Your Benefit Summary

HSA Qualified 1600 Gold

Providence Health Plan

Providence Signature Network	In-Network	Out-of-Network
Individual Calendar Year Deductible (family amount is 2 times individual)	$1,600	$3,200
Individual Out-of-Pocket Maximum (family amount is 2 times individual) This amount includes the Deductible.	$6,000	$12,000

Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and login at myProvidence.com .

- In-Network and Out-of-Network Deductibles and Out-of-Pocket Maximums accumulate separately.
- The individual deductible applies before the plan provides benefits for covered services when there are no family members enrolled.
- The family deductible applies before the plan provides benefits for covered services when two or more family members are enrolled.
  - Note that the in-network per person annual cost-sharing limit is $9,450, as stated by the Affordable Care Act, when 2 or more family members are enrolled.
- Some Services and penalties do not apply to the Out-of-Pocket Maximum.
- Prior Authorization is required for some Services.
- View a list of In-Network Providers and pharmacies at ProvidenceHealthPlan.com/findaprovider.
- To get the most out of your benefits, use the providers within the Providence Signature network.
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for Out-of-Network services are based on these UCR charges.
- Limitations and exclusions apply. See your handbook for details.
- HSA status is not automatic with enrollment in this High Deductible Health Plan (HDHP). See your handbook for more details.
- Not Medicare Part D creditable.
- Your first three Primary Care Provider (PCP) visits and first three outpatient behavioral health visits of each calendar year are eligible to be covered in full if you have met your deductible. If you have not met your deductible, you will be charged and the amount will go toward your deductible.
- Find important information about how to use your plan at ProvidenceHealthPlan.com/usingyourplan.
- Learn more about PHP's covered preventive services rated "A" or "B" by the U.S. Preventive Services Task Force at ProvidenceHealthPlan.com/PreventiveCare.

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
On-Demand Visits		
Providence ExpressCare Virtual	Covered in full	Not covered
Providence ExpressCare Retail Health Clinic visits	Covered in full	Not applicable
Preventive Care		
Periodic health exams and well-baby care	Covered in full ✓	50%
Routine immunizations and shots	Covered in full ✓	50%

Your Benefit Summary

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Preventive Care		
Colonoscopy (preventive, age 45+)	Covered in full ✓	50%
Gynecological exams (1 per calendar year), breast exams and Pap tests	Covered in full ✓	50%
Mammograms	Covered in full ✓	50%
Nutritional Counseling	Covered in full ✓	50%
Tobacco cessation, counseling/classes and deterrent medications	Covered in full ✓	Not covered
Diabetes Self-Management Education	Covered in full ✓	Covered in full ✓
Physician/Professional Services		
Office visits to a Primary Care Provider or Naturopath (In-Person or Virtually)	20%	50%
Office visits to an Alternative Care Provider (In-Person or Virtually) (Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.)	20%	50%
Office visits to specialists (In-Person or Virtually)	20%	50%
Inpatient Hospital visits	20%	50%
Allergy shots and allergy serums, injectable and infused medications	20%	50%
Surgery and anesthesia in an office or facility	20%	50%
Diagnostic Services		
X-ray, lab and testing services (includes ultrasound)	20%	50%
High-tech imaging Services (such as PET, CT or MRI)	20%	50%
Sleep studies	20%	50%
Diagnostic and Supplemental Breast Exams	Covered in full	50%
Emergency Care and Urgent Care Services		
Emergency Services (For Emergency Medical Conditions only. If admitted to the Hospital, all Services subject to inpatient benefits.)	20%	20%
Emergency medical transportation (air and/or ground) (Emergency transportation is covered under your In-Network benefit, regardless of whether or not the provider is an In-Network Provider.)	20%	20%
Urgent Care visits (for non-life threatening illness/minor injury)	20%	50%
Hospital Services		
Inpatient/Observation care	20%	50%
Skilled Nursing Facility (limited to 60 days per calendar year)	20%	50%
Inpatient rehabilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health and Substance Use Disorder Services.)	20%	50%
Inpatient habilitative care (Limited to 30 days per calendar year; 60 days for head/spinal injuries. Limits do not apply to Mental Health and Substance Use Disorder Services.)	20%	50%
Outpatient Services		
Outpatient surgery at an Ambulatory Surgery Center	10%	50%

