Your Benefit Summary

Swedish Health Services
2019 PPO Medical Plan

Administered by PROVIDENCE Health Plan

What You Pay In Network	What You Pay Out of Network	Calendar Year In-Network Medical Out-of-Pocket Maximum	Calendar Year Out-of-Network Medical Out-of-Pocket Maximum	Calendar Year In-Network Medical Deductible	Calendar Year Out-of-Network Medical Deductible
0-40% coinsurance (after deductible)	40-50% coinsurance (after deductible; UCR applies)	$3,000 single $6,000 family	$7,300 per person $14,600 per family	$350 per person $700 per family	$1,300 per person $2,600 per family

Important information about your plan

This summary provides only highlights of your benefits. Certain limitations and exclusions apply. To view all of your plan details, including your Summary Plan Description, register for myProvidence at **www.ProvidenceHealthPlan.com/getstarted.**

- Not sure what a word or phrase means? See the last page for the definitions used in this summary.
- Your in-network and out-of-network deductibles accumulate together, as do your in-network and out-of-network out-of-pocket maximums, to meet the calendar year limits listed above.
- Your Calendar Year Medical Deductible applies to your Calendar Year Medical Out-of-Pocket Maximum.
- You may pay a lower coinsurance when you choose a participating Accountable Care Organization (ACO) provider or facility. For details go to www.providencehealthplan.com/swedish
- This plan summary highlights some of the features of this Swedish medical plan. This summary does not include all plan rules and details. The terms of your benefit plans are governed by legal documents. Should there be any inconsistencies between this summary and the legal plan documents, the plan documents are the final authority. Swedish reserves the right to change or discontinue its benefit plans at any time and for any reason.

Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.	After you pay your calendar year deductible, then you pay the following for covered services:		
	ACO Network (Tier I)	Other In-Network Providers (Tier II)	Out-of-Network (Tier III)
Preventive Health and Wellness Services			
• Periodic health exams; well-baby care	Covered in full✓	Covered in full✓	40%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	Covered in full✓	40%
• Mammogram	Covered in full✓	Covered in full✓	40%
• Prostate screening exam (calendar year)	Covered in full✓	Covered in full✓	40%
• Colorectal exam	Covered in full✓	Covered in full✓	40%
• Colorectal cancer screening: sigmoidoscopy, colonoscopy (for members age 50 and over)	Covered in full✓	Covered in full✓	40%
• The following tests (when received with your periodic health exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood	Covered in full✓	Covered in full✓	40%
• The following services (for members with diabetes): HbA1c, retinal exam, urine test for kidney function, diabetic exams of mouth, teeth and feet	Covered in full✓	Covered in full✓	40%
• Pneumococcal vaccine	Covered in full✓	Covered in full✓	40%
• Flu vaccine	Covered in full✓	Covered in full✓	40%
• Routine immunizations/shots	Covered in full✓	Covered in full✓	40%
• Nutritional counseling	Covered in full✓	Covered in full✓	40%
• Vision and hearing screening	Covered in full✓	Covered in full✓	40%
• Tobacco use cessation; counseling/classes, and deterrent medications, including prescription and over the counter. **Medications must be purchased at an in-network pharmacy.**	Covered in full✓	Covered in full✓	Covered in full✓

Benefit Highlights (continued)	ACO Network	Other In-Network Providers	Out-of-Network
Physician / Provider Services			
• Office visits to Primary Care Provider	$20✓	$35✓	40%
• Office visits to specialist	20%, $60 max / visit	30%, $80 max / visit	40%
• Inpatient hospital visits	20%	20%	40%
• Surgery; anesthesia	20%	20%	40%
• Allergy shots	Covered in full✓	Covered in full✓	40%
• Infusions and injectible medications - outpatient	20%	20%	40%
Outpatient Diagnostic Services			
• X-ray services - facility	Covered in full	40%	50%
• Lab services - facility	Covered in full	20%	50%
• MRI & CT - facility	$100	$100 + 40%	$100 + 50%
Hospital Services			
• Acute care	$200	$200 + 40%	$200 + 50%
• Rehabilitative care (90 days/calendar year combined with skilled nursing facility)	$200	$200 + 40%	$200 + 50%
• Skilled nursing facility (90 days/calendar year combined with inpatient rehabilitative care)	$200 + 10%	$200 + 40%	$200 + 50%
Maternity			
• Prenatal services	Covered in full✓	Covered in full✓	40%
• Delivery and postnatal services	$350✓	$350✓	40%
• Hospital services	$200	$200 + 40%	$200 + 50%
• Routine newborn nursery care - inpatient professional	20%	20%	40%
• Infertility services (testing and counseling only)	20%, $60 max / visit	30%, $80 max / visit	40%
Medical Equipment, Supplies and Devices			
• Appliances and prosthetics	20%	20%	20%
• Removable custom shoe orthotics (limited to $350 per calendar year)	20%	20%	40%
• Diabetic supplies (See SPD for details)	Covered in full✓	Covered in full✓	Not covered
• Hearing Aids ($1500 maximum (for both ears) every rolling 36 months	20%	20%	40%
Emergency / Urgent Care / Emergency Medical Transportation			
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.) Second Visit: $200; Three or more visits: $250	$150 first visit✓	$150 first visit✓	$150 first visit✓
• Urgent care services (for non-life threatening illness/minor injury)	20%, $60 max / visit	30%, $80 max / visit	40%
• Emergency medical transportation	$75 + 20%	$75 + 20%	$75 + 20%
Other Covered Services			
• Outpatient rehabilitative services (45 visits per calendar year)	20%, $60 max / visit*	30%, $80 max / visit**	40%○
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	20%*	20%**	40%○
• Spinal manipulations (12 visits per calendar year)	20%	20%	20%
• Massage therapy and acupuncture (limited to 12 visits combined per calendar year)	20%	20%	20%
• Bariatric surgery - facility (only available at Swedish/PH&S facilities. Limitations apply.)	$200	Not covered	Not covered
• Temporomandibular joint (TMJ) service	20%*	20%**	40%○
• Home health care (limited to 40 visits per calendar year)	20%	20%	40%
• Hospice care (Limited to 6 months per lifetime)	20%*	20%**	40%○
Mental Health / Chemical Dependency (To initiate services call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.)			
• Inpatient, residential services	$200	$200 + 10%	$200 + 40%
• Day treatment, intensive outpatient and partial hospitalization services	Covered in full	10%	40%
• Applied behavior analysis	Covered in full	20%	40%
• Outpatient provider visits	Covered in full✓	10%	40%

