### Important Questions

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
</tr>
</thead>
</table>
| **What is the overall deductible?**                                       | **In-Network:** $4,500 person / $9,000 family (2 or more).  
**Out-of-Network:** $9,000 person / $18,000 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.  
**Why This Matters:** 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there services covered before you meet your deductible?**           | Yes. Most preventive care in-network.  
**Why This Matters:** 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
| **Are there other deductibles for specific services?**                    | No.  
**Why This Matters:** 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).  
**Out-of-Network:** $15,800 person / $31,600 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.  
**Why This Matters:** 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, chiropractic manipulation, acupunture, services not covered, fees above UCR.  
**Why This Matters:** 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](http://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.  
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| **Do you need a referral to see a specialist?**                          | No.  
**Why This Matters:** You can see the specialist you choose without a referral. |

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**Summary of Benefits and Coverage**: What this Plan Covers & What You Pay For Covered Services  
**Providence Health Plan: Balance 4500 Silver**  
**Coverage Period**: Beginning on or after 01/01/2019  
**Coverage for**: All Coverage Tiers | **Plan Type**: PPO  

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](http://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](http://www.cciio.cms.gov) or call 1-800-878-4445 to request a copy.  

Important Questions

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| **Are there services covered before you meet your deductible?**           | Yes. Most preventive care in-network.  
**Why This Matters:** 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/](https://www.healthcare.gov/coverage/preventive-care-benefits/). |
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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.  
**Why This Matters:** 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, chiropractic manipulation, acupunture, services not covered, fees above UCR.  
**Why This Matters:** 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](http://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.  
**Why This Matters:** 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.  
**Why This Matters:** You can see the specialist you choose without a referral. |
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>Network Provider (You will pay the least)</th>
<th>Out-of-Network Provider (You will pay the most)</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>If you visit a health care provider’s office or clinic</strong></td>
<td>Primary care visit to treat an injury or illness</td>
<td>$45 copay/per visit; deductible does not apply</td>
<td>50% coinsurance; deductible does not apply</td>
<td>Some services such as lab and x-ray will include additional member costs. Phone and video visits are covered in full in-network.</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$65 copay/per visit; deductible does not apply</td>
<td>50% coinsurance; deductible does not apply</td>
<td>Some services such as lab and x-ray will include additional member costs.</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/immunization</td>
<td>No charge; deductible does not apply</td>
<td>50% coinsurance</td>
<td>Some preventive services will include additional member costs. For more information see: <a href="https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf">https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf</a>.</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>30% coinsurance; deductible does not apply</td>
<td>50% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td>Generic drugs (preferred and non-preferred)</td>
<td>Preferred: $20 copay/per 30 day supply retail; deductible does not apply</td>
<td>Not covered</td>
<td>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).</td>
</tr>
<tr>
<td></td>
<td>Preferred Brand drug</td>
<td>$75 copay/per 30 day supply retail; deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Non-Preferred Brand drug</td>
<td>50% coinsurance retail; deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Specialty drug (preferred and non-preferred)</td>
<td>Preferred: 50% coinsurance up to $200 retail</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td><strong>If you have outpatient surgery</strong></td>
<td>Facility fee (e.g., ambulatory surgery center)</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
</tbody>
</table>

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>What You Will Pay</th>
<th>Limitations, Exceptions, &amp; Other Important Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>If you need immediate medical attention</td>
<td></td>
<td></td>
<td>For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.</td>
</tr>
<tr>
<td>Emergency room care</td>
<td></td>
<td>$250 <strong>copay</strong>/per visit then 30% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td></td>
<td>$250 <strong>copay</strong>/per visit then 30% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>Urgent care</td>
<td></td>
<td>$65 <strong>copay</strong>/per visit; deductible does not apply</td>
<td>Some services will include additional member costs.</td>
</tr>
<tr>
<td>If you have a hospital stay</td>
<td>Facility fee (e.g., hospital room)</td>
<td>30% <strong>coinsurance</strong></td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td></td>
<td>Physician/surgeon fees</td>
<td>30% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Office visit: $45 <strong>copay</strong>/per visit; deductible does not apply</td>
<td></td>
<td>All services except provider office visits must be prior authorized. See your benefit summary for ABA services.</td>
</tr>
<tr>
<td></td>
<td>All other services: 30% <strong>coinsurance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>30% <strong>coinsurance</strong></td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>30% <strong>coinsurance</strong></td>
<td>Coinsurance applies to provider delivery charges.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>30% <strong>coinsurance</strong></td>
<td>None</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see plan or policy document at www.ProvidenceHealthPlan.com
<table>
<thead>
<tr>
<th>Common Medical Event</th>
<th>Services You May Need</th>
<th>If you need help recovering or have other special health needs</th>
<th>If your child needs dental or eye care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home health care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rehabilitation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Habilitation services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Skilled nursing care</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Durable medical equipment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Hospice services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s eye exam</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s glasses</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Children’s dental check-up</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Common Medical Events

