# Your Benefit Summary

## Total Enhanced 4000 Gold

Providence Health Plan

| Providence Signature Network | In-Network | Out-of-Network |
|---|---|---|
| Individual Calendar Year Deductible (family amount is 2 times individual) | $4,000 Common | |
| Individual Out-of-Pocket Maximum (family amount is 2 times individual)<br>This amount includes the Deductible. | $9,000 Common | |

## Important information about your plan

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

- Medicare Part D creditable.
- In-Network and Out-of-Network Services accumulate toward your common Deductible and common Out-of-Pocket Maximum.
- 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.
- 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<br>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 ✓ | 40% ✓ |
| Routine immunizations and shots | Covered in full ✓ | 40% ✓ |
| Colonoscopy (preventive, age 45+) | Covered in full ✓ | 40% |
| Gynecological exams (1 per calendar year), breast exams and Pap tests | Covered in full ✓ | 40% |
| Mammograms | Covered in full ✓ | 40% |
| Nutritional Counseling | Covered in full ✓ | 40% |
| 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 | First 3 visits $5 ✓ then | 40% ✓ |
| In-Person | $30 ✓ | |

# Your Benefit Summary

| ✓ Deductible does not apply | Below is the amount you pay after you have met your calendar year Deductible<br>In-Network | Out-of-Network |
|---|---|---|
| **Physician/Professional Services** | | |
| Virtually | $10 ✓ | |
| Office visits to an Alternative Care Provider (In-Person or Virtually)<br>(Chiropractic manipulation and acupuncture services are covered separately from the office visit at the levels listed for those benefits.) | $30 ✓ | 40% ✓ |
| Office visits to specialists (In-Person or Virtually) | $60 ✓ | 40% ✓ |
| Inpatient Hospital visits | 25% | 40% |
| Allergy shots, allergy serums, injectable and infused medications | 25% | 40% |
| Surgery and anesthesia in an office or facility | 25% | 40% |
| **Diagnostic Services** | | |
| X-ray, lab and testing services (includes ultrasound) | 25% ✓ | 40% |
| High-tech imaging Services (such as PET, CT or MRI) | 25% | 40% |
| Sleep studies | 25% ✓ | 40% |
| Diagnostic and Supplemental Breast Exams | Covered in full ✓ | 40% |
| **Emergency Care and Urgent Care Services** | | |
| Emergency Services<br>(For Emergency Medical Conditions only. If admitted to the Hospital, all Services subject to inpatient benefits.) | $250 then 25% ✓ | $250 then 25% ✓ |
| Emergency medical transportation (air and/or ground)<br>(Emergency transportation is covered under your In-Network benefit, regardless of whether or not the provider is an In-Network Provider.) | 25% | 25% |
| Urgent Care visits (for non-life threatening illness/minor injury) | $60 ✓ | 40% ✓ |
| **Hospital Services** | | |
| Inpatient/Observation care | 25% | 40% |
| Skilled Nursing Facility (limited to 60 days per calendar year) | 25% | 40% |
| Inpatient rehabilitative care<br>(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.) | 25% | 40% |
| Inpatient habilitative care<br>(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.) | 25% | 40% |
| **Outpatient Services** | | |
| Outpatient surgery at an Ambulatory Surgery Center | 15% | 40% |
| Outpatient surgery at a Hospital-based facility | 25% | 40% |
| Colonoscopy (non-preventive) at an Ambulatory Surgery Center | 15% | 40% |
| Colonoscopy (non-preventive) at a Hospital-based facility | 25% | 40% |
| Outpatient dialysis, infusion, chemotherapy and radiation therapy | 25% | 40% |
| Cardiac Rehabilitation (post-surgery) | First 16 visits Covered in full ✓ then 25% after deductible | 40% |

