Administered by Providence Health Plan

Your Benefit Summary

Swedish

2024 PPO Medical Plan

What You Pay In Network	What You Pay Out of Network	Calendar Year In-Network Medical Out-of-Pocket Maximum	Calendar Year Out-of-Network Medical Out-of-Pocket Maximum	Calendar Year In-Network Medical Deductible	Calendar Year Out-of-Network Medical Deductible
0-40% coinsurance (after deductible)	**40-50%** coinsurance (after deductible; UCR applies)	**$3,000** per person **$6,000** per family (2 or more)	**$7,300** per person **$14,600** per family (2 or more)	**$350** per person **$700** per family (2 or more)	**$1,300** per person **$2,600** per family (2 or more)

Important information about your plan

This summary provides only highlights of your benefits. Certain limitations and exclusions apply. To view all of your plan details, including your Summary Plan Description, register for myProvidence at **www.ProvidenceHealthPlan.com/getstarted.**

- Not sure what a word or phrase means? See the last page for the definitions used in this summary.
- Your in-network and out-of-network deductibles accumulate together, as do your in-network and out-of-network out-of-pocket maximums, to meet the calendar year limits listed above.
- Your Calendar Year Medical Deductible applies to your Calendar Year Medical Out-of-Pocket Maximum.
- You may pay a lower coinsurance when you choose a participating Preferred Network provider or facility. For details go to ProvidenceHealthPlan.com/findaprovider
- This plan summary highlights some of the features of this Swedish medical plan. This summary does not include all plan rules and details. The terms of your benefit plans are governed by legal documents. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. Swedish reserves the right to change or discontinue its benefit plans at any time and for any reason.

Benefit Highlights	After you pay your calendar year deductible, then you pay the following for covered services:		
✓ No deductible needs to be met prior to receiving this benefit.	**Preferred Network** (Tier I)	**Other In-Network Providers** (Tier II)	**Out-of-Network** (Tier III)
Preventive Health and Wellness Services			
• Periodic health exams; well-baby care	Covered in full✓	Covered in full✓	40%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	Covered in full✓	40%
• Mammogram	Covered in full✓	Covered in full✓	40%
• Prostate screening exam (calendar year)	Covered in full✓	Covered in full✓	40%
• Colorectal exam	Covered in full✓	Covered in full✓	40%
• Colorectal cancer screening: sigmoidoscopy, colonoscopy (for members age 45 and over)	Covered in full✓	Covered in full✓	40%
• The following tests (when received with your periodic health exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood	Covered in full✓	Covered in full✓	40%
• The following services (for members with diabetes): HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet	Covered in full✓	Covered in full✓	40%
• Pneumococcal vaccine	Covered in full✓	Covered in full✓	40%
• Flu vaccine	Covered in full✓	Covered in full✓	40%
• Routine immunizations/shots	Covered in full✓	Covered in full✓	40%
• Nutritional counseling	Covered in full✓	Covered in full✓	40%
• Vision and hearing screening	Covered in full✓	Covered in full✓	40%
• Tobacco use cessation; counseling/classes, and deterrent medications, including prescription and over the counter.	Covered in full✓	Covered in full✓	Covered in full✓

Benefit Highlights (continued)	Preferred Network	Other In-Network Providers	Out-of-Network
Physician / Provider Services			
• Office visits to Primary Care Provider	$20✓	$35✓	40%
• Office visits to specialist	20%, $60 max / visit	30%, $80 max / visit	40%
• Inpatient hospital visits	20%	20%	40%
• Surgery; anesthesia	20%	20%	40%
• Allergy shots	Covered in full✓	Covered in full✓	40%
• Infusions and injectible medications - outpatient	20%	20%	40%
Outpatient Diagnostic Services			
• X-ray services - facility	Covered in full	40%	50%
• Lab services - facility	Covered in full	20%	50%
• MRI & CT - facility	$100	$100 + 40%	$100 + 50%
Hospital Services			
• Acute care	$200	$200 + 40%	$200 + 50%
• Rehabilitative care (90 days/calendar year combined with skilled nursing facility)	$200	$200 + 40%	$200 + 50%
• Skilled nursing facility (90 days/calendar year combined with inpatient rehabilitative care)	$200 + 10%	$200 + 40%	$200 + 50%
Maternity			
• Prenatal services	Covered in full✓	Covered in full✓	40%
• Delivery and postnatal services	$350✓	$350✓	40%
• Hospital services	$200	$200 + 40%	$200 + 50%
• Routine newborn nursery care - inpatient professional	20%	20%	40%
• Infertility services (testing and counseling only)	20%, $60 max / visit	30%, $80 max / visit	40%
Medical Equipment, Supplies and Devices			
• Appliances and prosthetics	20%	20%	20%
• Removable custom shoe orthotics (limited to $350 per calendar year)	20%	20%	40%
• Diabetic supplies (See SPD for details)	Covered in full✓	Covered in full✓	Covered in full✓
• Hearing Aids ($1500 maximum (for both ears) every rolling 36 months	20%	20%	40%
Emergency / Urgent Care / Emergency Medical Transportation			
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.) **Second Visit: $200; Three or more visits: $250**	$150 first visit✓	$150 first visit✓	$150 first visit✓
• Urgent care services (for non-life threatening illness/minor injury)	20%, $60 max / visit	30%, $80 max / visit	40%
• Emergency medical transportation	$75 + 20%	$75 + 20%	$75 + 20%
Other Covered Services			
• Outpatient rehabilitative services (45 visits per calendar year. Physical and Occupational Therapy require prior authorization through eviCore. Limits do not apply to Mental Health or Substance Use Disorder services.)	20%, $60 max / visit*	30%, $80 max / visit**	40%○
• Outpatient surgery (Including ambulatory surgery centers)	20%*	20%**	40% (no coverage for some facilities)○
• Infusion, chemotherapy and radiation therapy	20%*	20%**	40%○
• Spinal manipulations (12 visits per calendar year)	20%	20%	20%
• Massage therapy and acupuncture (limited to 12 visits combined per calendar year)	20%	20%	20%
• Bariatric surgery (Only at our wholly-owned facilities, Providence St. Joseph Health affiliates. Limitations apply.)	$200	Not covered	Not covered
• Temporomandibular joint (TMJ) service	20%*	20%**	40%○
• Home health care (limited to 40 visits per calendar year)	20%	20%	40%
• Hospice care (Limited to 6 months per lifetime)	20%*	20%**	40%○

