

# Your Benefit Summary

## Personal Option Plan (Base Plan)

### Clackamas County - General County Employees

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum	Calendar Year Deductible
\$25	20% coinsurance (after deductible)	\$3,000 per person \$6,000 per family (2 or more)	\$1,000 per person \$2,000 per family (2 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- Prior authorization is required for some services
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- View a list of Providence Signature network providers and pharmacies at [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

### Benefit Highlights

After you pay your calendar year deductible, then you pay the following for covered services:

✓ No deductible needs to be met prior to receiving this service	Copay or Coinsurance (from in-network providers only)
<b>Preventive Care</b>	
<ul style="list-style-type: none"> <li>• Periodic health exams and well-baby care</li> <li>• Vision and hearing screenings for children under 18</li> <li>• Routine immunizations and shots</li> <li>• Gynecological exams (calendar year) and Pap tests</li> <li>• Mammograms</li> <li>• Colonoscopy; sigmoidoscopy</li> <li>• Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	Covered in full ✓ Covered in full ✓
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits</li> <li>• Office visits to alternative care provider (Chiropractic manipulation &amp; acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)</li> <li>• Phone and video visits</li> <li>• Allergy shots, serums, infusions and injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul>	\$25 / visit ✓ \$25 / visit ✓ \$5 / visit ✓ \$25 / visit ✓ 20% 20%
<b>Diagnostic Services</b>	
<ul style="list-style-type: none"> <li>• X-ray and lab services</li> <li>• High-tech imaging services (such as PET, CT or MRI)</li> <li>• Sleep studies</li> </ul>	10% ✓ 10% ✓ 10% ✓
<b>Emergency and Urgent Services</b>	
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Emergency medical transportation (air and/or ground)</li> </ul>	\$100 ✓ \$25 / visit ✓ 20%
<b>Hospital Services</b>	
<ul style="list-style-type: none"> <li>• Inpatient/Observation care</li> <li>• Rehabilitative care (limited to 30 days per calendar year)</li> <li>• Skilled nursing facility (limited to 60 days per calendar year)</li> </ul>	20% 20% 20%
<b>Outpatient Services</b>	
<ul style="list-style-type: none"> <li>• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)</li> </ul>	20% 50% \$25 / visit ✓

Benefit Highlights (continued)	Copay or Coinsurance
<b>Maternity Services</b> <ul style="list-style-type: none"> <li>• Prenatal care</li> <li>• Delivery and postnatal services</li> <li>• Inpatient hospital/facility services</li> <li>• Routine newborn nursery care</li> </ul>	Covered in full ✓ \$150 / delivery ✓ 20% 20% ✓
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>• Medical equipment, appliances and supplies</li> <li>• Diabetes supplies (lancets, test strips and needles)</li> <li>• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year, deductible waived)</li> </ul>	20% ✓ 20% ✓ 20% ✓
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.) <ul style="list-style-type: none"> <li>• Inpatient and residential services</li> <li>• Day treatment, intensive outpatient, and partial hospitalization services</li> <li>• Applied behavior analysis</li> <li>• Outpatient provider visits</li> </ul>	20% 20% 20% \$25 / visit ✓
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>• Home health care</li> <li>• Hospice care</li> </ul>	20% Covered in full ✓

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

**Coinsurance**  
The percentage of the cost that you may need to pay for a 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 services before your plan pays any benefits within a calendar year. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your 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 drug treatment choices for covered medical conditions. The Providence Health Plan formulary includes both brand-name and generic medications.

**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.

**Limitations and Exclusions**  
All covered services are subject to the limitations and exclusions specified for your plan. Refer to your Summary Plan Description or contract for a complete list.

**Out-of-Network**  
Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

**Out-of-Pocket Maximum**  
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Summary Plan Description for details.

**Personal Physician/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.

**Prior authorization**  
Some services must be pre-approved, your in-network provider will request prior authorization for these services.

