




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.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 ? | \$1,720 employee \$3,450 employee+child(ren) \$4,300 family | 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 member on the policy, the overall family deductible must be met before the plan begins to pay. |
| Are there services covered before you meet your deductible ? | Yes. Most preventive care services 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 ? | \$2,400 employee \$4,800 employee+child(ren) \$5,750 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, copays or coinsurance for Supplemental Benefits, 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 . |

 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 | 5% coinsurance | 40% coinsurance | Some services will include additional member costs. |
| | Specialist visit | 5% coinsurance | 40% coinsurance | |
| | Preventive care/screening/immunization | No charge; deductible does not apply | 40% coinsurance | 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) | 5% coinsurance | 40% coinsurance | —————none————— |
| | Imaging (CT/PET scans, MRIs) | 5% coinsurance | 40% coinsurance | —————none————— |

| 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 www.ProvidenceHealthPlan.com | Preventive drug | No charge | 40% coinsurance | Deductible does not apply in-network to preventive drugs. |
| | Generic drug | 5% coinsurance retail and mail order | 40% coinsurance | Covers up to a 34-day supply (retail prescription); 90-day supply (mail-order prescription). |
| | Brand-name drug | 5% coinsurance retail and mail order | 40% coinsurance | |
| | Specialty drug | 5% coinsurance | Not covered | 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. Specialty drugs can only be purchased at a participating specialty pharmacy (limited to 30 days). |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | 5% coinsurance | 40% 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 | 5% coinsurance | 40% coinsurance | |
| If you need immediate medical attention | Emergency room care | 5% coinsurance | 5% coinsurance | For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits. |
| | Emergency medical transportation | 5% coinsurance | 5% coinsurance | —————none————— |
| | Urgent care | 5% coinsurance | 40% coinsurance | Some services will include additional member costs. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 5% coinsurance | 40% coinsurance | —————none————— |

| 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) | |
| | Physician/surgeon fees | 5% coinsurance | 40% coinsurance | |
| If you need mental health, behavioral health, or substance abuse services | Outpatient services | 5% coinsurance | 40% coinsurance | All out-of-network services except provider office visits may require prior authorization . If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. No prior authorization required for Applied Behavioral Analysis (ABA) services. |
| | Inpatient services | 5% coinsurance | 40% coinsurance | |
| If you are pregnant | Office visits | No charge; deductible does not apply | 40% coinsurance | —————none————— |
| | Childbirth/delivery professional services | No charge | 40% coinsurance | Coinsurance applies to provider delivery charges. |
| | Childbirth/delivery facility services | 5% coinsurance | 40% coinsurance | —————none————— |
| If you need help recovering or have other special health needs | Home health care | 5% coinsurance | 40% coinsurance | —————none————— |
| | Rehabilitation services | 5% coinsurance | 40% coinsurance | Outpatient services-developmental delay: coverage limited to 60 visits per therapy type per calendar year. |
| | Habilitation services | 5% coinsurance | 40% coinsurance | Outpatient services-developmental delay: coverage limited to 60 visits per therapy type per calendar year. |
| | Skilled nursing care | 5% coinsurance | 40% coinsurance | No limit in-network; 100 visit limit out-of-network. |
| | Durable medical equipment | Diabetic Supplies: no charge; deductible does not apply | 40% coinsurance | —————none————— |

| 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) | |
| | | All other equipment: 5% coinsurance | | |
| | Hospice services | No charge | 40% coinsurance | —————none————— |
| If your child needs dental or eye care | Children’s eye exam | Not covered | Not covered | No coverage for eye exam |
| | Children’s glasses | Not covered | Not covered | No coverage for glasses. |
| | Children’s dental check-up | 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 .) | | |
|---|--|---|
| <ul style="list-style-type: none"> • Cosmetic surgery (with certain exceptions) • Dental care (Adult) | <ul style="list-style-type: none"> • Dental check-up (Child) • Long-term care • Eye exams and glasses (Child) | <ul style="list-style-type: none"> • 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.) | | |
|---|---|---|
| <ul style="list-style-type: none"> • Bariatric surgery • Acupuncture (30 visits per calendar year) • Chiropractic care (30 visits per calendar year) | <ul style="list-style-type: none"> • Hearing Aids • Infertility treatment | <ul style="list-style-type: none"> • 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:

- Providence Health Plan at 503-574-8757/1-800-878-4445 (toll-free) or <http://www.ProvidenceHealthPlan.com>.
- For group health coverage subject to ERISA, contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.
- For non-federal governmental group health plans, contact the Department of Health and Human Services, Center for Consumer Information and Insurance Oversight, at 1-877-267-2323 x61565 or www.cciio.cms.gov.
- Church plans are not covered by the Federal COBRA continuation coverage rules. If the coverage is insured, individuals should contact the Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or <https://dfr.oregon.gov> regarding their possible rights to continuation coverage under State law.

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 503-574-5100 or <http://www.ProvidenceOregon.org/intel>
- 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](#).

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 | \$1,720 |
| ■ Specialist coinsurance | 5% |
| ■ Hospital (facility) coinsurance | 5% |
| ■ Other coinsurance | 5% |

This EXAMPLE event includes services like:

Specialist office visits (*prenatal 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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,720 |
| Copayments | \$0 |
| Coinsurance | \$512 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$60 |
| The total Peg would pay is | \$2,292 |

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,720 |
| ■ Specialist coinsurance | 5% |
| ■ Hospital (facility) coinsurance | 5% |
| ■ Other coinsurance | 5% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,720 |
| Copayments | \$0 |
| Coinsurance | \$239 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$55 |
| The total Joe would pay is | \$2,014 |

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

| | |
|---|---------|
| ■ The plan's overall deductible | \$1,720 |
| ■ Specialist coinsurance | 5% |
| ■ Hospital (facility) coinsurance | 5% |
| ■ Other coinsurance | 5% |

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:

| <i>Cost Sharing</i> | |
|-----------------------------------|----------------|
| Deductibles | \$1,696 |
| Copayments | \$0 |
| Coinsurance | \$0 |
| <i>What isn't covered</i> | |
| Limits or exclusions | \$0 |
| The total Mia would pay is | \$1,696 |

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。

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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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បម្រើអ្នក។ 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).

با باشد می ف (TTY: 711) توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما. بیگریید تماس 1-800-878-4445

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)