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Outpatient Services		
Outpatient surgery at a Hospital-based facility	20%	50%
Colonoscopy (non-preventive) at an Ambulatory Surgery Center	10%	50%
Colonoscopy (non-preventive) at a Hospital-based facility	20%	50%
Outpatient dialysis, infusion, chemotherapy and radiation therapy	20%	50%
Outpatient rehabilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health and Substance Use Disorder Services.)	20%	50%
Outpatient habilitative services: physical, occupational or speech therapy (Limited to 30 visits per calendar year; up to 30 additional visits per specified condition. Limits do not apply to Mental Health and Substance Use Disorder Services.)	20%	50%
Vision Therapy (convergence insufficiency) (Limited to 12 visits per lifetime)	20%	50%
Maternity Services		
Prenatal visits	Covered in full ✓	50%
Delivery and postnatal physician/provider visits	20%	50%
Inpatient Hospital/facility services	20%	50%
Routine newborn nursery care	20%	50%
Medical Equipment, Supplies and Devices		
Medical equipment, appliances, prosthetics/orthotics and supplies	20%	50%
Diabetes supplies (such as lancets, test strips, needles and glucose monitors)	20% ✓	50%
Hearing aids (Limited to one aid per ear every 3 calendar years)	20%	50%
Removable custom shoe orthotics (Limited to $200 per calendar year)	20%	50%
Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year)	20%	50%
Mental Health and Substance Use Disorder (Services, except outpatient provider office visits, may require prior authorization.)		
Inpatient and residential services	20%	50%
Day treatment, intensive outpatient, and partial hospitalization services	20%	50%
Outpatient provider visits (In-Person or Virtually)	20%	50%
Applied Behavior Analysis	20%	50%
Home Health and Hospice		
Home health care	20%	50%
Hospice care	Covered in full	Covered in full
Respite care (limited to Members receiving Hospice care; limited to 5 consecutive days, up to 30 days per lifetime)	20%	50%

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Biofeedback		
Biofeedback for specified diagnosis (limited to 10 visits per lifetime)	20%	50%
Chiropractic Manipulation and Acupuncture (Massage therapy not covered)		
Chiropractic manipulations (limited to 20 visits per calendar year)	$25	50%
Acupuncture (limited to 12 visits per calendar year)	$25	50%

Prescription Drugs

Formulary P-HSA

✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible
Up to a 30-Day Supply (From a participating retail, preferred or specialty pharmacy)	
Tier 1	Covered in full
Tier 2	20%
Tier 3	20%
Tier 4	20%
Tier 5	50% with $200 per script cap
Tier 6	50%
90-Day Supply (From a participating preferred retail pharmacy)	
Tier 1	Covered in full
Tier 2	20%
Tier 3	20%
Tier 4	20%
90-Day Supply (From a participating mail order pharmacy)	
Tier 1	Covered in full
Tier 2	15%
Tier 3	15%
Tier 4	15%

Pharmacies

Your prescription drug benefit requires that you fill your prescriptions at a Participating Pharmacy. There are four types of participating pharmacies:

- Retail: a Participating Pharmacy that allows up to a 30-day supply as outlined in your handbook of short-term and maintenance prescriptions.
- Preferred Retail: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and access to up to a 30-day supply of short-term prescriptions.
- Specialty: a Participating Pharmacy that allows up to a 30-day supply of specialty and self-administered chemotherapy prescriptions. These prescriptions require special delivery, handling, administration and monitoring by your pharmacist.
- Mail Order: a Participating Pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home. To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your Member identification number to one of our participating mail-order pharmacies.
- View a list of our participating pharmacies ProvidenceHealthPlan.com/planpharmacies.

