



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 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 ? | \$500 person / \$1,000 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 . |
| 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 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 ? | \$3,500 person / \$7,000 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 , balance billing , penalties, copays for adult vision services, chiropractic manipulation, acupuncture, 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 | First 3 visits \$5 copay /per visit; deductible does not apply then \$10 copay /per in-person visit; deductible does not apply or \$10 copay /per virtual visit; deductible does not apply | 30% coinsurance ; deductible does not apply | Some services such as lab and x-ray will include additional member costs. Providence ExpressCare phone and video visits are covered in full in-network . |
| | Specialist visit | \$25 copay /per visit; deductible does not apply | 30% coinsurance ; 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 | 30% 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) | 10% coinsurance ; deductible does not apply | 30% coinsurance | None |
| | Imaging (CT/PET scans, MRIs) | 10% coinsurance | 30% 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. |

| 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 ProvidenceHealthPlan.com | Tier 1 drugs | No charge retail; deductible does not apply | Not covered | 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 you do not obtain Prior authorization claims for those services will be denied and you will be responsible for payment of those services. 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). |
| | Tier 2 drugs | \$10 copay /per 30 day supply retail; deductible does not apply | Not covered | |
| | Tier 3 drugs | \$25 copay /per 30 day supply retail; deductible does not apply | Not covered | |
| | Tier 4 drugs | 30% coinsurance retail; deductible does not apply | Not covered | |
| | Tier 5 drugs | 50% coinsurance up to \$200 retail; deductible does not apply | Not covered | |
| | Tier 6 drugs | 50% coinsurance retail; deductible does not apply | Not covered | |
| If you have outpatient surgery | Facility fee (e.g., ambulatory surgery center) | Ambulatory surgery center: 5% coinsurance Hospital-based facility: 10% coinsurance | 30% 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 | 10% coinsurance | 30% coinsurance | |
| If you need immediate medical attention | Emergency room care | \$250 copay /per visit then 10% coinsurance ; deductible does not apply | \$250 copay /per visit then 10% coinsurance ; deductible does not apply | For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits. |
| | Emergency medical transportation | 10% coinsurance | 10% coinsurance | None |
| | Urgent care | \$25 copay /per visit; deductible does not apply | 30% coinsurance ; deductible does not apply | Some services will include additional member costs. |
| If you have a hospital stay | Facility fee (e.g., hospital room) | 10% coinsurance | 30% 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 | 10% coinsurance | 30% 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 need mental health, behavioral health, or substance abuse services | Outpatient services | Office visit: First 3 visits \$5 copay /per visit; deductible does not apply then \$10 copay /per in-person visit; deductible does not apply or \$10 copay /per virtual visit; deductible does not apply All other services: 10% coinsurance | Office visit: 30% coinsurance ; deductible does not apply All other services: 30% coinsurance | All services except provider office visits must be prior authorized . If you do not obtain Prior authorization claims for those services will be denied and you will be responsible for payment of those services. See your benefit summary for Applied Behavioral Analysis (ABA) services. |
| | Inpatient services | 10% coinsurance | 30% coinsurance | |
| If you are pregnant | Office visits | No charge; deductible does not apply | 30% coinsurance | None |
| | Childbirth/delivery professional services | 10% coinsurance | 30% coinsurance | Coinsurance applies to provider delivery charges. |
| | Childbirth/delivery facility services | 10% coinsurance | 30% coinsurance | None |
| If you need help recovering or have other special health needs | Home health care | 10% coinsurance | 30% 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. |
| | Rehabilitation services | Inpatient: 10% coinsurance Outpatient - Physical Therapy: 10% coinsurance ; deductible does not apply Outpatient - Occupational & Speech Therapy: 10% coinsurance ; deductible does not apply | 30% coinsurance | Inpatient services: Limited to 30 days per calendar year. Limited to 60 days per calendar year for head/spinal injuries. 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. 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 and Substance Use Disorder Services. |

| 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) | |
| | Habilitation services | Inpatient: 10% coinsurance Outpatient: 10% coinsurance ; deductible does not apply | 30% coinsurance | Inpatient services: Limited to 30 days per calendar year. Limited to 60 days per calendar year for head/spinal injuries. 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. Outpatient services: Limited to 30 visits per calendar year. Limits do not apply to Mental Health and Substance Use Disorder Services. |
| | Skilled nursing care | 10% coinsurance | 30% 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. Limited to 60 days per calendar year. |
| | Durable medical equipment | Diabetic Supplies: 10% coinsurance ; deductible does not apply All other equipment: 10% coinsurance | 30% coinsurance | None |
| | Hospice services | Hospice: No charge; deductible does not apply Respite care: 10% coinsurance | Hospice: No charge; deductible does not apply Respite care: 30% 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. Respite care: Limited to 5 days, up to 30 days per lifetime. |
| If your child needs dental or eye care | Children's eye exam | No charge; deductible does not apply | Covered up to: \$45; deductible does not apply | Limited to 1 exam per calendar year. |
| | Children's glasses | No charge; deductible does not apply | 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; deductible does not apply | No charge; deductible does not apply | Limited to 1 service per every 6 months. |

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](#).)