| ✓ Deductible does not apply | Below is the amount you pay after you have met your calendar year Deductible<br>In-Network | Out-of-Network |
|---|---|---|
| **Outpatient Services** | | |
| 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.) | | |
| Physical Therapy | 25% ✓ | 40% |
| Occupational or Speech Therapy | 25% ✓ | 40% |
| 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.) | 25% ✓ | 40% |
| Vision Therapy (convergence insufficiency) (Limited to 12 visits per lifetime) | 25% | 40% |
| **Maternity Services** | | |
| Prenatal visits | Covered in full ✓ | 40% |
| Delivery and postnatal physician/provider visits | 25% | 40% |
| Inpatient Hospital/facility services | 25% | 40% |
| Routine newborn nursery care | 25% | 40% |
| **Medical Equipment, Supplies and Devices** | | |
| Medical equipment, appliances, prosthetics/orthotics and supplies | 25% | 40% |
| Diabetes supplies (such as lancets, test strips, needles and glucose monitors) | 25% ✓ | 40% |
| Hearing aids (Limited to one aid per ear every 3 calendar years) | 25% ✓ | 40% |
| Removable custom shoe orthotics | 25% ✓ | 40% ✓ |
| Oral Sleep Apnea Appliance (Out-of-Network limited to $2,000 per calendar year) | 25% | 40% |
| **Mental Health and Substance Use Disorder (Services, except outpatient provider office visits, may require prior authorization.)** | | |
| Inpatient and residential services | 25% | 40% |
| Day treatment, intensive outpatient, and partial hospitalization services | 25% | 40% |
| Outpatient provider visits | First 3 visits $5 ✓ then | 40% ✓ |
| In-Person | $30 ✓ | |
| Virtually | $10 ✓ | |
| Applied Behavior Analysis | 25% | 40% |
| **Home Health and Hospice** | | |
| Home health care | 25% | 40% |
| 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) | 25% | 40% |

| ✓ Deductible does not apply | Below is the amount you pay after you have met your calendar year Deductible<br>In-Network | Out-of-Network |
|---|---|---|
| Biofeedback | | |
| Biofeedback for specified diagnosis (limited to 10 visits per lifetime, limits do not apply to Mental Health and Substance Use Disorder Services) | 25% | 40% |
| Chiropractic Manipulation and Acupuncture (Massage therapy not covered) | | |
| Chiropractic manipulations (limited to 20 visits per calendar year) | $30 ✓ | 50% ✓ |
| Acupuncture (limited to 12 visits per calendar year) | $30 ✓ | 50% ✓ |

# Prescription Drugs

Formulary P

| ✓ Deductible does not apply | Below is the amount you pay after you have met your calendar year Deductible |
|---|---|
| **Up to a 30-Day Supply**<br>(From a participating retail, preferred or specialty pharmacy) | |
| Tier 1 | Covered in full ✓ |
| Tier 2 | $20 ✓ |
| Tier 3 | $60 ✓ |
| Tier 4 | 30% ✓ |
| Tier 5 | 50% ✓ with $300 per script cap |
| Tier 6 | 50% ✓ |
| **90-Day Supply**<br>(From a participating preferred retail pharmacy) | |
| Tier 1 | Covered in full ✓ |
| Tier 2 | $60 ✓ |
| Tier 3 | $180 ✓ |
| Tier 4 | 30% ✓ |
| **90-Day Supply**<br>(From a participating mail order pharmacy) | |
| Tier 1 | Covered in full ✓ |
| Tier 2 | $40 ✓ |
| Tier 3 | $120 ✓ |
| Tier 4 | 25% ✓ |

