




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 ?	\$0	See the Common Medical Events chart below for your costs for services this plan covers.
Are there services covered before you meet your deductible ?	No.	See the Common Medical Events chart below for your costs for services this plan covers.
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 ?	\$1,250 per person / \$2,500 per family (2 or more). Pharmacy: \$5,350 per person/ \$10,700 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.	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. See ProvidenceHealthPlan.com/stjhs or call 1-800-878-4445 for a list of network providers.	This plan uses a provider network . You will pay less if you use a provider in the plan's network . Be aware, your network provider might use a non-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)	In-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	\$15 copay /visit	\$15 copay /visit	Some services such as labs and x-ray will include additional member costs.
	Specialist visit	\$25 copay /visit	\$25 copay /visit	
	Preventive care/screening/immunization	No charge	No charge	For more information on preventive services that are covered in full see: ProvidenceHealthPlan.com/PreventiveCare You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray and Lab: no charge at facility; \$15 provider copay	X-ray and Lab: no charge at facility; \$15 provider copay	—————none—————
	Imaging (CT/PET scans, MRIs)	\$25 copay	\$25 copay	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Domestic Network (You will pay the least)	In-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	ACA Preventive drugs are covered in full in-network. Covers up to a 90-day supply (retail and mail order prescription). <u>Prior authorization</u> may apply. If you do not obtain <u>prior authorization</u> claims for those services will be denied and you will be responsible for payment of those services. *Certain <u>specialty drugs</u> are subject to the Smart RxAssist program and its rules: the list of specialty drugs subject to this program can be found at: ProvidenceHealthPlan.com/stjhs
	Generic drug	\$10 copay retail \$25 copay mail order	\$10 copay retail \$25 copay mail order	
	Brand-name drug	\$35 copay retail \$87.50 copay mail order	\$35 copay retail \$87.50 copay mail order	
	Specialty drug	Generic: \$10 copay retail* Brand-name: \$35 copay retail*	Generic: \$10 copay retail* Brand-name: \$35 copay retail*	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	<u>Prior authorization</u> required. If you do not obtain <u>prior authorization</u> claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	No charge	No charge	
If you need immediate medical attention	Emergency room care	\$150 copay	\$150 copay	For emergency medical conditions only. If admitted to hospital from emergency room, copayment is waived. All services subject to inpatient benefits.
	Emergency medical transportation	No charge	No charge	—————none—————
	Urgent care	\$50 copay /visit	\$50 copay /visit	Some services will include additional member costs.
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered unless emergency	<u>Prior authorization</u> required. If you do not obtain <u>prior authorization</u> claims for those services will be denied and you will be responsible for payment of those services.
	Physician/surgeon fees	No charge	No charge	

For more information about limitations and exceptions, see the plan or policy document at www.providencehealthplan.com/stjhs

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Domestic Network (You will pay the least)	In-Network Provider (You will pay the most)	
If you need mental health, behavioral health, or substance abuse services	Outpatient services	\$15 copay /provider office visit	\$15 copay /provider office visit	Additional services available through the Caregiver Assistance Program. All services except provider office visits may require prior authorization . If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services.
	Applied behavioral analysis	\$15 copay /provider office visit	\$15 copay /provider office visit	
	Inpatient services	No charge	No charge	
If you are pregnant	Office visits	No charge	No charge	—————none—————
	Childbirth/delivery professional services	No charge	Not covered unless emergency	—————none—————
	Childbirth/delivery facility services	No charge	Not covered unless emergency	—————none—————
If you need help recovering or have other special health needs	Home health care	\$15 copay	\$15 copay	Limited to 100 visits maximum per benefit year.
	Rehabilitation services	Inpatient: No charge Outpatient: \$15 copay	Inpatient: Not covered unless emergency Outpatient: \$15 copay	Inpatient services: No limit Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Habilitation services	Inpatient: No charge Outpatient: \$15 copay	Inpatient: Not covered unless emergency Outpatient: \$15 copay	Inpatient services: No limit Outpatient services: coverage limited to 30 visits per calendar year. Limits do not apply to Mental Health Services.
	Skilled nursing care	No charge	Not covered unless emergency	Prior authorization required. If you do not obtain prior authorization claims for those services will be denied and you will be responsible for payment of those services. Coverage is limited to 100 days per calendar year.

For more information about limitations and exceptions, see the plan or policy document at www.providencehealthplan.com/stjhs

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Domestic Network (You will pay the least)	In-Network Provider (You will pay the most)	
	Durable medical equipment	Diabetes supplies: No charge All other equipment: \$25 copay	Diabetes supplies: No charge All other equipment: \$25 copay	—————none—————
	Hospice services	\$25 copay	\$25 copay	Prior authorization required or \$500 penalty
If your child needs dental or eye care	Children's eye exam	Not covered	Not covered	No coverage for eye exam.
	Children's glasses	Not covered	Not covered	No coverage for glasses.
	Children's dental check-up	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"> • Infertility treatments (Diagnostic testing and counseling of infertility are covered. Limits may apply.) • Long-term care • Private-duty nursing 	<ul style="list-style-type: none"> • Non-emergency care when traveling outside the U.S. • 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 (limited to 40 visits combined with chiropractic care) • Bariatric surgery 	<ul style="list-style-type: none"> • Chiropractic care (limited to 40 visits combined with acupuncture) 	<ul style="list-style-type: none"> • Hearing Aids (limited to one per ear every 36 months)

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 on how 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 503-574-8757/1-800-878-4445 (toll-free) or <http://www.ProvidenceHealthPlan.com>.
- Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Does this plan provide Minimum Essential Coverage? Yes

[Minimum Essential Coverage](#) generally includes [plans](#), [health insurance](#) available through the [Marketplace](#) or other individual market policies, Medicare, Medicaid, CHIP, TRICARE, and certain other coverage. If you are eligible for certain types of [Minimum Essential Coverage](#), you may not be eligible for the [premium tax credit](#).

Does this plan meet 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, 2023. 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 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](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

This EXAMPLE event includes services like:
[Specialist](#) office visits (*pre-natal care*)
 Childbirth/Delivery Professional Services
 Childbirth/Delivery Facility Services
[Diagnostic tests](#) (*ultrasounds and blood work*)
[Specialist](#) visit (*anesthesia*)

Total Example Cost \$12,700

In this example, Peg would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$520
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Peg would pay is	\$580

Managing Joe's type 2 Diabetes
(a year of routine in-network care of a well-controlled condition)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 \$5,600

In this example, Joe would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$1,250
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$60
The total Joe would pay is	\$1,310

Mia's Simple Fracture
(in-network emergency room visit and follow up care)

- The [plan's](#) overall [deductible](#) \$0
- [Specialist copayment](#) \$15
- Hospital (facility) [coinsurance](#) 0%
- Other [coinsurance](#) 0%

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 \$2,800

In this example, Mia would pay:

Cost Sharing	
Deductibles	\$0
Copayments	\$640
Coinsurance	\$0
What isn't covered	
Limits or exclusions	\$0
The total Mia would pay is	\$640

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。

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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 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).

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

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)