* Inpatient facility charges at Providence-Swedish Health Alliance facility - $200 copay, outpatient facility charges at Providence-Swedish Health Alliance facility - Covered in full.
○ Inpatient facility charges at out-of-network facility - $200 + 50%, outpatient facility charges at out-of-network facility - 50%
** Inpatient facility charges at in-network facility - $200 + 40%, outpatient facility charges at in-network facility - 40%

Benefit Highlights (continued)	Preferred Network	Other In-Network Providers	Out-of-Network
Mental Health / Chemical Dependency			
• Inpatient, residential services	$200	$200 + 10%	$200 + 40%
• Day treatment, intensive outpatient and partial hospitalization services	Covered in full	10%	40%
• Applied behavior analysis	Covered in full✓	Covered in full✓	40%
• Outpatient provider visits	Covered in full✓	Covered in full✓	40%
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies; not subject to deductible)			
The annual out-of-pocket maximum for prescription drugs is $1,500 Individual / $3,000 Family.			
• ACA Preventive Drugs	Covered in full✓	Covered in full✓	Not covered
• Enhanced Preventive drugs			
- Retail pharmacy	$3✓	$3✓	Not covered
- Mail Order Pharmacy - Postal Prescription Services	Covered in full✓	Not covered	Not covered
• Generic	$7.50✓	$15✓	Not covered
• Formulary brand-name drugs	$30✓	$40✓	Not covered
• Non-formulary brand-name drugs	$60✓	$70✓	Not covered
• Specialty drugs (limited to a 30-day supply)	$75✓	Not covered	Not covered

Your guide to the words or phrases used to explain your benefits

ACA Preventive drug
ACA Preventive drugs are medications which are listed in our formulary and are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

Enhanced Preventive drug
Enhanced preventive does not include any drug or medication used to treat an existing illness, injury or condition. Enhanced Preventive drugs are subject to formulary as well as pharmacy management programs such as prior authorization, step therapy and/or quantity limits. Drugs indicated as Enhanced preventive on your formulary must be filled at PPS Mail Order pharmacy.

Formulary
A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

In-Network benefit
The in-network benefit is an extensive network of highly qualified physicians and health care providers, also known as network providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from network providers. To find a in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

In-Network provider
A physician or provider of health care services who belongs to the Providence Health Plan in-network provider panel. To find an in-network provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

Medical/pharmacy deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays or coinsurance for any supplemental benefits provided by your employer, such as routine vision care
- Copays and coinsurance for services that do not apply to the deductible.

Medical/pharmacy out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in and out-of-plan services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Summary Plan Description for details.

Out-of-Network benefit
Refers to services you receive from a non-network provider. Your out-of-pocket costs are generally higher when you receive covered services from non-network providers. To find a network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Out-of-Network provider
Any health care professional who does not participate within Providence Health Plan's in-network panel of physicians and providers of health care services.

Participating pharmacies
Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply of short-term and maintenance prescriptions.
- Preferred Retail: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.
- Specialty: a participating pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.

Primary Care Provider
A qualified practitioner who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics or gynecology.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

Usual, Customary & Reasonable (UCR)
Describes your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us
Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

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 and 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
Email: 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 *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*.

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 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (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 1-800-878-4445 (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 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (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。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

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

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (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 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ຊືນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).