



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, www.ProvidenceHealthPlan.com. 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.cciio.cms.gov or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network : \$2,850 person / \$5,700 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 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 : \$7,900 person / \$15,800 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 , penalties, 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. For a list of participating providers see www.ProvidenceHealthPlan.com/providerdirectory or call 1-800-878-4445.	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	
		Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$40 copay /per visit; deductible does not apply	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	\$80 copay /per visit; deductible does not apply	Some services such as lab and x-ray will include additional member costs.
	Preventive care/screening/immunization	No charge; deductible does not apply	Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf .
If you have a test	Diagnostic test (x-ray, blood work)	30% coinsurance	None
	Imaging (CT/PET scans, MRIs)	30% coinsurance	Prior authorization required.
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProvidenceHealthPlan.com	Generic drugs (preferred and non-preferred)	\$15 copay /per 30 day supply retail; deductible does not apply	ACA Preventive drugs are covered in full in-network . Covers up to a 30-day supply (retail); 90-day supply (preferred retail and mail order) covered at 3 times retail. 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 non-preferred brand cost-share. Specialty drugs can only be purchased at a participating specialty pharmacy (limited to 30 days).
	Preferred Brand drug	\$60 copay /per 30 day supply retail; deductible does not apply	
	Non-Preferred Brand drug	50% coinsurance retail; deductible does not apply	
	Specialty drug (preferred and non-preferred)	50% coinsurance retail; deductible does not apply	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	Prior authorization required.
	Physician/surgeon fees	30% coinsurance	
If you need immediate medical attention	Emergency room care	30% coinsurance	For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	30% coinsurance	None
	Urgent care	\$70 copay /per visit; deductible does not apply in-network	Some services will include additional member costs.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)		
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance		Prior authorization required.
	Physician/surgeon fees	30% coinsurance		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$40 copay /per visit; deductible does not apply All other services: 30% coinsurance		All services except provider office visits must be prior authorized. See your benefit summary for ABA services.
	Inpatient services	30% coinsurance		
If you are pregnant	Office visits	No charge; deductible does not apply		None
	Childbirth/delivery professional services	30% coinsurance		Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	30% coinsurance		None

Common Medical Event	Services You May Need	What You Will Pay	
		Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
If you need help recovering or have other special health needs	Home health care	30% coinsurance	Prior authorization required.
	Rehabilitation services	Inpatient: 30% coinsurance Outpatient - Physical Therapy: \$40 copay /per visit; deductible does not apply Outpatient - Occupational & Speech Therapy: \$40 copay /per visit; deductible does not apply	Inpatient services: Limited to 30 visits for in-network providers per calendar year. Limited to 60 visits 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	Inpatient: 30% coinsurance Outpatient: \$40 copay /per visit; deductible does not apply	Inpatient services: Prior authorization required. Limited to 30 visits for in-network providers per calendar year. Outpatient services: Limited to 30 visits for in-network providers per calendar year. Limits do not apply to Mental Health Services.
	Skilled nursing care	30% coinsurance	Prior authorization required. Limited to 60 days for in-network providers per calendar year.
	Durable medical equipment	Diabetic Supplies: No charge; deductible does not apply All other equipment: 30% coinsurance	None
	Hospice services	30% coinsurance	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; deductible does not apply
Children's glasses		No charge; deductible does not apply	Limited to 1 pair per calendar year.
Children's dental check-up		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](#).)

- | | | |
|--|-------------------------|---|
| • Acupuncture | • Dental care (Child) | • Routine eye care (Adult) |
| • Bariatric surgery | • Infertility treatment | • Routine foot care (covered for diabetics) |
| • Chiropractic care | • Long-term care | • Voluntary termination of pregnancy |
| • Cosmetic surgery (with certain exceptions) | • Private-duty nursing | • Weight loss programs |
| • Dental care (Adult) | | |

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your [plan](#) document.)

- | | |
|-------------------------------|---|
| • Hearing aids (limits apply) | • Non-emergency care when traveling outside the U.S. See www.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 cp.ins@oregon.gov or go to <http://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx>, 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, the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>, or you can contact the Oregon Insurance Division by:

- Calling (503) 947-7984 or the toll free message line at (888) 877-4894
- Writing to the Oregon Insurance Division, Consumer Protection Unit, 350 Winter Street NE, Salem, OR 97301-3883
- Through the Internet at <http://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx>
- E-mail at: cp.ins@state.or.us

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 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](#).

-----*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)																																											
■ The plan's overall deductible	\$2,850	■ The plan's overall deductible	\$2,850	■ The plan's overall deductible	\$2,850																																										
■ Specialist copayment	\$80	■ Specialist copayment	\$80	■ Specialist copayment	\$80																																										
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■ Other coinsurance	30%	■ Other coinsurance	30%	■ Other coinsurance	30%																																										
<p>This EXAMPLE event includes services like: Specialist office visits (<i>prenatal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>)</p>		<p>This EXAMPLE event includes services like: Primary care physician office visits (<i>including disease education</i>) Diagnostic tests (<i>blood work</i>) Prescription drugs Durable medical equipment (<i>glucose meter</i>)</p>		<p>This EXAMPLE event includes services like: Emergency room care (<i>including medical supplies</i>) Diagnostic test (<i>x-ray</i>) Durable medical equipment (<i>crutches</i>) Rehabilitation services (<i>physical therapy</i>)</p>																																											
Total Example Cost	\$12,800	Total Example Cost	\$7,400	Total Example Cost	\$1,900																																										
<p>In this example, Peg would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$2,850</td> </tr> <tr> <td>Copayments</td> <td>\$40</td> </tr> <tr> <td>Coinsurance</td> <td>\$2,200</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$10</td> </tr> <tr> <td>The total Peg would pay is</td> <td>\$5,100</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$2,850	Copayments	\$40	Coinsurance	\$2,200	What isn't covered		Limits or exclusions	\$10	The total Peg would pay is	\$5,100	<p>In this example, Joe would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$200</td> </tr> <tr> <td>Copayments</td> <td>\$1,500</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$30</td> </tr> <tr> <td>The total Joe would pay is</td> <td>\$1,730</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$200	Copayments	\$1,500	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$30	The total Joe would pay is	\$1,730	<p>In this example, Mia would pay:</p> <table border="1"> <thead> <tr> <th colspan="2">Cost Sharing</th> </tr> </thead> <tbody> <tr> <td>Deductibles</td> <td>\$1,400</td> </tr> <tr> <td>Copayments</td> <td>\$200</td> </tr> <tr> <td>Coinsurance</td> <td>\$0</td> </tr> <tr> <th colspan="2">What isn't covered</th> </tr> <tr> <td>Limits or exclusions</td> <td>\$200</td> </tr> <tr> <td>The total Mia would pay is</td> <td>\$1,800</td> </tr> </tbody> </table>		Cost Sharing		Deductibles	\$1,400	Copayments	\$200	Coinsurance	\$0	What isn't covered		Limits or exclusions	\$200	The total Mia would pay is	\$1,800
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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: បើសិនអ្នកនិយាយខ្មែរ, សេវាជំនួយភាសាខ្មែរមិនគិតលុយ គឺចូលសំបុត្រអក្សរចូរស័ព្ទ 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).

فیم دشا اب اب 1-800-878-4445 (TTY: 711) سامت دیری گب. امش یارب ناگی ار تروصب ی نابز تالی هست، دینک یم وگتفگ ی سراف نابز هب رگا: هجوت

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)