## Summary of Benefits and Coverage

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, ProvidenceHealthPlan.com. For 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

<table>
<thead>
<tr>
<th>Questions</th>
<th>Answers</th>
<th>Why This Matters:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What is the overall deductible?</strong></td>
<td>In-Network: $6,000 person / $12,000 family (2 or more). Out-of-Network: $12,000 person / $24,000 family (2 or more).</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Are there services covered before you meet your deductible?</strong></td>
<td>Yes. Most preventive care in-network.</td>
<td>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 <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a>.</td>
</tr>
<tr>
<td><strong>Are there other deductibles for specific services?</strong></td>
<td>No.</td>
<td>You don’t have to meet deductibles for specific services.</td>
</tr>
<tr>
<td><strong>What is the out-of-pocket limit for this plan?</strong></td>
<td>In-Network: $8,550 person / $17,100 family (2 or more). Out-of-Network: $17,100 person / $34,200 family (2 or more).</td>
<td>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.</td>
</tr>
<tr>
<td><strong>What is not included in the out-of-pocket limit?</strong></td>
<td>Premiums, balance billing, penalties, copays for adult vision services, chiropractic manipulation, acupuncture, services not covered, fees above UCR.</td>
<td>Even though you pay these expenses, they don’t count toward the out-of-pocket limit.</td>
</tr>
<tr>
<td><strong>Will you pay less if you use a network provider?</strong></td>
<td>Yes. See ProvidenceHealthPlan.com/findaprovider or call 1-800-878-4445 for a list of network providers.</td>
<td>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.</td>
</tr>
<tr>
<td><strong>Do you need a referral to see a specialist?</strong></td>
<td>No.</td>
<td>You can see the specialist you choose without a referral.</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></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<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>$40 copay/per visit; deductible does not apply</td>
<td>50% coinsurance; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Specialist visit</td>
<td>$60 copay/per visit; deductible does not apply</td>
<td>50% coinsurance; deductible does not apply</td>
</tr>
<tr>
<td></td>
<td>Preventive care/screening/ immunization</td>
<td>No charge; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td><strong>If you have a test</strong></td>
<td>Diagnostic test (x-ray, blood work)</td>
<td>35% coinsurance; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td>Imaging (CT/PET scans, MRIs)</td>
<td>35% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td>Common Medical Event</td>
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<td>What You Will Pay</td>
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</tr>
<tr>
<td>----------------------</td>
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<td>--------------------------------------------------</td>
</tr>
<tr>
<td><strong>If you need drugs to treat your illness or condition</strong></td>
<td></td>
<td></td>
<td>ACA Preventive drugs are covered in full in-network. Covers up to a 30-day supply (retail); 90-day mail-order supply covered at 2 times the retail copay or 5% less than the retail coinsurance. 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 Tier 4 or Tier 6 cost-share. Specialty drugs (listed in Tier 5 and Tier 6 on your formulary) can only be purchased at a participating specialty pharmacy (limited to 30 days).</td>
</tr>
<tr>
<td>More information about prescription drug coverage is available at ProvidenceHealthPlan.com</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tier 1 drugs</td>
<td>No charge retail; deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 2 drugs</td>
<td>$20 copay per 30 day supply retail; deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 3 drugs</td>
<td>$65 copay per 30 day supply retail; deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 4 drugs</td>
<td>50% coinsurance retail; deductible does not apply</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 5 drugs</td>
<td>50% coinsurance up to $200 retail</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>Tier 6 drugs</td>
<td>50% coinsurance 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>Ambulatory surgery center: 25% coinsurance. Hospital-based facility: 35% coinsurance</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>35% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td><strong>If you need immediate medical attention</strong></td>
<td>Emergency room care</td>
<td>$250 copay per visit then 35% coinsurance</td>
<td>For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.</td>
</tr>
<tr>
<td>Emergency medical transportation</td>
<td>35% coinsurance</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
<tr>
<td>Urgent care</td>
<td>$60 copay per visit; deductible does not apply</td>
<td>50% coinsurance; deductible does not apply</td>
<td>Some services will include additional member costs.</td>
</tr>
<tr>
<td><strong>If you have a hospital stay</strong></td>
<td>Facility fee (e.g., hospital room)</td>
<td>35% coinsurance</td>
<td>Prior authorization required.</td>
</tr>
<tr>
<td>Physician/surgeon fees</td>
<td>35% coinsurance</td>
<td>50% coinsurance</td>
<td></td>
</tr>
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<td>Limitations, Exceptions, &amp; Other Important Information</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
<td>-------------------------------</td>
<td>----------------------------------------------------------------------------------</td>
<td>--------------------------------------------------------</td>
</tr>
<tr>
<td>If you need mental health, behavioral health, or substance abuse services</td>
<td>Outpatient services</td>
<td>Network Provider (You will pay the least)</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></td>
<td>Office visit: $40 copay/visit; deductible does not apply</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>All other services: 35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient services</td>
<td>35% coinsurance</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>50% coinsurance</td>
<td></td>
</tr>
<tr>
<td>If you are pregnant</td>
<td>Office visits</td>
<td>No charge; deductible does not apply</td>
<td>None</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery professional services</td>
<td>35% coinsurance</td>
<td>Coinurance applies to provider delivery charges.</td>
</tr>
<tr>
<td></td>
<td>Childbirth/delivery facility services</td>
<td>35% coinsurance</td>
<td>None</td>
</tr>
</tbody>
</table>