Using your prescription drug benefit

Prescription Drugs

Formulary P-HSA

- To find if a drug is covered under your plan check online at ProvidenceHealthPlan.com/pharmacy. Note that your plan's formulary includes ACA Preventive drugs which are medications that are covered at no cost when received from participating pharmacies as required by the Patient Protection and Affordable Care Act.
- FDA-approved women's contraceptives, as listed on your formulary, are covered at no cost for up to a 12-month supply, after a 3-month initial fill, at any Participating Pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail-service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.
- If you or your provider request or prescribe a brand-name drug when a generic is available, regardless of reason, you will be responsible for the cost difference between the brand-name and generic drug in addition to the Tier 4 or Tier 6 copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Approved non-formulary non-specialty drugs will be covered at the Tier 4 cost sharing tier. Approved non-formulary specialty drugs will be covered at the Tier 6 cost sharing tier.
- Compounded medications are prescriptions that are custom prepared by your pharmacist. They must contain at least one FDA-approved drug to be eligible for coverage under your plan. Compounded medications are covered for up to a 30-day supply at a 50% after the deductible. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Safe Harbor Preventive drugs: The safe harbor drug list is made up of first-line medications that PHP has selected that may prevent the onset of a disease or condition when taken by a person who has developed risk factors for the disease or condition that has not yet manifested itself or has not become clinically apparent, or may prevent the recurrence of a disease or condition from which a person has recovered. Safe Harbor drugs are exempt from the deductible, subject to the formulary and applicable tier cost share.
- Specialty drugs, which can be found in Tier 5 and Tier 6, are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies.
- Diabetes supplies may be obtained at your participating pharmacy, and are covered under your prescription benefit. Refer to your formulary and Member Handbook for details.
- Certain drugs, devices, and supplies obtained from your pharmacy may apply towards your medical benefit.
- Insulin cost share capped at $85 for a 30-day supply, $255 for a 90-day supply, after deductible is met.
- Some prescription drugs require Prior Authorization for medical necessity, place of therapy, length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not in the formulary, please contact us.
- Self-administered chemotherapy is covered under the Prescription Drug Benefit unless the Outpatient Chemotherapy coverage results in a lower out-of-pocket expense to you. Please refer to your Handbook for more information.
- Self-injectable medications are only covered when they are being self-administered and labeled by the FDA for self-administration; in some cases, a Prior Authorization may be required for the drug. Documentation of self-administration may also be required. Drugs labeled for self-administration that are being administered by a provider will fall to the Member's medical benefit.
- Be sure you present your current Providence Health Plan Member identification card.

Routine Vision Services

Provided by VSP

VSP Choice Network (For Customer Service call 800-877-7195) ✓ Deductible does not apply	Below is the amount you pay after you have met your calendar year Deductible In-Network	Out-of-Network
Pediatric Vision Services (under age 19)		
Routine eye exam (limited to 1 exam per calendar year)	Covered in full ✓	Covered up to $45 ✓
Lenses (limited to 1 pair per calendar year)		
Single vision	Covered in full ✓	Covered up to $30 ✓
Lined bifocal	Covered in full ✓	Covered up to $50 ✓
Lined trifocal	Covered in full ✓	Covered up to $70 ✓
Lenticular lenses	Covered in full ✓	Covered up to $100 ✓
Frames (limited to 1 pair per calendar year; select from VSP's Otis & Piper ™ Eyewear Collection)	Covered in full ✓	Covered up to $70 ✓
Contact lens services and materials in place of glasses Standard: 1 pair per calendar year (1 contact lens per eye) Monthly: 6 month supply per calendar year (6 lenses per eye) Bi-weekly: 3 month supply per calendar year (6 lenses per eye) Dailies: 3 month supply per calendar year (90 lenses per eye)	Covered in full ✓	Covered up to $105 ✓
Adult Vision Services (Copayments do not apply to your Out-of-Pocket Maximum)		
Routine eye exam (limited to 1 exam per calendar year)	$30 ✓	Covered up to $45 ✓
Lenses (limited to 1 pair per 2 calendar years)		
Single vision	Covered in full ✓	Covered up to $30 ✓
Lined bifocal	Covered in full ✓	Covered up to $50 ✓
Lined trifocal	Covered in full ✓	Covered up to $70 ✓
Lenticular lenses	Covered in full ✓	Covered up to $100 ✓
Frames (limited to 1 pair per 2 calendar years)	Covered up to $120 ✓	Covered up to $70 ✓
Contact lens services and materials in place of glasses (limited to every 2 calendar years)	Covered up to $120 ✓	Covered up to $105 ✓

Pediatric Dental Service (under age 19)
Delta Dental Premier® Network

For customer service, including dental prior authorizations and claims, call 833-212-5035. ✓ Deductible does not apply	[Below is the amount you pay after you have met your calendar year deductible] In-Network	Out-of-Network
Preventive		
Routine Exams One per 6 months	Covered in full ✓	Covered in full ✓
Bitewing X-rays One set per 12 months	Covered in full ✓	Covered in full ✓
Cleanings One per 6 months	Covered in full ✓	Covered in full ✓
Topical Fluoride One per 6 months	Covered in full ✓	Covered in full ✓
Fissure sealants One service per tooth(molar) every 5 years (Limited to the unrestored occlusal surfaces of permanent molars)	Covered in full ✓	Covered in full ✓
Space Maintainers Once per space	Covered in full ✓	Covered in full ✓
Basic		
Restorative fillings	50%	50%
Endodontics and Periodontics	50%	50%
Major		
Oral surgery (extractions and other minor surgical procedures)	50%	50%
Stainless Steel Crowns Once per lifetime for primary teeth; once per 24 months for permanent teeth	50%	50%
Porcelain Crowns One service per tooth in a 7-year period	50%	50%
Denture and bridge work (construction or repair of fixed bridges, partials and complete dentures) Limited to once every 7 years. Dentures not covered for members under age 16. Partial dentures if placed within 2 months of the extraction of an anterior tooth or for missing anterior teeth for members age 16 and under.	50%	50%
Occlusal guard (nightguard) covered up to $200 every five years	50%	50%
Athletic mouthguards Limited to once every 12 months for under age 16 and once every 24 months for ages 16 and over	50%	50%
Orthodontia is covered to treat cleft palate with or without cleft lip	50%	50%