Benefit Highlights (continued)	ACO Network	Other In-Network Providers	Out-of-Network
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies; not subject to deductible) **The annual out-of-pocket maximum for prescription drugs is $1,500 Individual / $3,000 Family.**			
• Preventive drugs	Covered in full✓	Covered in full✓	Not covered
• Generic	$7.50✓	$15✓	Not covered
• Formulary brand-name drugs	$30✓	$40✓	Not covered
• Non-formulary brand-name drugs	$60✓	$70✓	Not covered
• Specialty drugs (limited to a 30-day supply)	$75✓	$75✓	Not covered

* Inpatient facility charges at Providence-Swedish Health Alliance facility - $200 copay, outpatient facility charges at Providence-Swedish Health Alliance facility - Covered in full.
○ Inpatient facility charges at out-of-network facility - $200 + 50%, outpatient facility charges at out-of-network facility - 50%
** Inpatient facility charges at in-network facility - $200 + 40%, outpatient facility charges at in-network facility - 40%

Your guide to the words or phrases used to explain your benefits

ACA Preventive drug
Affordable Care Act (ACA) preventive drugs are medications, including contraceptives, that are listed in our formulary as such, and are covered at no cost when received from Participating Pharmacies.
Over-the-counter preventive drugs received from Participating Pharmacies require a written prescription from your Qualified Provider to be covered in full under this benefit.

ACO Network Provider
Accountable Care Organization (ACO) offering a large network of providers – doctors, hospitals, clinics and more – that are accountable for the cost and quality of care they provide
- All Providence and Swedish facilities and pharmacies, Providence and Swedish Medical Groups
- Group providers: Pacific Medical Centers, Kadlec Regional Medical Center and Clinics, and more
- Includes CareUnity ACO in eastern Washington
- St Joseph Health and Covenant providers
- Walgreen's pharmacies

Coinsurance
The percentage of the cost that you may need to pay for a covered service.

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

In-Network benefit
The in-network benefit is an extensive network of highly qualified physicians and health care providers, also known as network providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from network providers. To find an in-network provider, go to www.providencehealthplan.com/swedish

In-Network provider
A physician or provider of health care services who belongs to the Providence Health Plan in-network provider panel. To find an in-network provider, refer to the directory available at www.providencehealthplan.com/swedish

Medical/pharmacy deductible
The dollar amount that an individual or family pays for covered services before your plan pays any benefits within a calendar year. The deductible can be met by using in-network or out-of-network providers, or the combination of both. The following expenses do not apply to an individual or family deductible:
- Services not covered by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays or coinsurance for any supplemental benefits provided by your employer, such as routine vision care
- Copays and coinsurance for services that do not apply to the deductible.

Medical/pharmacy out-of-pocket maximum
The limit on the dollar amount you will have to spend for specified covered health services (a combination of both in and out-of-plan services) in a calendar year. Some services and expenses do not apply to the common out-of-pocket maximum. See your Summary Plan Description for details.

Out-of-Network benefit
Refers to services you receive from a non-network provider. Your out-of-pocket costs are generally higher when you receive covered services from non-network providers. To find a network provider, go to www.providencehealthplan.com/swedish

Out-of-Network provider
Any health care professional who does not participate within Providence Health Plan's in-network panel of physicians and providers of health care services.

Preventive drugs
Preventive drugs are subject to the formulary, as well as pharmacy management programs such as prior authorization, step therapy, and/or quantity limits.

Primary Care Provider
A qualified practitioner who specializes in family practice, general practice, internal medicine, pediatrics, obstetrics or gynecology.

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.

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 difference. These amounts do not apply to your out-of-pocket maximums.

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: www.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, 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 Information

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

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

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 1-800-878-4445 (TTY: 711).

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

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

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

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711 (TTY).

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 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).

توجه: اگر به زبان فارسی گفتگو یم کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم یم باشد. با (TTY: 711) 1-800-878-4445 تماس بگیرید.

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)