Your Benefit Summary

St. Joseph Health EPO

Administered by PROVIDENCE Health Plan

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum
$15/$25	Covered in full	$1,250 per person $2,500 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.

- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of network providers and pharmacies at www.ProvidenceHealthPlan.com/stjhs .
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.

Benefit Highlights

	You pay the following for covered services	
	Domestic Network Provider (Tier I)	Other In-Network Providers (Tier II)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full	Covered in full
• Routine immunizations; shots	Covered in full	Covered in full
• Colonoscopy (age 50 +)	Covered in full	Covered in full
• Gynecological exams (calendar year) and Pap tests	Covered in full	Covered in full
• Mammograms	Covered in full	Covered in full
• Tobacco cessation, counseling/classes and deterrent medications	$15	$15
Physician / Provider Services		
• Office visits to Primary Care Provider	$15 / visit	$15 / visit
• Office visits to Alternative Care Provider	$15 / visit	$15 / visit
• Office visits to Specialists/Other Providers	$25 / visit	$25 / visit
• Allergy shots and serums	Covered in full	Covered in full
• Infusions and injectable medications	Covered in full	Covered in full
• Surgery in an office or facility	Covered in full	Covered in full
• Anesthesia in an office or facility	Covered in full	Not covered*
• Inpatient hospital visits	Covered in full	Not covered*
Diagnostic Services		
• X-ray services - Facility	Covered in full	Covered in full
• X-ray services - Provider	$15	$15
• Lab services	$15	$15
• High-tech imaging services (such as PET, CT or MRI)	$25	$25
Emergency and Urgent Services		
• Emergency services (For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$150	$150
• Urgent care services (for non-life threatening illness/minor injury)	$50 / visit	$50 / visit
• Emergency medical transportation (air and/or ground)	Covered in full	Covered in full
Hospital Services		
• Inpatient/Observation care	Covered in full	Not covered*
• Rehabilitative care	Covered in full	Not covered*
• Habilitative Care	Covered in full	Not covered*
• Skilled nursing facility (Limited to 60 days per calendar year)	Covered in full	Not covered*
Maternity Services		
• Prenatal office visits	Covered in full	Covered in full
• Postnatal office visits	Covered in full	Covered in full
• Delivery - Provider	Covered in full	Covered in full
• Inpatient hospital/facility services	Covered in full	Not covered*
• Routine newborn nursery care	Covered in full	Not covered*

* Unless it's an emergency

Benefit Highlights (continued)

	Domestic Network Provider	Other In-Network Providers
Outpatient Services		
• Outpatient dialysis, infusion, chemotherapy, radiation therapy	$25	$25
• Outpatient Surgery - Facility	Covered in full	Not covered*
• Temporomandibular joint (TMJ) service	$25	$25
• Colonoscopy (non-preventive)	Covered in full	Covered in full
• 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.)	$15	$15
• Spinal manipulations and acupuncture (limited to 40 visits combined per calendar year)	$15	$15
Medical Equipment, Supplies and Devices		
• Prosthetic devices	$25	$25
• Medical equipment, appliances and supplies	$25	$25
• Diabetic supplies (See SPD for details)	Covered in full	Covered in full
• Orthotic devices	Covered in full	Covered in full
• Hearing Aids (One hearing aid per ear every 36 months)	$25	$25
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	Covered in full	Covered in full
• Day treatment, intensive outpatient and partial hospitalization services	Covered in full	Covered in full
• Outpatient provider office visits	$15 / visit	$15 / visit
Home Health and Hospice		
• Home health care	$15	$15
• Hospice care	$25	$25
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 $5,350 per person, $10,700 per family. Mail order drug copay is 2.5x retail.		
• ACA Preventive drugs	Covered in full	Covered in full
• Generic drugs (Enhanced preventive, formulary and non-formulary)	$10	$10
• Brand-name drugs (Enhanced preventive, formulary and non-formulary)	$35	$35

* Unless it's an emergency

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.

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-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.

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 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.

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).

توجـه: اگـر بـه زبـان فـارسی گفتگـــو می کنـید، تسـهیلات زبـانی بصـــورت رایـگان بـرای شما فراهم می باشـد. با (TTY: 711) 1-800-878-4445 تمـاس 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)