Explanation of terms and phrases

ACA Preventive Drugs - ACA Preventive drugs are medications, including contraceptives, which are listed in our formulary, and are covered at no cost when received from Participating Pharmacies as required by the Patient Protection and Affordable Care Act (ACA). Over the counter preventive drugs received from Participating Pharmacies cannot be covered in full without a written prescription from your Qualified Practitioner.

Annual Limit on Cost-sharing - The maximum amount a Member pays Out-of-Pocket per Calendar Year for In-Network essential health benefit Covered Service when two or more Family Member are enrolled in this plan.

Brand-name drugs - Brand-name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them.

Coinsurance - The percentage of the cost that you may need to pay for Covered Service.

Copay - The fixed dollar amount you pay to a healthcare provider for a Covered Service at the time care is provided.

Deductible

Individual - The Individual Deductible is the amount that applies when only one Member is enrolled in this plan, and is the amount that must be paid by the Member before the plan pays for any Covered Services for that Member.

Family - The Family Deductible is the amount that applies when two or more Family Member are enrolled on the plan, and is the amount that must be paid by the Family Members before the plan pays for any Covered Service for any enrolled Family Member. All amounts paid by Family Members towards Covered Service apply toward the Family Deductible. When the deductible is met, the Plan will begin pay for Covered Services for all enrolled Family Members.

NOTE: No Member will ever pay more than an Individual Deductible before the Plan begins paying for covered services for that Member.

Formulary - A formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer effective drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

Generic drugs - Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires.

Maintenance Prescriptions - Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those that you have received under our plan for at least 30 days and that you anticipate continuing to use in the future. Compounded and specialty medications are excluded from this definition; and are limited to a 30 day supply.

Maximum Plan Allowance (MPA) - The maximum amount that the Plan will reimburse providers. The MPA is based on a PPO Fee Schedule or a contracted rate. When using an Out-of-Network Dentist who does not have contracted rates with our dental network provider, the Plan will reimburse the provider at the MPA, and any amount above the MPA is your responsibility.

Medicare Part D creditable

Medicare Part D creditable - Coverage is creditable when the plan payout for prescription drugs is, on average for all plan participants, as much as the average payout under the standard Medicare Part D benefit.

Not Medicare Part D creditable - Coverage is non-creditable when the plan payout for prescription drugs is, on average for all plan participants, less than what standard Medicare Part D prescription drug coverage would be expected to pay.

Non-Formulary Medication - An FDA-approved drug, generic or brand-name, that is not included in the list of approved formulary medications. These prescriptions require a Prior Authorization by the health plan and, if approved, will pay at either the highest non-specialty or specialty cost sharing tier.

Office Visits Virtually - Scheduled visits with the member's PCP or Specialist using a teleconferencing application such as Zoom.

Out-of-Network - Refers to Services you receive from providers not in your plan's network. Your Out-of-Pocket costs are generally higher when you receive Covered Services outside of your plan's network. An Out-of-Network Provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an In-Network Provider, go to ProvidenceHealthPlan.com/findaprovider.

Out-of-Pocket Maximum

Explanation of terms and phrases

Health Savings Account (HSA) - A tax-exempt medical savings account available to taxpayers who are enrolled in a high-deductible health plan (HDHP) to be used for current and future health care expenses. Contributions can be deducted pre-tax from paychecks, and the money rolls over year to year and stays with the Member even with job changes and retirement.

In-Network - Refers to Services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your Out-of-Pocket costs will be less when you receive Covered Service from In-Network Providers.

Limitations and Exclusions - All Covered Services are subject to the limitations and exclusions specified for your plan. Refer to your Member handbook or contract for a complete list.

Individual - The Individual Out-of-Pocket Maximum applies when only one Member is enrolled in this plan, and is the total amount of Copayments, Coinsurance and Deductible that a Member must pay for specified Covered Services before the plan begins to pay 100% for Covered Services for that Member.

Family - The Family Out-of-Pocket Maximum applies when two or more Family Members are enrolled in this plan, and is the total amount of Copayments, Coinsurance and Deductible that a family must pay for specified Covered Services before the plan begins to pay 100% for any enrolled Family Member. The Family Out-of-Pocket Maximum can be met by the combined expenses of enroll Family Members. Once the Family Out-of-Pocket Maximum is met, the plans will begin to pay 100% for Covered Services for enrolled Family Members.