For more information about limitations and exceptions, see plan or policy document at ProvidenceHealthPlan.com DRAFT
<table>
<thead>
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</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient: 35% coinsurance Outpatient - Physical Therapy: 35% coinsurance; deductible does not apply Outpatient - Occupational &amp; Speech Therapy: 35% coinsurance; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Inpatient: 35% coinsurance Outpatient: 35% coinsurance; deductible does not apply</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>35% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Diabetic Supplies: 35% coinsurance; deductible does not apply All other equipment: 35% coinsurance</td>
<td>50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Hospice: No charge; deductible does not apply Respite care: 35% coinsurance</td>
<td>Hospice: No charge; deductible does not apply Respite care: 50% coinsurance</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

If you need help recovering or have other special health needs

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<table>
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<tr>
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<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 your child needs dental or eye care</td>
<td>Children's eye exam</td>
<td>Network Provider (You will pay the least)</td>
<td>Out-of-Network Provider (You will pay the most)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>Covered up to: $45; <strong>deductible</strong> does not apply</td>
</tr>
<tr>
<td></td>
<td>Children's glasses</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>Covered up to: $170; <strong>deductible</strong> does not apply</td>
</tr>
<tr>
<td></td>
<td>Children's dental check-up</td>
<td>No charge; <strong>deductible</strong> does not apply</td>
<td>30% <strong>coinsurance</strong>; <strong>deductible</strong> does not apply</td>
</tr>
</tbody>
</table>

**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 ProvidenceHealthPlan.com</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: Oregon Division of Financial Regulation at 1-888-877-4894, email **DFR.InsuranceHelp@oregon.gov** or go to **https://dfr.oregon.gov/help/Pages/index.aspx**, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or **http://www.dol.gov/ebsa/healthreform**, 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 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 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 Division of Financial Regulation by:  
• Calling 503-947-7984 or the toll free message line at 888-877-4894  
• Writing to the Oregon Division of Financial Regulation, Consumer Protection Unit at P.O. Box 14480 Salem, OR 97309-0405  
• Through the website at **https://dfr.oregon.gov/help/Pages/index.aspx**
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.

Language Access Services:
Navajo (Dine): Dinek’ehgo shika at’ohwol ninisingo, kwijigo holne’ 1-800-878-4445 (TTY: 711).

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

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The public reporting burden for this collection of information is estimated to average approximately one minute per respondent. Interested parties are encouraged to send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Office of Policy and Research, Attention: PRA Clearance Officer, 200 Constitution Avenue, N.W., Room N-5718, Washington, DC 20210 or email ebsa.opr@dol.gov and reference the OMB Control Number 12100123.
### 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: $6,000
  - Specialist copayment: $60
  - Hospital (facility) coinsurance: 35%
  - Other coinsurance: 35%

This EXAMPLE event includes services like:
- Specialist office visits (pre-natal 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:

<table>
<thead>
<tr>
<th>Cost-Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles</td>
<td>$6,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$10</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$1,400</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $20
- The total Peg would pay is: $7,430

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#### Managing Joe's Type 2 Diabetes

- **(a year of routine in-network care of a well-controlled condition)**
  - The plan's overall deductible: $6,000
  - Specialist copayment: $60
  - Hospital (facility) coinsurance: 35%
  - Other coinsurance: 35%

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:

<table>
<thead>
<tr>
<th>Cost-Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$10</td>
</tr>
<tr>
<td>Copayments</td>
<td>$1,300</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$300</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $0
- The total Joe would pay is: $1,610

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#### Mia's Simple Fracture

- **(in-network emergency room visit and follow up care)**
  - The plan's overall deductible: $6,000
  - Specialist copayment: $60
  - Hospital (facility) coinsurance: 35%
  - Other coinsurance: 35%

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:

<table>
<thead>
<tr>
<th>Cost-Sharing</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Deductibles*</td>
<td>$2,000</td>
</tr>
<tr>
<td>Copayments</td>
<td>$100</td>
</tr>
<tr>
<td>Coinsurance</td>
<td>$200</td>
</tr>
</tbody>
</table>

**What isn't covered**
- Limits or exclusions: $0
- The total Mia would pay is: $2,300

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*Note: This plan has other deductibles for specific services included in this coverage example. See “Are there other deductibles for specific services?” row above.

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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://oocrportal.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 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)로 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。


ATTENTION : Si vous parlez français, des services d’aide linguistique vous sont proposés gratuitement.Appelez le 1-800-878-4445 (ATS : 711).