# Your Benefit Summary

## Chiropractic Manipulation, Acupuncture and Massage Therapy Clackamas County - General County Employees on a Personal Option Plan (Base Plan)

<b>Copay</b>	<b>Maximum Calendar Year Benefit</b>
<b>\$25</b>	<b>\$2,000</b> per member

### Important information about your plan

These benefits are offered as an additional option to your medical plan. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- With this benefit you have access to in-network qualified practitioners, including chiropractors and acupuncturists, for chiropractic manipulations and acupuncture.
- For members enrolled in a Health Savings Account (HSA) plan, your deductible applies to these benefits and your copayment or coinsurance applies to your plan out-of-pocket maximum but not your annual limit on cost sharing. For members on all other plans, your medical plan deductible does not apply to these benefits, and copayment or coinsurance does not apply to your medical plan out-of-pocket maximum.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

### About your chiropractic manipulation, acupuncture, and massage therapy benefits

This plan covers chiropractic manipulations, acupuncture and massage therapy when they are:

- Received from an in-network qualified practitioner, including licensed chiropractic physician, acupuncturist or massage therapist, who is practicing within the scope of his or her license;
- Determined by your plan to be medically necessary; and
- Not listed as an exclusion in your Member Handbook.

### What you need to know before you use this benefit

- While you don't need a physician's referral to receive these benefits, you must see a Providence Health Plan in-network provider. To find an in-network provider in your area, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory) or call us.
- Only one copay is required per date of service, regardless of the number of covered services received during the visit. Unless you are enrolled in an HSA plan, you do not need to meet any applicable medical plan deductibles before receiving this benefit.
- Routine preventive care in the absence of an illness, injury, or disease is not covered.

### Chiropractic manipulation covered services

- Manipulation of the spine, and re-evaluation as necessary.
- Services may require review for medical necessity.

### Acupuncture covered services

- Acupuncture
- Services may require review for medical necessity.

### Massage therapy covered services

- Short-term rehabilitative therapy.
- Services may require review for medical necessity.

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

### **Copay**

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### **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 services from in-network providers.

### **Maximum calendar year benefit**

The total dollar amount of benefits that you can receive, per calendar year.

### **Medical Necessity Review**

A process to ensure that the care delivered or proposed is safe and appropriate for the patient, and is for the treatment of an illness, injury, disease or its symptoms.

### **Out-of-Network**

Refers to services you receive from providers not in your plan's network. To find an in-network provider, go to [www.ProvidenceHealthPlan.com/providerdirectory](http://www.ProvidenceHealthPlan.com/providerdirectory).

### **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: **711**



Have questions about your benefits and want to contact us via email? Go to our website at:  
[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)

# Your Benefit Summary

## Out-of-Area Dependent

## Clackamas County - General County Employees

What You Pay	Calendar Year Out-of-Pocket Maximum
20% coinsurance	\$1,000 per person \$2,000 per family (2 or more)