- | | | |
|--|-------------------------|---|
| • Abortion | • Dental care (Adult) | • Private-duty nursing |
| • Bariatric surgery | • Infertility treatment | • Routine foot care (covered for diabetics) |
| • Cosmetic surgery (with certain exceptions) | • Long-term care | • Weight loss programs |

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

- | | | |
|---------------------------------|---|----------------------------|
| • Acupuncture (12 visits) | • Hearing aids (one per ear every 3 calendar years) | • Routine eye care (Adult) |
| • Chiropractic care (20 visits) | • Non-emergency care when traveling outside the U.S. See 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 [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 [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 [ciio.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 [dfr.oregon.gov](#) regarding their possible rights to continuation coverage under State law.

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 [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 503-574-8757/1-800-878-4445 (toll-free) or [ProvidenceHealthPlan.com](#).
- Oregon Division of Financial Regulation at 503-947-7984/1-888-877-4894 (toll-free) or [dfr.oregon.gov](#).

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).

Chinese (中文): 如果需要中文的帮助, 请拨打这个号码1-800-878-4445 (TTY: 711).

Tagalog (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-878-4445 (TTY: 711).

Spanish (Español): Para obtener asistencia en Español, llame al 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.

PRA Disclosure Statement: According to the Paperwork Reduction Act of 1995 (Pub. L. 104-13) (PRA), no persons are required to respond to a collection of information unless such collection displays a valid Office of Management and Budget (OMB) control number. The department notes that a Federal agency cannot conduct or sponsor a collection of information unless it is approved by OMB under the PRA, and displays a currently valid OMB control number, and the public is not required to respond to a collection of information unless it displays a currently valid OMB control number. See 44 U.S.C. 3507. Also, notwithstanding any other provisions of law, no person shall be subject to penalty for failing to comply with a collection of information if the collection of information does not display a currently valid OMB control number. See 44 U.S.C. 3512.

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 ebssa.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.

| 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 | \$500 | ■ The plan's overall deductible | \$500 | ■ The plan's overall deductible | \$500 |
| ■ Specialist copayment | \$25 | ■ Specialist copayment | \$25 | ■ Specialist copayment | \$25 |
| ■ Hospital (facility) coinsurance | 10% | ■ Hospital (facility) coinsurance | 10% | ■ Hospital (facility) coinsurance | 10% |
| ■ Other coinsurance | 10% | ■ Other coinsurance | 10% | ■ Other coinsurance | 10% |
| This EXAMPLE event includes services like: Specialist office visits (<i>pre-natal care</i>) Childbirth/Delivery Professional Services Childbirth/Delivery Facility Services Diagnostic tests (<i>ultrasounds and blood work</i>) Specialist visit (<i>anesthesia</i>) | | 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>) | | 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>) | |
| Total Example Cost | \$12,700 | Total Example Cost | \$5,600 | Total Example Cost | \$2,800 |
| In this example, Peg would pay: | | In this example, Joe would pay: | | In this example, Mia would pay: | |
| Cost-Sharing | | Cost-Sharing | | Cost-Sharing | |
| Deductibles | \$500 | Deductibles * | \$10 | Deductibles * | \$500 |
| Copayments | \$10 | Copayments | \$500 | Copayments | \$60 |
| Coinsurance | \$1,200 | Coinsurance | \$90 | Coinsurance | \$200 |
| <i>What isn't covered</i> | | <i>What isn't covered</i> | | <i>What isn't covered</i> | |
| Limits or exclusions | \$20 | Limits or exclusions | \$0 | Limits or exclusions | \$400 |
| The total Peg would pay is | \$1,730 | The total Joe would pay is | \$600 | The total Mia would pay is | \$1,160 |

*Note: This [plan](#) has other [deductibles](#) for specific services included in this coverage example. See "Are there other [deductibles](#) for specific services?" row above.

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, sexual orientation, religion, gender identity, marital status 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, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides 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)
- Provides free language services to people whose primary language is not English, such as:
 - Qualified interpreters
 - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status 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
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: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>.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit <https://dfr.oregon.gov/Pages/index.aspx>.

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).

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

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: បើអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយភាសាឥតគិតថ្លៃសម្រាប់អ្នកចូលរួមស្តាប់ 1-800-878-4445 (TTY: 711)។

XIYEEFFANNAA: 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 (TTY: 711) 1-800-878-4445 سامت دیری گب. امش یارب ناگیار تروصب ینابز تالی هست، دینک یم وگتفگ یراف 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)