## Your Benefit Summary

**St Joseph Health**  
**2020 OAP**

### What You Pay

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>20% coinsurance (after deductible)</td>
<td>40% coinsurance (after deductible; UCR applies)</td>
</tr>
</tbody>
</table>

### Calendar Year

<table>
<thead>
<tr>
<th>In-Network</th>
<th>Out-of-Network</th>
</tr>
</thead>
<tbody>
<tr>
<td>Out-of-Pocket Maximum</td>
<td>Out-of-Pocket Maximum</td>
</tr>
<tr>
<td>$2,000 per person</td>
<td>$6,000 per person</td>
</tr>
<tr>
<td>$4,000 per family (2 or more)</td>
<td>$12,000 per family (2 or more)</td>
</tr>
<tr>
<td>Deductible</td>
<td>Deductible</td>
</tr>
<tr>
<td>$250 per person</td>
<td>$250 per person</td>
</tr>
<tr>
<td>$500 per family (2 or more)</td>
<td>$500 per family (2 or more)</td>
</tr>
</tbody>
</table>

### 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](http://www.myProvidence.com).

- Your deductible(s) are included in the out-of-pocket maximum amount(s) listed above.
- In-network and out-of-network services accumulate separately.
- Prior authorization is required for some services.
- 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](http://www.ProvidenceHealthPlan.com/stjhs).
- If you choose to go outside the network, you may be subject to billing for charges that are above Usual, Customary and Reasonable charges (UCR). Benefits for out-of-network services are based on these UCR charges.
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

## Option Advantage Benefit Highlights

<table>
<thead>
<tr>
<th>Preventive Care</th>
<th>In-Network Copay or Coinsurance (after deductible, when you see an in-network provider)</th>
<th>Out-of-Network Copay or Coinsurance (after deductible, when you see a non-network provider)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Periodic health exams and well-baby care</td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td>Colonoscopy (age 50 +)</td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td>Routine immunizations; shots</td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td>Gynecological exams (calendar year) and Pap tests</td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td>Mammograms</td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td>Tobacco cessation, counseling/classes and deterrent medications</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
</tbody>
</table>

**Physician / Provider Services**

- Office visits to Primary Care Provider 20% 40%
- Office visits to Alternative Care Provider 20% 40%
- Office visits to Specialists/Other Providers 20% 40%
- Allergy shots and serums 20% 40%
- Infusions and injectable medications 20% 40%
- Surgery; anesthesia in an office or facility 20% 40%
- Inpatient hospital visits 20% 40%

**Diagnostic Services**

- X-ray and lab services 20% 40%
- Imaging services (such as PET, CT, MRI) 20% 40%

**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.) 20% 20%
- Urgent care services (for non-life threatening illness/minor injury) 20% 20%
- Emergency medical transportation (air and/or ground) 20% 20%

**Hospital Services**

- Inpatient/Observation care 20% 40%
- Rehabilitative care 20% 40%
- Habilitative care 20% 40%
- Skilled nursing facility (90 days per calendar year) 20% 40%
<table>
<thead>
<tr>
<th>Option</th>
<th>Advantage</th>
<th>Benefit Highlights</th>
<th>In-Network Copay or Coinsurance</th>
<th>Out-of-Network Copay or Coinsurance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient Services</strong></td>
<td></td>
<td>● Outpatient surgery, infusion, dialysis, chemotherapy, radiation therapy (Prior authorization required for outpatient hospital-based infusions)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Temporomandibular joint (TMJ) service (limited to $3,000/lifetime)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Colonoscopy (non-preventive)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Outpatient rehabilitative and habilitative services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Maternity Services</strong></td>
<td></td>
<td>● Prenatal office visits</td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Delivery and postnatal services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Inpatient hospital/facility services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Routine newborn nursery care</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Medical Equipment, Supplies and Devices</strong></td>
<td></td>
<td>● Medical equipment, appliances and supplies</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Diabetic supplies (See SPD for details)</td>
<td>Covered in full</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Prosthetic and orthotic devices</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Mental Health / Chemical Dependency</strong></td>
<td></td>
<td>● Inpatient and residential services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Day treatment, intensive outpatient and partial hospitalization services</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Applied behavior analysis</td>
<td>20%</td>
<td>20%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Outpatient provider office visits</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Home Health and Hospice</strong></td>
<td></td>
<td>● Home health care (100 visits per calendar year)</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Hospice care</td>
<td>20%</td>
<td>40%</td>
</tr>
<tr>
<td><strong>Prescription Drugs</strong></td>
<td></td>
<td>● ACA Preventive drugs (deductible waived)</td>
<td>Covered in full</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Generic drugs (including Enhanced Preventive drugs)</td>
<td>$10</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Brand-name drugs (including Enhanced Preventive drugs)</td>
<td>$35</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>● Non-formulary drugs</td>
<td>$35</td>
<td>Not covered</td>
</tr>
<tr>
<td></td>
<td></td>
<td>(Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)</td>
<td>Annual prescription drug out-of-pocket maximum is $4,600 per person, $9,200 per family. There is no annual prescription drug deductible. Mail order drug copay is 2.5x retail.</td>
<td></td>
</tr>
</tbody>
</table>
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.

Deductible
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. 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 and coinsurance for services that do not apply to the deductible

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.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers.

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-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/stjh.

Out-of-Pocket Maximum
The limit on the dollar amount that an individual or family pays for specified covered services in a plan year. This plan has both in-network and out-of-network out-of-pocket maximums. These out-of-pocket maximums accumulate separately and are not combined. Some services and expenses do not apply to the individual or family out-of-pocket maximum. See your member handbook 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. 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.
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
Atttn: 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)

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

ATENCION: 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 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 говорите українською мовою, ви маєте звернутися до безкоштовної служби мовної підтримки. Звертесь 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。


ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție serviciile de asistență lingvistică, gratuit. Sunăți la 1-800-878-4445 (TTY: 711).

XYYEFFANAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhanu ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).


ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement.Appelez le 1-800-878-4445 (ATS : 711).