Administered by PROVIDENCE Health Plan

Your Benefit Summary

St. Joseph Health
2019 Flex Health Savings (HSA)
St. Mary Medical Plan

What You Pay In Network	What You Pay Out of Network	Calendar Year In-Network Medical/Pharmacy Out-of-Pocket Maximum	Calendar Year Out-of-Network Medical/Pharmacy Out-of-Pocket Maximum	Calendar Year In-Network Medical/Pharmacy Deductible	Calendar Year Out-of-Network Medical/Pharmacy Deductible
20% coinsurance (after deductible)	30% coinsurance (after deductible; UCR applies)	$4,000 per person $8,000 per family (2 or more)	$8,000 per person $16,000 per family (2 or more)	$2,000 per person $4,000 per family (2 or more)	$3,000 per person $6,000 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.
- The single deductible and out-of-pocket maximum apply when only the employee is enrolled. The family deductible and out-of-pocket maximum apply when an employee and dependent(s) are enrolled.
- Your Calendar Year Medical/Pharmacy Deductible applies to your Calendar Year Medical/Pharmacy Out-of-Pocket Maximum.
- This plan includes a Health Savings Account that can be used to pay for eligible health expenses.
- You may pay a lower coinsurance when you choose a participating In-Network facility or specialist. For details go to www.providencehealthplan.com/stjhs.
- This plan summary highlights some of the features of this Providence 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. Providence 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: In-Network Copay or Coinsurance (when you see an in-network provider)	Out-of-Network Copay or Coinsurance (when you see an out-of-network provider)
Preventive Health and Wellness Services		
• Periodic health exams; well-baby care	Covered in full✓	30%
• Gynecological exams (calendar year) and Pap tests	Covered in full✓	30%
• Mammogram	Covered in full✓	30%
• Prostate screening exam (calendar year)	Covered in full✓	30%
• Colorectal exam	Covered in full✓	30%
• Colorectal cancer screening: sigmoidoscopy, colonoscopy (for members age 50 and over)	Covered in full✓	30%
• The following tests (when received with your periodic health exam): CBC, urinalysis, chemical profile, glucose, cholesterol, fecal blood	Covered in full✓	30%
• 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✓	30%
• Pneumococcal vaccine	Covered in full✓	30%
• Flu vaccine	Covered in full✓	30%
• Routine immunizations/shots	Covered in full✓	30%
• Nutritional counseling	Covered in full✓	30%
• Vision and hearing screening	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.**	Covered in full✓	Not covered

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Physician / Provider Services		
• Office visits to Primary Care Provider	20%	30%
• Office visits to specialist	20%	30%
• Inpatient hospital visits	20%	30%
• Surgery; anesthesia	20%	30%
• Allergy shots, serums, infusions, and injectable medications	20%	30%
Outpatient Diagnostic Services		
• X-ray; lab services	20%	30%
• High-tech imaging services (such as PET, CT, MRI)	20%	30%
Hospital Services		
• Acute care	20%	30%
• Rehabilitative care	20%	30%
• Skilled nursing facility (90 days per calendar year)	20%	30%
Maternity		
• Prenatal services	Covered in full✓	30%
• Delivery and postnatal services	20%	30%
• Hospital services	20%	30%
• Routine newborn nursery care	20%	30%
Medical Equipment, Supplies and Devices		
• Durable medical equipment and appliances	20%	30%
• Prosthetic and Orthotic Devices (Removable custom shoe orthotics are limited to $500 per calendar year)	20%	30%
• Diabetic supplies (See SPD for details)	Covered in full✓	30%
Emergency / Urgent Care / Emergency Medical Transportation		
• Emergency services (for emergency medical conditions only. If admitted to hospital, all services subject to inpatient benefits.)	20%	20%
• Urgent care services (for non-life threatening illness/minor injury)	20%	30%
• Emergency medical transportation	20%	20%
Other Covered Services		
• Outpatient Rehabilitative Services (36 days for cardiac rehab)	20%	30%
• Outpatient surgery (Including ambulatory surgery centers)	20%	30% (no coverage for some facilities)
• Infusion, chemotherapy and radiation therapy	20%	30%
• Spinal manipulations (Limited to 20 visits per calendar year)	20%	20%
• Bariatric Surgery	20%	Not covered
• Temporomandibular joint (TMJ) service (limited to $3,000 per lifetime)	20%	30%
• Home health care (limited to 100 visits per calendar year)	20%	30%
• Hospice care	Covered in full	Covered in full
Mental Health / Chemical Dependency (To initiate services, you must call 800-711-4577. All inpatient, residential, and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient, residential services	20%	30%
• Day treatment, intensive outpatient and partial hospitalization services	20%	30%
• Applied behavior analysis	20%	20%
• Outpatient provider office visits	20%	30%
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
• ACA Preventive drugs	Covered in full✓	Not covered
• Safe Harbor Preventive drugs		
- Generic drugs	$10✓	Not covered
- Brand-name drugs	$35✓	Not covered
• Generic drugs	$10	Not covered
• Brand-name drugs	$35	Not covered
• Non-formulary drugs	Not covered	Not covered

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.

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 Savings Account (HSA)
An IRS-qualified tax-excempt account established for paying qualifying 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
- 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-plan 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.

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.

Safe Harbor Preventive drugs
HSA-Qualified health plans typically provide benefits only after the deductible has been met. The Internal Revenue Code governing HSA-Qualified plans provides for a “safe harbor” for qualifying preventive medications, allowing these safe harbor medications to be exempt from the deductible. The preventive safe harbor does not include any drug or medication used to treat an existing illness, injury or condition. Safe Harbor Preventive drugs are subject to formulary as well as pharmacy management programs such as prior authorization, step therapy and/or quantity limits.

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