NOTE: Once any Member meets the Individual Out-of-Pocket Maximum, the Plan will begin to pay 100% for Covered Services for that Member.

Primary Care Provider - A qualified physician or practitioner that can provide most of your care and, when necessary, will coordinate care with other providers in a convenient and cost-effective manner.

Explanation of terms and phrases

Prescription drug Prior Authorization - The process used to request an exception to the Providence Health Plan drug formulary. A Prior Authorization can be requested by the prescriber, member or pharmacy. Some drugs require Prior Authorization for Medical Necessity, place of therapy, length of therapy, step therapy or number of doses. Visit us online for additional information at ProvidenceHealthPlan.com.

Prescription drug Tier - The prescription drug tier number correlates to a drug's placement on the formulary. Tier 1 and Tier 2 consists of mainly generic drugs while Tier 3 and Tier 4 contains both generic and brand-name drugs. Specialty drugs are listed in Tier 5 and Tier 6.

Prior Authorization - Some Services must be pre-approved. In-Network, your provider will request Prior Authorization. Out-of-Network, you are responsible for obtaining Prior Authorization.

Providence ExpressCare Virtual - Services for common conditions (such as sore throat, cough, or fever, etc.) using Providence's web-bases platform through a tablet, smartphone, or computer for same day appointments.

Providence ExpressCare Retail Health Clinic - A walk-in health clinic, other than an office, Urgent Care facility, pharmacy or independent clinic that is located within a retail operation. A Retail Health Clinic provides same-day visits for basic illness and injuries or preventive services.

Safe Harbor Preventive drugs - The safe harbor drug list is made up of medications that Providence Health Plan has selected, with the guidance of our Clinical Pharmacy Division. These are first-line medications that may prevent the onset of a disease or condition when taken by a person who has developed risk factors for the disease or condition that has not yet manifested itself or has not become clinically apparent, or may prevent the recurrence of a disease or condition from which a person has recovered. Safe Harbor Preventive drugs are subject to formulary and tier status, as well as pharmacy management programs such as Prior Authorization, step therapy and/or quantity limits. The IRS definition of safe harbor is contained in Notice 2004-23, section 223 (c) (2) (C).

Specialty Drugs - Specialty drugs are injectable, infused, oral, topical, or inhaled therapies that often require specialized delivery, handling, monitoring and administration and are generally high cost. These drugs must be purchased through our designated specialty pharmacy. Due to the nature of these medications, specialty drugs are limited to a 30-day supply. Your benefits include specialty drugs listed on our formulary in Tier 5 and Tier 6. Generally your out-of-pocket costs will be less for Tier 5 drugs.

Usual, Customary & Reasonable (UCR) - Describes your plan's allowed charges for Services that you receive from an Out-of-Network Provider. When the cost of Out-of-Network Services exceeds UCR amounts, you are responsible for paying the provider any differences. These amounts do not apply to your Out-of-Pocket Maximums.

Contact us

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY:711

ProvidenceHealthPlan.com/contactus

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:

- 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 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 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, 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
E-mail: 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 [1-800-898-8174] (TTY: [711]).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-898-8174 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-898-8174 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-898-8174 (TTY: 711).

Traditional Chinese: 注意：如果您說中文， 您可以免費獲得語言支援服務。請致電 1-800-898-8174 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-898-8174 (TTY: 711).

Farsi:
توجه: اگر به زبان فارسی صحبت میکنید، تسهیلات زبا ی ن به صورت رایگان به شما ارائه میشود. با 1-800-898-8174 (TTY: 711) تماس بگ رییید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-898-8174 (телетайп: 711).

Japanese:
お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-898-8174 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-898-8174(TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले दनम्र भाषा सहायता सेवाहरू दन:शुल्क रूपमा उपलब्ध छन् । 1-800-898-8174 (TTY: 711) मा फोन गनुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-898-8174 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-898-8174 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-898-8174 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ ប ើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចម្ដនបសវាជំនួយខ្នកភាសាបោយមិនគិតថ្លៃពីបោកអ្នក។

សូមបៅទូរស័ពទបលម 1-800-898-8174 (TTY: 711)។

Laotian: ເຊີນຊາບ: ຖ້ າວ່າທ່ານເວ ້ າພາສາລາວ, ຈະມີການຊ່ວຍເຫ ຼືອ ດ້ ານພາສາ ໂດຍບ ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-898-8174 (TTY: 711)