### Important information about your plan

This summary provides only highlights of your benefits. To view your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- Some services must be prior authorized by us or a penalty will apply. See your Member Handbook for a list of these services.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Benefit Highlights	You pay the following for covered services:
	<b>Coinsurance</b>
<b>Preventive Care</b>	
<ul style="list-style-type: none"> <li>• Periodic health exams and well-baby care</li> <li>• Routine immunizations and shots</li> <li>• Colonoscopy (age 50 +)</li> <li>• Gynecological exams (calendar year) and Pap tests</li> <li>• Mammograms</li> <li>• Tobacco cessation, counseling/classes and deterrent medications</li> </ul>	Covered in full Covered in full Covered in full Covered in full Covered in full Covered in full
<b>Physician / Provider Services</b>	
<ul style="list-style-type: none"> <li>• Office visits</li> <li>• Office visits to alternative care providers (Chiropractic manipulation &amp; acupuncture services are covered only if a separate benefit has been purchased by your employer. Consult your member materials for these benefits.)</li> <li>• Phone and video visits</li> <li>• Allergy shots, serums, infusions, and injectable medications</li> <li>• Inpatient hospital visits</li> <li>• Surgery; anesthesia</li> </ul>	20% 20% \$5 / visit 20% 20% 20%
<b>Diagnostic Services</b>	
<ul style="list-style-type: none"> <li>• X-ray; lab services</li> <li>• High-tech Imaging services (such as PET, CT, MRI)</li> <li>• Sleep studies</li> </ul>	20% 20% 20%
<b>Emergency and Urgent Services</b>	
<ul style="list-style-type: none"> <li>• Emergency services (for emergency medical conditions only. If admitted to the hospital, all services subject to inpatient benefits)</li> <li>• Urgent care services (for non-life threatening illness/minor injury)</li> <li>• Emergency medical transportation (air and/or ground)</li> </ul>	20% 20% 20%
<b>Hospital Services</b>	
<ul style="list-style-type: none"> <li>• Inpatient/Observation care</li> <li>• Rehabilitative care (limited to 30 days per calendar year)</li> <li>• Skilled nursing facility (limited to 60 days per calendar year)</li> </ul>	20% 20% 20%
<b>Outpatient Services</b>	
<ul style="list-style-type: none"> <li>• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy</li> <li>• Colonoscopy (non-preventive)</li> <li>• Temporomandibular joint (TMJ) service (limited to \$1,000 per calendar year / \$5,000 per lifetime)</li> <li>• Outpatient rehabilitative services: physical, occupational or speech therapy (limited to 30 visits per calendar year)</li> </ul>	20% 20% 50% 20%
<b>Maternity Services</b>	
<ul style="list-style-type: none"> <li>• Prenatal office visits</li> <li>• Delivery and postnatal services</li> <li>• Inpatient hospital/facility services</li> <li>• Routine newborn nursery care</li> </ul>	Covered in full 20% 20% 20%

Benefit Highlights (continued)	Coinsurance
<b>Medical Equipment, Supplies and Devices</b> <ul style="list-style-type: none"> <li>• Medical equipment, appliances and supplies</li> <li>• Diabetes supplies (lancets, test strips and needles)</li> <li>• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to \$200 per calendar year)</li> </ul>	20% 20% 20%
<b>Mental Health / Chemical Dependency</b> (To initiate services, you must call 800-711-4577. All services, except outpatient provider visits, must be prior authorized.) <ul style="list-style-type: none"> <li>• Inpatient and residential services</li> <li>• Day treatment, intensive outpatient, and partial hospitalization services</li> <li>• Applied behavior analysis</li> <li>• Outpatient provider office visits</li> </ul>	20% 20% 20% 20%
<b>Home Health and Hospice</b> <ul style="list-style-type: none"> <li>• Home health care</li> <li>• Hospice care</li> </ul>	20% Covered in full

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

### Coinsurance

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

### Copay

The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

### 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

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 services 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.

### Out-of-network

Refers to health care professionals who do not participate in Providence Health Plan's network of participating physicians and providers of health care services.

### Out-of-Pocket Maximum

The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbook for details.

### Prior authorization

Some services must be pre-approved. 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-plan provider. When the cost of out-of-plan 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

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 All other areas: **800-878-4445**  
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[www.ProvidenceHealthPlan.com/contactus](http://www.ProvidenceHealthPlan.com/contactus)

# Your Benefit Summary

## Personal Option Plan (Base Plan)

### Prescription Drug Plan

#### Clackamas County - General County Employees

#### Important information about your plan

This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, register and log in at [www.myProvidence.com](http://www.myProvidence.com).

- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) or call us.
- You have broad access to our network of participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) or call us.
- Not sure what a word or phrase means? See the back for the definitions used in this summary.
- Copayments and coinsurance apply to your medical plan out-of-pocket maximum.

