



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

Important Questions	Answers	Why This Matters:
What is the overall <a href="#">deductible</a> ?	<a href="#">In-Network</a> : \$3,550 person / \$7,100 family (2 or more).	Generally, you must pay all of the costs from <a href="#">providers</a> up to the <a href="#">deductible</a> amount before this <a href="#">plan</a> begins to pay. If you have other family members on the <a href="#">plan</a> , each family member must meet their own individual <a href="#">deductible</a> until the total amount of <a href="#">deductible</a> expenses paid by all family members meets the overall family <a href="#">deductible</a> .
Are there services covered before you meet your <a href="#">deductible</a> ?	Yes. Most <a href="#">preventive care in-network</a> .	This <a href="#">plan</a> covers some items and services even if you haven't yet met the <a href="#">deductible</a> amount. But a <a href="#">copayment</a> or <a href="#">coinsurance</a> may apply. For example, this <a href="#">plan</a> covers certain <a href="#">preventive services</a> without <a href="#">cost sharing</a> and before you meet your <a href="#">deductible</a> . See a list of covered <a href="#">preventive services</a> at <a href="https://www.healthcare.gov/coverage/preventive-care-benefits/">https://www.healthcare.gov/coverage/preventive-care-benefits/</a> .
Are there other <a href="#">deductibles</a> for specific services?	No.	You don't have to meet <a href="#">deductibles</a> for specific services.
What is the <a href="#">out-of-pocket limit</a> for this <a href="#">plan</a> ?	<a href="#">In-Network</a> : \$8,150 person / \$16,300 family (2 or more).	The <a href="#">out-of-pocket limit</a> is the most you could pay in a year for covered services. If you have other family members in this <a href="#">plan</a> , they have to meet their own <a href="#">out-of-pocket limits</a> until the overall family <a href="#">out-of-pocket limit</a> has been met.
What is not included in the <a href="#">out-of-pocket limit</a> ?	<a href="#">Premiums</a> , penalties, services not covered, fees above <a href="#">UCR</a> .	Even though you pay these expenses, they don't count toward the <a href="#">out-of-pocket limit</a> .
Will you pay less if you use a <a href="#">network provider</a> ?	Yes. For a list of participating <a href="#">providers</a> see <a href="http://phppd.providence.org/">http://phppd.providence.org/</a> or call 1-800-878-4445.	This <a href="#">plan</a> uses a <a href="#">provider network</a> . You will pay less if you use a <a href="#">provider</a> in the <a href="#">plan's network</a> . You will pay the most if you use an <a href="#">out-of-network provider</a> , and you might receive a bill from a <a href="#">provider</a> for the difference between the <a href="#">provider's</a> charge and what your <a href="#">plan</a> pays ( <a href="#">balance billing</a> ). Be aware your <a href="#">network provider</a> might use an <a href="#">out-of-network provider</a> for some services (such as lab work). Check with your <a href="#">provider</a> before you get services.
Do you need a <a href="#">referral</a> to see a <a href="#">specialist</a> ?	Yes.	This <a href="#">plan</a> will pay some or all of the costs to see a <a href="#">specialist</a> for covered services but only if you have a <a href="#">referral</a> before you see the <a href="#">specialist</a> .



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	
		Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
<b>If you visit a health care <a href="#">provider's</a> office or clinic</b>	Primary care visit to treat an injury or illness	\$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply	Some services such as lab and x-ray will include additional member costs. Phone and video visits are covered in full <a href="#">in-network</a> . Some services such as lab and x-ray will include additional member costs. 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> .
	<a href="#">Specialist</a> visit	\$80 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply	
	<a href="#">Preventive care/screening/immunization</a>	No charge; <a href="#">deductible</a> does not apply	
<b>If you have a test</b>	<a href="#">Diagnostic test</a> (x-ray, blood work)	30% <a href="#">coinsurance</a>	None
	Imaging (CT/PET scans, MRIs)	30% <a href="#">coinsurance</a>	Prior authorization required.
<b>If you need drugs to treat your illness or condition</b> More information about <a href="#">prescription drug coverage</a> is available at <a href="http://www.ProvidenceHealthPlan.com">www.ProvidenceHealthPlan.com</a>	Generic drugs (preferred and non-preferred)	\$15 <a href="#">copay</a> /per 30 day supply retail; <a href="#">deductible</a> does not apply	ACA Preventive drugs are covered in full <a href="#">in-network</a> . 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 or non-preferred specialty cost-share. Specialty drugs can only be purchased at a participating specialty pharmacy (limited to 30 days).
	Preferred Brand drug	\$60 <a href="#">copay</a> /per 30 day supply retail; <a href="#">deductible</a> does not apply	
	Non-Preferred Brand drug	50% <a href="#">coinsurance</a> retail; <a href="#">deductible</a> does not apply	
	<a href="#">Specialty drug</a> (preferred and non-preferred)	50% <a href="#">coinsurance</a> retail; <a href="#">deductible</a> does not apply	
<b>If you have outpatient surgery</b>	Facility fee (e.g., ambulatory surgery center)	30% <a href="#">coinsurance</a>	Prior authorization required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>	

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)		
If you need immediate medical attention	<a href="#">Emergency room care</a>	30% <a href="#">coinsurance</a>		For emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.
	<a href="#">Emergency medical transportation</a>	30% <a href="#">coinsurance</a>		None
	<a href="#">Urgent care</a>	\$70 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply <a href="#">in-network</a>		Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	30% <a href="#">coinsurance</a>		Prior authorization required.
	Physician/surgeon fees	30% <a href="#">coinsurance</a>		
If you need mental health, behavioral health, or substance abuse services	Outpatient services	Office visit: \$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply All other services: 30% <a href="#">coinsurance</a>		All services except provider office visits must be prior authorized. See your benefit summary for ABA services.
	Inpatient services	30% <a href="#">coinsurance</a>		
If you are pregnant	Office visits	No charge; <a href="#">deductible</a> does not apply		None
	Childbirth/delivery professional services	30% <a href="#">coinsurance</a>		Coinsurance applies to provider delivery charges.
	Childbirth/delivery facility services	30% <a href="#">coinsurance</a>		None

