Your Benefit Summary

St. Joseph Health

2019 SJH HRA 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	10%-25% coinsurance (after deductible)	50% coinsurance (after deductible; UCR applies)	$3,300 per person $6,600 per family (2 or more)	$6,600 per person $13,200 per family (2 or more)	$1,150 per person $2,300 per family (2 or more)	$2,300 per person $4,600 per family (2 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 Calendar Year Medical/Pharmacy Deductible applies to your Calendar Year Medical/Pharmacy Out-of-Pocket Maximum.
- This plan may include a Health Reimbursement Account that can be used toward deductibles, copays and coinsurance.
- 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/stjhs.
- 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.
- This plan summary highlights some of the features of this St. Joseph Health 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. St. Joseph Health 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 and well baby care	Covered in full✓	Covered in full✓	50%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	Covered in full✓	50%
• Mammogram	Covered in full✓	Covered in full✓	50%
• Prostate screening exam (calendar year)	Covered in full✓	Covered in full✓	50%
• Colorectal exam	Covered in full✓	Covered in full✓	50%
• Colorectal cancer screening: sigmoidoscopy, colonoscopy (for members age 50 and over)	Covered in full✓	Covered in full✓	50%
• The following tests (when received with your periodic health exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood	Covered in full✓	Covered in full✓	50%
• 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✓	50%
• Pneumococcal vaccine	Covered in full✓	Covered in full✓	50%
• Flu vaccine	Covered in full✓	Covered in full✓	50%
• Routine immunizations/shots	Covered in full✓	Covered in full✓	50%
• Nutritional counseling	Covered in full✓	Covered in full✓	50%
• Vision and hearing screening	Covered in full✓	Covered in full✓	50%
• 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✓	Not covered

Benefit Highlights (continued)	ACO Network	Other In-Network Providers	Out-of-Network
Physician / Provider Services			
• Office visits to Primary Care Provider	$20 / visit✓	$20 / visit✓	50%
• Office visits to specialist	10%	25%	50%
• Inpatient hospital visits	10%	25%	50%
• Surgery; anesthesia	10%	25%	50%
• Allergy shots, serums, infusions, and injectable medications	10%	25%	50%
Outpatient Diagnostic Services			
• X-ray; lab services	10%	25%	50%
• High-tech imaging services (such as PET, CT, MRI)	10%	25%	50%
Hospital Services			
• Acute care	10%	25%	50%
• Rehabilitative care	10%	25%	50%
• Skilled nursing facility	25%	25%	50%
Maternity			
• Prenatal services	Covered in full✓	Covered in full✓	50%
• Delivery and postnatal services	Covered in full✓	Covered in full✓	50%
• Routine newborn nursery care	10%✓	25%✓	50%✓
• Hospital services	10%	25%	50%
• Infertility services (limited to $500 per calendar year; testing and counseling only)	10%	25%	50%
Medical Equipment, Supplies and Devices			
• Durable medical equipment and appliances	25%	25%	50%
• Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $500 per calendar year)	25%	25%	50%
• Diabetic supplies (See SPD for details)	Covered in full✓	Covered in full✓	50%
• Hearing Aids ($1,500 maximum rolling 36 months)	10%	25%	50%
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.)	$250✓	$250✓	$250✓
• Urgent care services (for non-life threatening illness/minor injury)	10%	25%	50%
• Emergency medical transportation	25%	25%	25%
Other Covered Services			
• Outpatient rehabilitative services (75 visits per calendar year)	10%	25%	50%
• Outpatient surgery, infusion, chemotherapy, radiation therapy	10%	25%	50%
• Bariatric surgery (only available at Swedish/PH&S facilities. Limitations apply.)	10%	Not covered	Not covered
• Temporomandibular joint (TMJ) service (limited to $3,000 per lifetime)	10%	25%	50%
• Spinal manipulations and acupuncture (limited to 12 visits combined per calendar year)	25%	25%	25%
• Home health care (limited to 130 visits per calendar year)	25%	25%	50%
• Hospice care	Covered in full	Covered in full	Covered in full
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	10%	25%	50%
• Day treatment, intensive outpatient and partial hospitalization services	10%	25%	50%
• Applied behavior analysis	10%	25%	25%
• Outpatient provider office visits	Covered in full✓	Covered in full✓	50%
Prescription drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)			
• Preventive drugs (not subject to deductible)	Covered in full✓	Covered in full✓	Not covered
• Generic	$10✓	$10✓	Not covered
• Formulary brand-name drugs	20% (max $150 per 30-day supply)	30% (max $150 per 30-day supply)	Not covered
• Non-formulary brand-name drugs	40% (max $150 per 30-day supply)	50% (max $150 per 30-day supply)	Not covered

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

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 St Joseph Health, Providence, Covenant, and Grace facilities and pharmacies,
- Providence, Heritage, SJH and Covenant Medical Groups and providers
- Walgreen's pharmacies

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.

Health Reimbursement Account (HRA)
An employer-funded tax-exempt account established for paying qualified medical expenses.

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.

Preventive drugs

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