Drug Coverage Category	Copay or Coinsurance		
	All Participating and Preferred Retail Pharmacies (for up to a 30-day supply)	All Mail Order and Preferred Retail Pharmacies (for up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (for up to a 30-day supply of specialty and self-administered chemotherapy drugs)
Generic drug (preferred and non-preferred)	\$10	\$20	N/A
Brand-name drug (preferred and non-preferred)	50% up to \$200	50% up to \$400	
Specialty drug	N/A	N/A	50% up to \$200

#### What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan.
- ACA Preventive Drugs are covered in full for up to a 30-day supply purchased at a participating / preferred retail pharmacy. Mail order: Covered in full for up to a 90-day supply of maintenance drugs at a participating / preferred retail or mail order pharmacy.
- If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If your brand-name benefit includes a copayment or a coinsurance and you request 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 brand-name drug copayment or coinsurance indicated on the benefit summary. Your total cost, however, will never exceed the actual cost of the drug.
- Compounded drugs are covered at 50% coinsurance up to \$200 for up to 30-day supply at participating retail or preferred retail pharmacies.
- Compounded drugs are medications that are custom prepared by your pharmacist. These prescriptions must contain at least one Food and Drug Administration (FDA) approved drug.
- Specialty drugs are prescriptions that require special delivery, handling, administration and monitoring by your pharmacist.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows for your lowest out-of-pocket cost. Please refer to your medical Benefit Summary for more information.

#### Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may be assessed multiple copayments for a multi-use or unit-of-use container or package depending on the medication and the number of days supplied.
- 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.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information, visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).
- Diabetes supplies may be obtained at your participating pharmacy, and are subject to your group's medical supplies and devices benefits, limitations, and coinsurance. See your Member Handbook for details.

## Using your prescription drug formulary

- The Providence formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- The formulary can help you and your physician choose effective medications that are less costly and minimize your out-of-pocket expense.
- Some prescription drugs require prior authorization or a formulary exception in order to be covered; these may include select formulary agents, non-formulary agents, step therapy, and/or quantity limits as listed in our Prescription Drug Formulary available on our website. If a formulary exception is approved, your generic or brand-name cost share will apply.
- Effective generic drug choices are available to treat most medical conditions. Visit [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com) for answers to frequently asked questions about both generic drugs and the formulary.

## Ordering prescriptions by mail

- 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.
- To find participating mail-order pharmacy information visit us online at [www.ProvidenceHealthPlan.com](http://www.ProvidenceHealthPlan.com).

## If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy.
- If this occurs, you will need to pay full price for your prescription at the time of purchase. Reimbursement forms are available online.
- Reimbursement is subject to your plan's limitations and exclusions.

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

### Brand-name drug / Preferred brand-name drug

Brand name drugs are protected by U.S. patent laws and only a single manufacturer has the rights to produce and sell them. Your benefits include drugs listed on our formulary as Brand-name or Preferred brand-name drugs. Generally your out-of-pocket costs will be less for Preferred brand-name drugs.

### Coinsurance

The percentage of the cost that you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

### Copay

The fixed dollar amount you pay to a participating pharmacy, at the time of purchase, for a covered prescription drug.

### 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.

### Generic drug / Preferred generic drug

Generic drugs have the same active-ingredient formula as the brand-name drug. Generic drugs are usually available after the brand-name patent expires. Your benefits include drugs listed on our formulary as Generic or Preferred generic drugs. Generally your out-of-pocket costs will be less for Preferred generic drugs.

### Maintenance drug

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. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs obtained from specialty pharmacies.

### Participating pharmacies

Pharmacies that have a signed contract with Providence Health Plan to provide medications and other services at special rates. There are four types of participating pharmacies:

- Retail: a participating pharmacy that allows up to a 30-day supply 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.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

### Preventive drug

A generic or brand medication included on the formulary, and required to be covered at no cost per federal regulation.

### Prior authorization

The process used to request an exception to the Providence Health Plan drug formulary. This process can be initiated by the prescriber of the medication or the member. 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.

### Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

## Contact us

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All other areas: **800-878-4445**  
TTY: **711**



Have questions about your benefits and want to contact us via email? Go to our website at:  
[www.ProvidenceHealthPlan.com/contactus](http://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: (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: បើសិនជាអ្នកនិយាយភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់ប្រើអ្នក។ 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).

دیوری بگ. شما یرا گان یرا بصورت یر زبان لات یر تسه، دی کن یم گفتگ و یر فارس زبان به اگر: توجه  
ف یم باشد. یا (TTY: 711) 1-800-878-4445 تماس

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)

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.

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).