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: $150 person / $300 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: $1,075 person / $2,150 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 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 $10 copay/per in-person visit; deductible does not apply or $10 copay/per virtual visit; deductible does not apply	Not covered	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. $5 copay applies to the first three Primary Care Provider and/ or behavioral health outpatient visits combined.
	Specialist visit	$20 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; 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)	10% coinsurance	Not covered	None
	Imaging (CT/PET scans, MRIs)	10% coinsurance	Not covered	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	$5 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 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 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	$5 copay/per 30 day supply retail; deductible does not apply	Not covered	
	Tier 3 drugs	$10 copay/per 30 day supply retail; deductible does not apply	Not covered	
	Tier 4 drugs	25% coinsurance retail; deductible does not apply	Not covered	
	Tier 5 drugs	25% coinsurance retail; deductible does not apply	Not covered	
	Tier 6 drugs	25% coinsurance retail; deductible does not apply	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	10% coinsurance	Not covered	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	10% coinsurance	Not covered	
If you need immediate medical attention	Emergency room care	10% coinsurance	10% coinsurance	For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	10% coinsurance	10% coinsurance	None
	Urgent care	$30 copay/per visit; deductible does not apply in-network	$30 copay/per visit	Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	10% coinsurance	Not covered	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	10% coinsurance	Not covered	

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 $10 copay/per in-person visit; deductible does not apply or $10 copay/per virtual visit; deductible does not apply All other services: 10% coinsurance	Not covered	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. $5 copay applies to the first three Primary Care Provider and/or behavioral health outpatient visits combined.
	Inpatient services	10% coinsurance	Not covered	
If you are pregnant	Office visits	No charge; deductible does not apply	Not covered	None
	Childbirth/delivery professional services	10% coinsurance	Not covered	Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	10% coinsurance	Not covered	None
If you need help recovering or have other special health needs	Home health care	10% coinsurance	Not covered	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)	
	Rehabilitation services	Inpatient: 10% coinsurance Outpatient - Physical Therapy: $10 copay/per visit; deductible does not apply Outpatient - Occupational & Speech Therapy: $10 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. 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 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 and Substance Use Disorder Services.
	Habilitation services	Inpatient: 10% coinsurance Outpatient: $10 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. 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 for in-network providers per calendar year. Limits do not apply to Mental Health and Substance Use Disorder Services.
	Skilled nursing care	10% coinsurance	Not covered	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 for in-network providers per calendar year.

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)	
	Durable medical equipment	Diabetic Supplies: No charge; deductible does not apply All other equipment: 10% coinsurance	Not covered	None
	Hospice services	10% coinsurance	Not covered	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 for in-network providers.
If your child needs dental or eye care	Children's eye exam	No charge; deductible does not apply	Not covered	Limited to 1 exam per calendar year.
	Children's glasses	No charge; deductible does not apply	Not covered	Limited to 1 pair per calendar year.
	Children's dental check-up	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.)

- Abortion
- 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)
- 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

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.
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or dfr.oregon.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 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.

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	$150
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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	$150
Copayments	$0
Coinsurance	$900
What isn't covered	
Limits or exclusions	$20
The total Peg would pay is	**$1,070**

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

The plan's overall deductible	$150
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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*	$100
Copayments	$300
Coinsurance	$0
What isn't covered	
Limits or exclusions	$0
The total Joe would pay is	**$400**

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

The plan's overall deductible	$150
Specialist copayment	$20
Hospital (facility) coinsurance	10%
Other coinsurance	10%

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*	$150
Copayments	$50
Coinsurance	$200
What isn't covered	
Limits or exclusions	$400
The total Mia would pay is	**$800**

*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:

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, sexual orientation, religion, gender identity, marital status 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, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- 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 need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 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, sexual orientation, religion, gender identity, marital status 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
E-mail: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: 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 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 hhs.gov/ocr/office/file/index.html.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-898-8174 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文， 您可以免費獲得語言支援服務。請致電 1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت میکنید، تسهیلات زبا ی ن به صورت رایگان به شما ارائه میشود. با 1-800-898-8174 (TTY: 711) تماس بگ رییید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese: お知らせ：日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174（TTY: 711）まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174(TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले दनम्र भाषा सहायता सेवाहरू दन:शुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गनुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ ប ើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចម្គនបសវាជំនួយខ្នកភាសាបោយមិនគិតថ្លៃពីបោកអ្នក។ សូមបៅទូរស័ពទបលម 1-800-898-8174 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້າວ່າທ່ານເວ ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫ ຼືອ ດ້ ານພາສາ ໂດຍບ ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711)