

 The Summary of Benefits and Coverage (SBC) document will help you choose a health [plan](#). The SBC shows you how you and the [plan](#) would share the cost for covered health care services. **NOTE: Information about the cost of this [plan](#) (called the [premium](#)) will be provided separately. This is only a summary.** For more information about your coverage, or to get a copy of the complete terms of coverage, www.ProvidenceHealthPlan.com. For general definitions of common terms, such as [allowed amount](#), [balance billing](#), [coinsurance](#), [copayment](#), [deductible](#), [provider](#), or other underlined terms see the Glossary. You can view the Glossary at www.healthcare.gov/sbc-glossary or call 1-800-878-4445 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible ?	In-Network: \$250/per person \$750/per family (3 or more). Out-of-Network: \$500/per person \$1,500/per family (3 or more). Deductibles cross-accumulate between benefit tiers and are for medical only.	Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible .
Are there services covered before you meet your deductible ?	Yes. Office visits, most preventive care, emergency and urgent care services.	This plan covers some items and services even if you haven't yet met the annual deductible amount. But a copayment or coinsurance may apply. For example, this plan covers certain preventive services without cost-sharing and before you meet your deductible . See a list of covered preventive services at https://www.healthcare.gov/coverage/preventive-care-benefits/ .
Are there other deductibles for specific services?	No.	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan ?	In-Network: \$1,500/per person \$3,000/per family (2 or more). Out-of-Network: \$3,500/per person \$7,000/per family (2 or more). OOP expenses cross-accumulate between benefit tiers. Prescription drugs in-network: \$5,100/per person; \$10,200/per family.	The out-of-pocket limit is the most you could pay in a year for covered services. If you have other family members in this plan , they have to meet their own out-of-pocket limits until the overall family out-of-pocket limit has been met.
What is not included in the out-of-pocket limit ?	Premiums, penalties, your costs for Supplemental Benefits, services not covered, fees above UCR.	Even though you pay these expenses, they don't count toward the out-of-pocket limit.
Will you pay less if you use a network provider ?	Yes. For a list of participating providers see www.providencehealthplan.com/stjhs or call 1-800-878-4445.	This plan uses a provider network. You will pay less if you use a provider in the plan 's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (a balance bill). Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist ?	No.	You can see the specialist you choose without a referral.



All **copayment** and **coinsurance** costs shown in this chart are after your **deductible** has been met, if a **deductible** applies.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	\$20 copay/visit	\$20 copay/visit	30% coinsurance	Deductible does not apply in-network. Some services such as lab and x-ray will include additional member costs.
	<u>Specialist</u> visit	\$40 copay/visit	\$40 copay/visit	30% coinsurance	
	<u>Preventive care/screening/immunization</u>	No charge	No charge	30% coinsurance	Deductible does not apply. Some preventive services will include additional member costs. For more information see: https://healthplans.providence.org/pdfs/members/documents/preventive-care-costs.pdf .
If you have a test	<u>Diagnostic test</u> (x-ray, blood work)	No charge	\$20 copay	30% coinsurance	Deductible does not apply in-network.
	Imaging (CT/PET scans, MRIs)	No charge	10% coinsurance	30% coinsurance	Deductible does not apply in-network. Prior authorization required.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.ProvidenceHealthPlan.com	Preventive drugs: Generic and Brand-name	No charge	No charge	Not covered	Deductible does not apply. ACA Preventive drugs are covered in full in-network. Covers up to a 90-day supply (retail and mail order prescription). Prior authorization may apply. Specialty drugs can only be purchased at a participating specialty pharmacy.
	Generic drug	\$10 copay retail \$25 copay mail order	\$10 copay retail \$25 copay mail order	Not covered	
	Brand-name drug	\$35 copay retail \$87.50 copay mail order	\$35 copay retail \$87.50 copay mail order	Not covered	
	Specialty drug	Generic: \$10 copay retail Brand-name: \$35 copay retail	Generic: \$10 copay retail Brand-name: \$35 copay retail	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	\$150 copay	\$150 copay then 10% coinsurance	30% coinsurance	Prior authorization required.
	Physician/surgeon fees	No charge	10% coinsurance	30% coinsurance	
If you need immediate medical attention	Emergency room care	\$150 copay	\$150 copay	\$150 copay	For emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.
	Emergency medical transportation	No charge	No charge	No charge	Deductible does not apply.
	Urgent care	\$50 copay	\$50 copay	\$50 copay	Deductible does not apply. Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	\$200 copay per admission	\$200 copay then 10% coinsurance	30% coinsurance	Prior authorization required.
	Physician/surgeon fees	No charge	10% coinsurance	30% coinsurance	

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$20 copay	\$20 copay	30% coinsurance	All services except provider office visits must be prior authorized. Deductible does not apply in-network to provider office visits. See your benefit summary for ABA services.
	Inpatient services	\$200 copay per admit	\$200 copay per admit then 10% coinsurance	30% coinsurance	
If you are pregnant	Office visits	No charge	No charge	30% coinsurance	Deductible does not apply in-network.
	Childbirth/delivery professional services	\$200 copay	\$200 copay then 10% coinsurance	30% coinsurance	Copay applies to provider delivery charges. Deductible does not apply in-network.
	Childbirth/delivery facility services	\$200 copay	\$200 copay then 10% coinsurance	30% coinsurance	—————none—————
If you need help recovering or have other special health needs	Home health care	\$20 copay	\$20 copay	30% coinsurance	Limited to 100 visits maximum per benefit year
	Rehabilitation services	\$20 copay	\$20 copay	30% coinsurance	Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Habilitation services	\$20 copay	\$20 copay	30% coinsurance	Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Skilled nursing care	\$200 copay	\$200 copay, then 10% coinsurance	\$500 copay, then 30% coinsurance	Prior authorization required. Coverage is limited to 100 days per calendar year.
	Durable medical equipment	No charge	No charge	30% coinsurance	Deductible does not apply to diabetes supplies from in-network providers.
	Hospice services	\$200 copay	\$200 copay, then 10% coinsurance	\$500 copay, then 30% coinsurance	Deductible does not apply in-network.