#### Network Provider (You will pay the least)

- **Home health care**: 30% coinsurance
- **Rehabilitation services**: Inpatient: 30% coinsurance; Outpatient - Physical Therapy: 30% coinsurance; deductible does not apply; Outpatient - Occupational & Speech Therapy: 30% coinsurance
- **Habilitation services**: 30% coinsurance
- **Skilled nursing care**: 30% coinsurance
- **Durable medical equipment**: Diabetic Supplies: 30% coinsurance; deductible does not apply; All other equipment: 30% coinsurance
- **Hospice services**: Hospice: No charge; deductible does not apply; Respite care: 30% coinsurance
- **Children’s eye exam**: No charge; deductible does not apply
- **Children’s glasses**: No charge; deductible does not apply
- **Children’s dental check-up**: No charge; deductible does not apply

#### Out-of-Network Provider (You will pay the most)

- **Home health care**: 50% coinsurance
- **Rehabilitation services**: 50% coinsurance
- **Habilitation services**: 50% coinsurance
- **Skilled nursing care**: 50% coinsurance
- **Durable medical equipment**: 50% coinsurance
- **Hospice services**: Hospice: No charge; deductible does not apply; Respite care: 50% coinsurance
- **Children’s eye exam**: Covered up to: $45; deductible does not apply
- **Children’s glasses**: Covered up to: $170; deductible does not apply
- **Children’s dental check-up**: 30% coinsurance; deductible does not apply

### Limitations, Exceptions, & Other Important Information

- **Home health care**: Prior authorization required.
- **Rehabilitation services**: Inpatient services: Limited to 30 visits per calendar year. Limited to 60 visits per calendar year for head/spinal injuries. Prior authorization required. Outpatient services: Limited to 30 visits per calendar year. Additional visits per specified condition: Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
- **Habilitation services**: Inpatient services: Prior authorization required. Limited to 30 visits per calendar year. Outpatient services: Limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
- **Skilled nursing care**: Prior authorization required. Limited to 60 days per calendar year.
- **Durable medical equipment**: None
- **Hospice services**: Prior authorization required. Respite care: Limited to 5 days, up to 30 days per lifetime.
- **Children’s eye exam**: Limited to 1 exam per calendar year.
- **Children’s glasses**: Limited to 1 pair per calendar year. Coverage maximum depends on lens type.
- **Children’s dental check-up**: Limited to 1 services per every 6 months.

For more information about limitations and exceptions, see plan or policy document at www.ProvidenceHealthPlan.com.
**Excluded Services & Other Covered Services:**

<table>
<thead>
<tr>
<th>Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Bariatric surgery</td>
</tr>
<tr>
<td>• Cosmetic surgery (with certain exceptions)</td>
</tr>
<tr>
<td>• Dental care (Adult)</td>
</tr>
<tr>
<td>• Infertility treatment</td>
</tr>
<tr>
<td>• Long-term care</td>
</tr>
<tr>
<td>• Private-duty nursing</td>
</tr>
<tr>
<td>• Routine foot care (covered for diabetics)</td>
</tr>
<tr>
<td>• Voluntary termination of pregnancy</td>
</tr>
<tr>
<td>• Weight loss programs</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Acupuncture (limits apply)</td>
</tr>
<tr>
<td>• Chiropractic care (limits apply)</td>
</tr>
<tr>
<td>• Hearing aids (limits apply)</td>
</tr>
<tr>
<td>• Non-emergency care when traveling outside the U.S. See <a href="http://www.ProvidenceHealthPlan.com">www.ProvidenceHealthPlan.com</a></td>
</tr>
<tr>
<td>• Routine eye care (Adult)</td>
</tr>
</tbody>
</table>

**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: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, 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.

For more information about limitations and exceptions, see plan or policy document at www.ProvidenceHealthPlan.com
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.

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### Peg is Having a Baby
(9 months of in-network pre-natal care and a hospital delivery)

- The plan's overall deductible: $4,500
- Specialist copayments: $65
- 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**: $12,800

**In this example, Peg would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$4,500</td>
</tr>
<tr>
<td>Copayments</td>
<td>$40</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,700</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $10

**The total Peg would pay is**: $6,250

---

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

- The plan's overall deductible: $4,500
- Specialist copayments: $65
- 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**: $7,400

**In this example, Joe would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$60</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,700</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$500</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $30

**The total Joe would pay is**: $2,290

---

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

- The plan's overall deductible: $4,500
- Specialist copayments: $65
- Hospital (facility) coinsurance: 30%
- Other coinsurance: 30%

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**: $1,900

**In this example, Mia would pay:**

<table>
<thead>
<tr>
<th>Cost Sharing</th>
<th>Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$1,400</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$10</td>
</tr>
</tbody>
</table>

**What isn't covered**

- Limits or exclusions: $200

**The total Mia would pay is**: $1,710

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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)

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 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。

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

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


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)