### 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 at ProvidenceHealthPlan.com/PlanPharmacies.

### Using your prescription drug benefit

# Prescription Drugs

Formulary P

- 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, you will be responsible for the cost difference between the brand-name and generic drug.
- Not all drugs are included in the formulary. A formulary exception (a form of Prior Authorization) is required for coverage of drugs that are not in the formulary.
- Prior Authorization is not required for medications used to treat Substance Use Disorders, including opiate addiction and withdrawal. Additionally, if your Substance Use Disorder medication has been lost, stolen, or destroyed, you are entitled to up to three early refills of your medication. If you need a refill of your Substance Use Disorder medication and your prescription has expired in the last 12 months, you are entitled to one refill of your medication without a current prescription.
- Approved formulary exceptions for non-specialty medications will be covered at the Tier 4 cost-sharing tier. Approved formulary exceptions for 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% coinsurance after the deductible. Claims are subject to clinical review for medical necessity and are not guaranteed for payment.
- Specialty drugs are prescriptions that may require special delivery, handling, administration, and/or monitoring. They may also be limited to a 30-day supply. These medications may be found on any tier and will be indicated as "Specialty" on your formulary. 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 $35 for a 30-day supply, $105 for a 90-day supply. Deductible does not apply.
- Some drugs require Prior Authorization for coverage to determine that the drug is medically necessary and appropriate for the intended use (such as evaluating place and length of therapy, trial of more cost-effective therapies, or number of doses).
- 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.
- Certain injectable medications are deemed as Self-Administered Drugs by Providence Health Plan and will not be covered when administered by your provider, unless Prior Authorization is approved. Drugs may be deemed as Self-Administered Drugs if they are labeled by the FDA for administration by a patient (or their caregiver). Injectable medications labeled by the FDA for administration only by a health care provider will generally be covered by your medical benefit.
- If you take an eligible medication, the Pharmacy Variable Copay Program (known as HelpScript) may help lower your out-of-pocket costs. The list of medications eligible for this program is available at ProvidenceHealthPlan.com/HelpScript. Refer to your handbook for more information.

## Prescription Drugs

Formulary P

- Your plan covers postexposure prophylaxis medications (PEP) at no cost after reimbursement.
- 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)<br>✓ Deductible does not apply | Below is the amount you pay after you have met your calendar year Deductible<br>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<br>Standard: 1 pair per calendar year (1 contact lens per eye)<br>Monthly: 6-month supply per calendar year (6 lenses per eye)<br>Bi-weekly: 3-month supply per calendar year (6 lenses per eye)<br>Dailies: 3-month supply per calendar year (90 lenses per eye) | Covered in full ✓ | Covered up to $105 ✓ |
| Adult Vision Services<br>(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 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 ✓ |
| Progressive lenses | $50 ✓ | Covered up to $50 ✓ |
| Frames (limited to 1 pair per calendar year) | Covered up to $130 ✓ | Covered up to $70 ✓ |
| Contact lens services and materials in place of glasses (limited to every calendar year) | Covered up to $130 ✓ | Covered up to $105 ✓ |

| For Customer Service, including dental Prior Authorizations and claims, call 833-212-5035.<br>✓ Deductible does not apply | Below is the amount you pay after you have met your calendar year Deductible<br>In-Network | Out-of-Network |
|---|---|---|
| **Preventive** | | |
| Routine exams (2 every calendar year) | Covered in full ✓ | Covered in full ✓ |
| Bitewing X-rays (1 set every 12 months) | Covered in full ✓ | Covered in full ✓ |
| Cleanings (2 every calendar year) | Covered in full ✓ | Covered in full ✓ |
| Topical fluoride (2 every calendar year) | Covered in full ✓ | Covered in full ✓ |
| Sealants (1 per tooth every 5 years; limited to unrestored occlusal surfaces of permanent molars) | Covered in full ✓ | Covered in full ✓ |
| Space maintainers (1 per quadrant) | 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 (1 per tooth for lifetime of primary teeth; 1 per tooth every 24 months for permanent teeth) | 50% | 50% |
| Porcelain and gold crowns (1 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 under age 16, except partial dentures if placed within 2 months of the extraction of an anterior tooth or for missing anterior teeth. | 50% | 50% |
| Athletic mouthguards (1 every 12 months for under age 16 and 1 every 24 months for ages 16 and over) | 50% | 50% |
| Occlusal guards (nightguard) covered up to $200 every 5 years | 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.