Common Medical Event	Services You May Need	What You Will Pay			Limitations, Exceptions, & Other Important Information
		Domestic Network (You will pay the least)	Network Provider	Out-of-Network Provider (You will pay the most)	
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	Not covered	Not covered	Not covered	No coverage for dental check-up.

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services .)		
<ul style="list-style-type: none"> • Cosmetic surgery (with certain exceptions) • Dental care (Adult) • Dental check-up (Child) • Eye exam and glasses (Child) 	<ul style="list-style-type: none"> • Long-term care • Non-emergency care when traveling outside the U.S. • Private-duty nursing 	<ul style="list-style-type: none"> • Routine eye care (Adult) • Routine foot care (covered for diabetics) • Weight loss programs

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)		
<ul style="list-style-type: none"> • Acupuncture (limits apply) • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care • Hearing Aids (limits apply) 	<ul style="list-style-type: none"> • Infertility treatment (limits apply)

Your Rights to Continue Coverage: There are agencies that can help if you want to continue your coverage after it ends. The contact information for those agencies is: U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or <http://www.dol.gov/ebsa>, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or <http://www.cciio.cms.gov>. Other coverage options may be available to you too, including buying individual insurance coverage through the Health Insurance [Marketplace](#). For more information about the [Marketplace](#), visit www.HealthCare.gov or call 1-800-318-2596.

Your Grievance and Appeals Rights: There are agencies that can help if you have a complaint against your [plan](#) for a denial of a [claim](#). This complaint is called a [grievance](#) or [appeal](#). For more information about your rights, look at the explanation of benefits you will receive for that medical [claim](#). Your [plan](#) documents also provide complete information to submit a [claim](#), [appeal](#), or a [grievance](#) for any reason to your [plan](#). For more information about your rights, this notice, or assistance, contact: Providence Health Plan at 1-800-878-4445. Additionally, if your plan is governed by ERISA, you may also contact the U.S. Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or <http://www.dol.gov/ebsa/healthreform>.

Does this plan provide Minimum Essential Coverage? Yes

If you don't have [Minimum Essential Coverage](#) for a month, you'll have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

Does this plan meet the Minimum Value Standards? Yes

If your [plan](#) doesn't meet the [Minimum Value Standards](#), you may be eligible for a [premium tax credit](#) to help you pay for a [plan](#) through the [Marketplace](#).

This Summary of Benefits and Coverage required by the Affordable Care Act summarizes the benefit options available to eligible employees as of January 1, 2021. The official plan document and summary plan description will provide more complete details regarding the terms of the Plan. If there is any conflict between the statements in this Summary and the official plan documents, the terms of the plan documents will govern all rights and obligations of participants, beneficiaries, plan fiduciaries and the Company. St Joseph Health System reserves the right to amend or terminate these benefits or change the cost of coverage, for any reason, at any time.

To see examples of how this plan might cover costs for a sample medical situation, see the next section.

About these Coverage Examples:



This is not a cost estimator. Treatments shown are just examples of how this [plan](#) might cover medical care. Your actual costs will be different depending on the actual care you receive, the prices your [providers](#) charge, and many other factors. Focus on the [cost sharing](#) amounts ([deductibles](#), [copayments](#) and [coinsurance](#)) and [excluded services](#) under the [plan](#). Use this information to compare the portion of costs you might pay under different health [plans](#). Please note these coverage examples are based on self-only coverage.

Peg is Having a Baby

(9 months of in-network pre-natal care and a hospital delivery)

■ The plan's overall deductible	\$250
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Specialist office visits (*prenatal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
 Diagnostic tests (*ultrasounds and blood work*)
 Specialist visit (*anesthesia*)

Total Example Cost	\$12,800
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In this example, Peg would pay:

<i>Cost Sharing</i>	
Deductibles	\$0
Copayments	\$1,500
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Peg would pay is	\$1,560

Managing Joe's type 2 Diabetes

(a year of routine in-network care of a well-controlled condition)

■ The plan's overall deductible	\$250
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Primary care physician office visits (*including disease education*)
 Diagnostic tests (*blood work*)
 Prescription drugs
 Durable medical equipment (*glucose meter*)

Total Example Cost	\$7,400
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In this example, Joe would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$1,010
Coinsurance	\$0
<i>What isn't covered</i>	
Limits or exclusions	\$60
The total Joe would pay is	\$1,320

Mia's Simple Fracture

(in-network emergency room visit and follow up care)

■ The plan's overall deductible	\$250
■ Specialist copayment	\$20
■ Hospital (facility) coinsurance	10%
■ Other coinsurance	10%

This EXAMPLE event includes services like:

Emergency room care (*including medical supplies*)
 Diagnostic test (*x-ray*)
 Durable medical equipment (*crutches*)
 Rehabilitation services (*physical therapy*)

Total Example Cost	\$1,960
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In this example, Mia would pay:

<i>Cost Sharing</i>	
Deductibles	\$250
Copayments	\$200
Coinsurance	\$60
<i>What isn't covered</i>	
Limits or exclusions	\$0
The total Mia would pay is	\$510

The [plan](#) would be responsible for the other costs of these EXAMPLE covered services.

Non-Discrimination Statement:

Providence Health Plan complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Providence Health Plan does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Providence Health Plan:

- Provides 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)
- Provides 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 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
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 Services:

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, សេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បម្រើអ្នក។ 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).

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

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)