	
If you need immediate medical attention	Emergency room care	No charge	No charge	No charge	For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	No charge	No charge	No charge	None
	Urgent care	No charge	$100 copay/per visit; deductible does not apply in-network	No charge	Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	No charge	Not covered	Prior authorization required.
	Physician/surgeon fees	No charge	No charge	Not covered	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Office visit: $50 copay/per in-person visit; deductible does not apply or $50 copay/per virtual visit; deductible does not apply All other services: No charge	Not covered	All services except provider office visits must be prior authorized. See your benefit summary for ABA services.
	Inpatient services	No charge	No charge	Not covered	
If you are pregnant	Office visits	No charge	No charge; deductible does not apply	Not covered	None
	Childbirth/delivery professional services	No charge	No charge	Not covered	None
	Childbirth/delivery facility services	No charge	No charge	Not covered	None

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
If you need help recovering or have other special health needs	Home health care	No charge	No charge	Not covered	Prior authorization required.
	Rehabilitation services	No charge	Inpatient: No charge Outpatient - Physical Therapy: $50 copay/per visit; deductible does not apply Outpatient - Occupational & Speech Therapy: $50 copay/per visit; deductible does not apply	Not covered	Inpatient services: Limited to 30 days for in-network providers per calendar year. Limited to 60 days for in-network providers per calendar year for head/spinal injuries. Prior authorization required. Outpatient services: Limited to 30 visits for in-network providers per calendar year. Additional visits per specified condition: Limited to 30 visits for in-network providers per calendar year. Limits do not apply to Mental Health Services.
	Habilitation services	No charge	Inpatient: No charge Outpatient: $50 copay/per visit; deductible does not apply	Not covered	Inpatient services: Limited to 30 days for in-network providers per calendar year. Limited to 60 days for in-network providers per calendar year for head/spinal injuries. Prior authorization required. Outpatient services: Limited to 30 visits for in-network providers per calendar year. Limits do not apply to Mental Health Services.
	Skilled nursing care	No charge	No charge	Not covered	Prior authorization required. Limited to 60 days for in-network providers per calendar year.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Indian Health Care Provider (IHCP) (You will pay the least)	Non-IHCP In-Network Provider (You will pay more)	Non-IHCP Out-of-Network Provider (You will pay the most)	
	Durable medical equipment	No charge	Diabetic Supplies: No charge; deductible does not apply All other equipment: No charge	Not covered	None
	Hospice services	No charge	No charge	Not covered	Prior authorization required. Respite care: Limited to 5 days, up to 30 days per lifetime for in-network providers.
If your child needs dental or eye care	Children's eye exam	No charge	No charge; deductible does not apply	Not covered	Limited to 1 exam per calendar year.
	Children's glasses	No charge	No charge; deductible does not apply	Not covered	Limited to 1 pair per calendar year.
	Children's dental check-up	Not covered	Not covered	Not covered	None

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.)

- Bariatric surgery
- Cosmetic surgery (with certain exceptions)
- Dental care (Adult)
- Dental care (Child)
- Infertility treatment
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care (covered for diabetics)
- Voluntary termination of pregnancy
- 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)
- Chiropractic care (limits apply)
- Hearing aids (limits apply)
- Non-emergency care when traveling outside the U.S. See 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: Oregon Division of Financial Regulation at 1-888-877-4894, email DFR.InsuranceHelp@oregon.gov or go to https://dfr.oregon.gov/help/Pages/index.aspx, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-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 1-800-878-4445, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or https://www.dol.gov/agencies/ebsa/about-ebsa/ask-a-question/ask-ebsa, or you can contact the Oregon Division of Financial Regulation by:

- Calling 503-947-7984 or the toll free message line at 888-877-4894
- Writing to the Oregon Division of Financial Regulation, Consumer Protection Unit at P.O. Box 14480 Salem, OR 97309-0405
- Through the website at https://dfr.oregon.gov/help/Pages/index.aspx
- E-mail at: DFR.InsuranceHelp@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.

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	$8,700
Specialist copayment	$100
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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	$8,700
Copayments	$0
Coinsurance	$0
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$8,720**

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

The plan's overall deductible	$8,700
Specialist copayment	$100
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$3,700
Copayments	$500
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$4,200**

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

The plan's overall deductible	$8,700
Specialist copayment	$100
Hospital (facility) coinsurance	0%
Other coinsurance	0%

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*	$2,100
Copayments	$400
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Mia would pay is	**$2,500**

*Note: These numbers assume the patient received care from an IHCP provider or with IHCP referral at a non-IHCP. If you receive care from a non-IHCP provider without a referral from an IHCP your costs may be higher.

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 1-800-878-4445. 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 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: (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៖ 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)