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: $5,500/**per person **$11,000/**per family (**2** or more). **Out-of-Network: $11,000/**per person **$22,000/**per 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 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.** Office visits, outpatient lab/x-ray, most preventive care and urgent care services in-network.	This plan covers some items and services even if you haven't yet met the annual 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: $7,150/**per person **$14,300/**per family (**2** or more). **Out-of-Network: $14,300/**per person **$28,600/**per 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, copays for adult vision services or chiropractic manipulation and 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 www.ProvidenceHealthPlan.com/providerdirectory 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 (a balance bill). 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?	**Yes.**	This plan will pay some or all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

 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	$35 copay/visit	50% coinsurance	Deductible does not apply in-network. 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	$65 copay/visit	50% coinsurance	Deductible does not apply in-network. Some services such as lab and x-ray will include additional member costs.
	Preventive care/screening/ immunization	No charge	50% coinsurance	Deductible does not apply in-network. 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	50% coinsurance	Deductible does not apply in-network.
	Imaging (CT/PET scans, MRIs)	30% coinsurance	50% coinsurance	Prior authorization required.

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	Preferred generic drug	$15 copay retail $45 copay mail order	Not covered	ACA Preventive drugs are covered in full in-network. Deductible does not apply to Preferred generic, Non-preferred generic, Preferred brand-name and Non-preferred brand-name drugs. Covers up to a 30-day supply (retail prescription); 90-day supply (mail order prescription). 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 copay.
	Non-preferred generic drug	$35 copay retail $105 copay mail order	Not covered	
	Preferred brand-name drug	$75 copay retail $225 copay mail order	Not covered	
	Non-preferred brand-name drug	50% coinsurance retail and mail order	Not covered	
	Specialty drug	50% coinsurance retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	30% coinsurance	50% coinsurance	Prior authorization required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need immediate medical attention	Emergency room care	$250 then 30% coinsurance	$250 then 30% coinsurance	For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	Emergency medical transportation	30% coinsurance	30% coinsurance	——————none——————
	Urgent care	$65 copay/visit	50% coinsurance	Deductible does not apply in-network. Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% coinsurance	50% coinsurance	Prior authorization required.
	Physician/surgeon fees	30% coinsurance	50% coinsurance	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	$35 copay/ provider office visit 30% coinsurance all other services	50% coinsurance	All services except provider office visits must be prior authorized. Deductible does not apply in-network to provider office visits. See your benefit summary for ABA services.
	Inpatient services	30% coinsurance	50% coinsurance	

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 are pregnant	Office visits	No charge	50% coinsurance	Deductible does not apply to in-network prenatal care.
	Childbirth/delivery professional services	30% coinsurance	50% coinsurance	20% coinsurance for CNM or PCP. 30% coinsurance for all other providers.
	Childbirth/delivery facility services	30% coinsurance	50% coinsurance	——————none——————
If you need help recovering or have other special health needs	Home health care	30% coinsurance	50% coinsurance	Prior authorization required.
	Rehabilitation services	30% coinsurance	50% coinsurance	Inpatient services: coverage limited to 30 days; 60 visits for head/spinal injuries per calendar year. Prior authorization required. Outpatient services: coverage limited to 30 visits per calendar year, up to 30 additional visits per specified condition. Limits to not apply to Mental Health Services.
	Habilitation services	30% coinsurance	50% coinsurance	Inpatient services: coverage limited to 30 days; 60 visits for head/spinal injuries per calendar year. Prior authorization required. Outpatient services: coverage limited to 30 visits per calendar year, up to 30 additional visits per specified condition. Limits to not apply to Mental Health Services.
	Skilled nursing care	30% coinsurance	50% coinsurance	Prior authorization required. Coverage is limited to 60 days per calendar year.
	Durable medical equipment	30% coinsurance	50% coinsurance	Deductible does not apply to diabetes supplies from in-network providers.
	Hospice services	Hospice: No charge Respite care: 30% coinsurance	Hospice: No charge Respite care: 50% coinsurance	Deductible does not apply to Hospice service. Prior authorization required. Respite care limited to 5 days, up to 30 days per lifetime.

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 your child needs dental or eye care	Children's eye exam	No charge	Covered up to $45	Deductible does not apply. Limited to 1 exam per calendar year.
	Children's glasses	No charge	Covered up to $170	Deductible does not apply. Limited to 1 pair per calendar year. Coverage maximum depends on lens type.
	Children's dental check-up	No charge	30% coinsurance	Deductible does not apply to preventive services. Limited to 2 services in a benefit period.

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)
- Infertility treatment
- Long-term care
- Private-duty nursing
- 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 www.ProvidenceHealthPlan.com
- Routine eye care (Adult)

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	$5,500
Specialist *copayment*	$35
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

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	**$7,540**

In this example, Peg would pay:

Cost Sharing	
Deductibles	$5,500
Copayments	$20
Coinsurance	$530
What isn't covered	
Limits or exclusions	$150
The total Peg would pay is	**$6,200**

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

The plan's overall deductible	$5,500
Specialist *copayment*	$35
Hospital (facility) *coinsurance*	30%
Other *coinsurance*	30%

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	**$5,400**

In this example, Joe would pay:

Cost Sharing	
Deductibles	$5,270
Copayments	$
Coinsurance	$
What isn't covered	
Limits or exclusions	$80
The total Joe would pay is	**$5,350**

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

The plan's overall deductible	
Specialist *copayment*	
Hospital (facility) *coinsurance*	
Other *coinsurance*	

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	

In this example, Mia would pay:

Cost Sharing	
Deductibles	
Copayments	
Coinsurance	
What isn't covered	
Limits or exclusions	
The total Mia would pay is	

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: 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 فارسی زبان هستید، می‌توانید از سرویس‌های کمک زبانی به صورت رایگان استفاده کنید. با 1-800-878-4445 (TTY: 711) 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)