**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 health care provider for a Covered Service at the time care is provided.

**Deductible** - The dollar amount that an individual or family pays for Covered Service before the plan pays any benefits within a Calendar Year. The following expenses do not apply to the individual or family deductible: Services not covered by the plan; fees that exceed Usual, Customary and Reasonable (UCR) charges as established by the plan; penalties incurred if you do not follow the plan's Prior Authorization requirements; copays and Coinsurance for Services that do not apply to the deductible.

**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 brand-name, generic, and specialty medications.

**Generic drugs** - Generic drugs have the same active ingredients as the brand-name formulation. Generic drugs are equivalent to the brand-name formulation in safety and effectiveness. Generic drugs are usually available after the patent expires for the brand-name formulation.

**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.

**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.

**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 formulary exception (a form of Prior Authorization) by the health plan and, if approved, will be covered 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** - The limit on the dollar amount that an individual or family pays for specified Covered Services in a Calendar Year. Some Services and expenses do not apply to the individual or family Out-of-Pocket Maximum. See your Member handbook or contract for details.

## Explanation of terms and phrases

**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.

**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 typically listed in Tier 5 and Tier 6. Some may be listed on lower tiers. These are designated as "Specialty" on the formulary.

**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-based 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.

**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.

**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

Discrimination is against the law. Providence Health Plan ("PHP") does not discriminate or treat people unfairly based on:

- Age
- Color
- Disability
- National origin
- Gender identity
- Language proficiency
- Race
- Sexual orientation
- Religion
- Sex
- Pregnancy

**You have the following rights:**

- To get free help from a qualified language interpreter.
- To get written information in the language you speak.
- To get information in a way you understand, including:
  - free help from a qualified sign language interpreter,
  - written information in large print, audio, Braille, or other formats, or
  - other reasonable modifications.

**Contact the Civil Rights Coordinator at PHP if you:**

- Need reasonable modifications, appropriate auxiliary aids and services, or language assistance services,
- Believe PHP failed to provide services and discriminated against you, or
- Want to file a grievance.

**Please contact our Civil Rights Coordinator in one of these ways:**

1) **You can call us.**
   **Toll-Free: 1-800-878-4445** **Oregon: 1-503-574-7500**
   Hearing Impaired members may call our TTY line at 711.
2) **You can mail or email us.**
   Providence Health Plan Attn: Civil Rights Coordinator
   PO Box 4158 Portland, OR 97208-4158
   Email: PHPAppealsandGrievances@providence.org
3) **You also have a right to file a complaint with the following:**
   U.S. Department of Health and Human Services, Office for Civil Rights
   Web portal: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsfWA
   Email: OCRComplaint@hhs.gov
   Phone: 1-800-368-1019, 1-800-537-7697 (TTY: 711)
   Mail: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Bldg., Washington, DC 20201

   Oregon Division of Financial Regulation
   Web: https://dfr.oregon.gov/Pages/index.aspx
   Email: DFR.InsuranceHelp@dcbs.oregon.gov
   Phone: 1-888-877-4894

**Language Access Information**

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

**Spanish:** ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

**Russian:** ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (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 1-800-878-4445 (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 1-800-878-4445 (TTY: 711)。

**Kushite:** XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

**Farsi:**

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

**Ukrainian:** УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (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。1-800-878-4445 (TTY: 711) まで、お電話ください。

**Korean:** 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오.

**Nepali:** ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू नि:शुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

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

**German:** ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (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 1-800-878-4445 (TTY: 711).

**Cambodian:** កំណត់សម្គាល់ៈ បើសិនជាអ្នកនិយាយភាសាខ្មែរ អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

**Laotian:** ເຊີນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ ໂດຍບ່ໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).

## Notes