Common Medical Event	Services You May Need	What You Will Pay	
		Network Provider (You will pay the least)	Limitations, Exceptions, & Other Important Information
<b>If you need help recovering or have other special health needs</b>	<a href="#">Home health care</a>	30% <a href="#">coinsurance</a>	Prior authorization required.
	<a href="#">Rehabilitation services</a>	Inpatient: 30% <a href="#">coinsurance</a> Outpatient - Physical Therapy: \$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply Outpatient - Occupational & Speech Therapy: \$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply	Inpatient services: Limited to 30 days for <a href="#">in-network providers</a> per calendar year. Limited to 60 days for <a href="#">in-network providers</a> per calendar year for head/spinal injuries. Prior authorization required. Outpatient services: Limited to 30 visits for <a href="#">in-network providers</a> per calendar year. Additional visits per specified condition: Limited to 30 visits for <a href="#">in-network providers</a> per calendar year. Limits do not apply to Mental Health Services.
	<a href="#">Habilitation services</a>	Inpatient: 30% <a href="#">coinsurance</a> Outpatient: \$40 <a href="#">copay</a> /per visit; <a href="#">deductible</a> does not apply	Inpatient services: Limited to 30 days for <a href="#">in-network providers</a> per calendar year. Limited to 60 days for <a href="#">in-network providers</a> per calendar year for head/spinal injuries. Prior authorization required. Outpatient services: Limited to 30 visits for <a href="#">in-network providers</a> per calendar year. Limits do not apply to Mental Health Services.
	<a href="#">Skilled nursing care</a>	30% <a href="#">coinsurance</a>	Prior authorization required. Limited to 60 days for <a href="#">in-network providers</a> per calendar year.
	<a href="#">Durable medical equipment</a>	Diabetic Supplies: No charge; <a href="#">deductible</a> does not apply All other equipment: 30% <a href="#">coinsurance</a>	None
	<a href="#">Hospice services</a>	30% <a href="#">coinsurance</a>	Prior authorization required. Respite care: Limited to 5 days, up to 30 days per lifetime for <a href="#">in-network providers</a> .
	<b>If your child needs dental or eye care</b>	Children's eye exam	No charge; <a href="#">deductible</a> does not apply
Children's glasses		No charge; <a href="#">deductible</a> does not apply	Limited to 1 pair per calendar year.
Children's dental check-up		Not covered	None

## Excluded Services & Other Covered Services:

### Services Your [Plan](#) Generally Does NOT Cover (Check your policy or [plan](#) document for more information and a list of any other [excluded services](#).)

- |  |   |  |
|--|---|--|
| <ul style="list-style-type: none"><li>• Acupuncture</li><li>• Bariatric surgery</li><li>• Chiropractic care</li><li>• Cosmetic surgery (with certain exceptions)</li><li>• Dental care (Adult)</li></ul> | <ul style="list-style-type: none"><li>• Dental care (Child)</li><li>• Infertility treatment</li><li>• Long-term care</li><li>• Private-duty nursing</li></ul> | <ul style="list-style-type: none"><li>• Routine eye care (Adult)</li><li>• Routine foot care (covered for diabetics)</li><li>• Voluntary termination of pregnancy</li><li>• Weight loss programs</li></ul> |
|--|---|--|

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

- |   |   |
|---|---|
| <ul style="list-style-type: none"><li>• Hearing aids (limits apply)</li></ul> | <ul style="list-style-type: none"><li>• Non-emergency care when traveling outside the U.S. See <a href="http://www.ProvidenceHealthPlan.com">www.ProvidenceHealthPlan.com</a></li></ul> |
|---|---|

**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 [cp.ins@oregon.gov](mailto:cp.ins@oregon.gov) or go to <http://dfr.oregon.gov/gethelp/ins-help/health/Pages/index.aspx>, 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](http://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](mailto: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](http://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.

### Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,550
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$12,800</b>
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#### In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$3,550
Copayments	\$40
Coinsurance	\$2,000
<i>What isn't covered</i>	
Limits or exclusions	\$10
<b>The total Peg would pay is</b>	<b>\$5,600</b>

### Managing Joe's type 2 Diabetes

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,550
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$7,400</b>
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#### In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$200
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$30
<b>The total Joe would pay is</b>	<b>\$1,730</b>

### Mia's Simple Fracture

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

■ The <a href="#">plan's</a> overall <a href="#">deductible</a>	\$3,550
■ <a href="#">Specialist copayment</a>	\$80
■ Hospital (facility) <a href="#">coinsurance</a>	30%
■ Other <a href="#">coinsurance</a>	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*)

<b>Total Example Cost</b>	<b>\$1,900</b>
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#### In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$1,400
Copayments	\$300
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$0
<b>The total Mia would pay is</b>	<b>\$1,700</b>

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).

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: (TTY: 711).

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

ប្រយ័ត្ន: បើសិនអ្នកនិយាយខ្មែរ, សេវាជំនួយផ្នែកភាសាសេរីគឺមានសំបាប់ឲ្យអ្នក។ ចូរទូរស័ព្ទ 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).

فیم دشا اب اب 1-800-878-4445 (TTY: 711) سامت دیری گب. امش یارب ناگیار تروصب ی نابز تالی هست، دینک یم وگتفگ ی سراف 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)