Your Benefit Summary

St. Joseph Health

2020 SJH PPO Medical Plan

Administered by PROVIDENCE Health Plan

Copay	What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum	Calendar Year Out-of-Network Out-of-Pocket Maximum	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible
$20/$40	0%-10% coinsurance (after deductible)	30% coinsurance (after deductible; UCR applies)	$1,500 per person $3,000 per family (2 or more)	$3,500 per person $7,000 per family (2 or more)	$250 per person $750 per family (3 or more)	$500 per person $1,500 per family (3 or more)

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 deductibles apply to your out-of-pocket maximums.
- Benefits for out-of-network services are based on Usual, Customary & Reasonable charges (UCR).
- Some services and penalties do not apply to out-of-pocket maximums.

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 benefit.	Domestic Network Provider (Tier I)	Other In-Network Providers (Tier II)	Out-of-Network (Tier III)
Preventive Health and Wellness Services			
• Periodic health exams and well baby care	Covered in full✓	Covered in full✓	30%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	Covered in full✓	30%
• Mammogram	Covered in full✓	Covered in full✓	30%
• Colonoscopy (age 50+)	Covered in full✓	Covered in full✓	30%
• Routine immunizations/shots	Covered in full✓	Covered in full✓	30%
• Vision and hearing screening	Covered in full✓	Covered in full✓	30%
• Tobacco use cessation; counseling/classes, and deterrent medications, including prescription and over the counter. Medications must be purchased at an in-network pharmacy.	$20	$20	30%
Physician / Provider Services			
• Office visits to Primary Care Provider	$20 / visit✓	$20 / visit✓	30%
• Office visits to specialist	$40 / visit✓	$40 / visit✓	30%
• Inpatient hospital visits	Covered in full	10%	30%
• Surgery; anesthesia	Covered in full	10%	30%
• Allergy shots, serums, infusions, and injectable medications	Covered in full✓	Covered in full✓	30%
Outpatient Diagnostic Services			
• X-Ray; Lab Services - facility	Covered in full✓	$20✓	30%
• X-Ray; Lab Services - Provider	Covered in full✓	$20✓	30%
• High-tech imaging services - Facility	Covered in full✓	10%✓	30%
• High-tech imaging services - Provider	Covered in full✓	10%✓	30%
Hospital Services			
• Acute care	$200 / admit	$200 + 10%	30%
• Rehabilitative care	$200 / admit	$200 + 10%	30%
• Skilled nursing facility	$200 / admit	$200 + 10%	$500 + 30%

Benefit Highlights (continued)	Domestic Network Provider	Other In-Network Providers	Out-of-Network
Maternity			
• Prenatal services	Covered in full✓	Covered in full✓	30%
• Delivery and postnatal services	Covered in full✓	Covered in full✓	30%
• Routine newborn nursery care	$200 / admit	$200 + 10%	30%
• Hospital services	$200 / admit	$200 + 10%	30%
• Infertility services	$20✓	$20✓	30%
Medical Equipment, Supplies and Devices			
• Durable medical equipment and appliances	Covered in full	Covered in full	30%
• Prosthetic and orthotic devices	Covered in full	10%	30%
• Diabetic supplies (See SPD for details)	Covered in full✓	Covered in full✓	Covered in full✓
• Hearing aids	10%	25%	30%
Emergency / Urgent Care / Emergency Medical Transportation			
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$150	$150	$150
• Urgent care services (for non-life threatening illness/minor injury)	$50 / visit✓	$50 / visit✓	$50 / visit✓
• Emergency medical transportation	Covered in full✓	Covered in full✓	100% of UCR✓
Other Covered Services			
• Outpatient rehabilitative and habilitative services (Outpatient rehabilitative occupation, speech and physical therapy limited to 30 visits combined per calendar year. Limits do not apply to mental health services.)	$20✓	$20✓	30%
• Outpatient surgery, infusion, chemotherapy, radiation therapy	$150	$150 + 10%	30%
• Spinal manipulations and acupuncture (limited to 40 visits combined per calendar year)	$20✓	$20✓	30%
• Bariatric surgery (limitations apply	$200	$200 + 10%	30%
• Temporomandibular joint (TMJ) service	$40✓	$40✓	30%
• Home health care (limited to 100 visits per calendar year)	$20✓	$20✓	30%
• Hospice care	$200 / admit	$200 + 10%	30%
Mental Health / Chemical Dependency (All services, except outpatient provider office visits, must be prior authorized. For information, please call 800-878-4445.)			
• Inpatient and residential services	$200 / admit	$200 + 10%	30%
• Day treatment, intensive outpatient and partial hospitalization services	Covered in full✓	$150 + 10%	30%
• Outpatient provider office visits	$20 / visit✓	$20 / visit✓	30%
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies) Annual prescription drug out-of-pocket maximum is $5,100 per person, $10,200 per family. There is no annual prescription drug deductible. Mail order drug copay is 2.5x retail.			
• ACA Preventive drugs (deductible waived)	Covered in full	Covered in full	Not covered
• Generic drugs (including Enhanced Preventive drugs)	$10	$10	Not covered
• Brand-name drugs (including Enhanced Preventive drugs)	$35	$35	Not covered
• Non-formulary drugs	$35	$35	Not covered

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

ACA Preventive drug
ACA Preventive drugs are medications 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.

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.

Enhanced Preventive drug
Enhanced preventive does not include any drug or medication used to treat an existing illness, injury or condition. Enhanced Preventive drugs are subject to formulary as well as pharmacy management programs such as prior authorization, step therapy and/or quantity limits.

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 a in-network provider, go to www.providencehealthplan.com/stjhs

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/stjhs.

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
- 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 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-network 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/stjhs.

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.

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.
- Mail Order: a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.
- 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.

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: (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៖ 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 می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می 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)