Administered by Providence Health Plan

Your Benefit Summary

Providence

2024 SJH EPO Medical Plan - Northern California

Copay	What You Pay	Calendar Year Out-of-Pocket Maximum
$15/$25	Covered in full	$1,250 per person $2,500 per family (2 or more)

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.

- Some services and penalties do not apply to out-of-pocket maximums.
- Prior authorization is required for some services.
- This plan only provides benefits for medically necessary services when provided by in-network physicians or providers.
- To get the most out of your benefits, use the providers within the Providence Signature network. View a list of in-network providers and pharmacies at ProvidenceHealthPlan.com/findaprovider
- Limitations and exclusions apply to your benefits. See your Summary Plan Description for details.
- 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	You pay the following for covered services	
	Preferred Network (Tier I)	**Other In-Network Providers** (Tier II)
Preventive Care		
• Periodic health exams and well-baby care	Covered in full	Covered in full
• Routine immunizations; shots	Covered in full	Covered in full
• Colonoscopy (Age 45+)	Covered in full	Covered in full
• Gynecological exams (calendar year) and Pap tests	Covered in full	Covered in full
• Mammograms	Covered in full	Covered in full
• Tobacco cessation, counseling/classes and deterrent medications	Covered in full	Covered in full
Physician / Provider Services		
• Office visits to Primary Care Provider	$15 / visit	$15 / visit
• Office visits to Alternative Care Provider	$15 / visit	$15 / visit
• Office visits to Specialists/Other Providers	$25 / visit	$25 / visit
• Allergy shots and serums	Covered in full	Covered in full
• Infusions and injectable medications	Covered in full	Covered in full
• Surgery in an office or facility	Covered in full	Covered in full
• Anesthesia in an office or facility	Covered in full	Not covered*
• Inpatient hospital visits	Covered in full	Not covered*
Diagnostic Services		
• X-ray services - Facility	Covered in full	Covered in full
• X-ray services - Provider	$15	$15
• Lab services	$15	$15
• High-tech imaging services (such as PET, CT or MRI)	$25	$25
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.)	$150	$150
• Urgent care services (for non-life threatening illness/minor injury)	$50 / visit	$50 / visit
• Emergency medical transportation (air and/or ground)	Covered in full	Covered in full

* Unless it's an emergency

Benefit Highlights (continued)	Preferred Network	Other In-Network Providers
Hospital Services		
• Inpatient/Observation care	Covered in full	Not covered*
• Rehabilitative care	Covered in full	Not covered*
• Habilitative Care	Covered in full	Not covered*
• Skilled nursing facility (Limited to 60 days per calendar year)	Covered in full	Not covered*
Maternity Services		
• Prenatal office visits	Covered in full	Covered in full
• Postnatal office visits	Covered in full	Covered in full
• Delivery - Provider	Covered in full	Covered in full
• Inpatient hospital/facility services	Covered in full	Not covered*
• Routine newborn nursery care	Covered in full	Not covered*
Outpatient Services		
• Outpatient dialysis and infusion	Covered in full	Covered in full
• Outpatient chemotherapy and radiation	$25	$25
• Outpatient Surgery - Facility	Covered in full	Not covered*
• Temporomandibular joint (TMJ) service	$25	$25
• Colonoscopy (non-preventive)	Covered in full	Covered in full
• Outpatient rehabilitative and habilitative services (Outpatient rehabilitative occupation, speech and physical therapy limited to 30 visits combined per calendar year. Limits do not apply to Mental Health or Substance Use Disorder services.)	$15**	$15**
• Spinal manipulations and acupuncture (limited to 40 visits combined per calendar year)	$15	$15
Medical Equipment, Supplies and Devices		
• Prosthetic devices	$25	$25
• Medical equipment, appliances and supplies	$25	$25
• Diabetic supplies (See SPD for details)	Covered in full	Covered in full
• Orthotic devices	Covered in full	Covered in full
• Hearing Aids (One hearing aid per ear every 36 months 18 +) & (one hearing aid per year annually under 18)	$25	$25
Mental Health / Chemical Dependency		
• Inpatient and residential services	Covered in full	Covered in full
• Day treatment, intensive outpatient and partial hospitalization services	Covered in full	Covered in full
• Applied behavior analysis	Covered in full	Covered in full
• Outpatient provider office visits	$15 / visit	$15 / visit
Home Health and Hospice		
• Home health care	$15	$15
• Hospice care	$25	$25
Prescription Drugs (Up to a 30-day supply/retail and preferred retail pharmacies; 90-day supply/mail-order and preferred retail pharmacies)		
Annual prescription drug out-of-pocket maximum is $5,350 per person, $10,700 per family. Mail order drug copay is 2.5x retail.		
• ACA Preventive drugs	Covered in full	Covered in full
• Generic drugs (Enhanced preventive, formulary and non-formulary)	$10	$10
• Brand-name drugs (Enhanced preventive, formulary and non-formulary)	$35	$35

*Unless it's an emergency
**Physical and Occupational Therapy require prior authorization through eviCore.

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.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

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 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/providerdirectory.

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/providerdirectory.

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-Pocket Maximum
The limit on the dollar amount you will have to spend for specified covered health services in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Summary Plan Description 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, your in-network provider will request prior authorization for these services.

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, sexual orientation, religion, gender identity, marital status 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, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- 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 need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY: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*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

Language Access Information

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

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

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

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ຊືນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).