

St. Joseph Health System - Humboldt County PPO Health Plan Summary
Effective January 1, 2008

Annual Deductible	PPO: \$150/\$300 Single/Family	Non-PPO: \$400/\$800 Single/Family
Out-of-Pocket Maximum	PPO: \$1,000/\$3,000 Single/Family	Non-PPO: \$2,000/\$6,000 Single/Family
Maximum Plan Benefits	\$2,000,000 per member	
Network(s)	Humboldt Del Norte IPA (local), California Foundation for Medical Care (state), and Plan Vista (national)	

Medical Services	In-Network Coverage	Out-of-Network Coverage	Comments
Physician/Podiatrist – Office services	\$20 copay, then 100%, no deductible	50% of Medicare after deductible	Includes wellness, maternity & 2nd opinions
Physician/Podiatrist – Inpatient/Outpatient services	80% after deductible	50% of Medicare after deductible	Includes wellness, maternity & 2nd opinions
Laboratory – SJE/RMH facility	100%, no deductible		
Laboratory – non-SJE/RMH facility	80% after deductible	50% of Medicare after deductible	MRCH is out-of-network
X-ray – SJE/RMH facility	100%, no deductible		Humboldt Radiology is in-network
X-ray – non-SJE/RMH facility	80% after deductible	50% of Medicare after deductible	MRCH is out-of-network
Hospital – Emergency – All locations	\$50 copay, then 100%, no deductible	\$50 copay, then 100%, no deductible	Copay waived if admitted. Includes MD fees.
Hospital – Inpatient – SJE/RMH facility	100%, no deductible		
Hospital – Inpatient – non-SJE/RMH facility	80% after deductible	50% of Medicare after deductible	MRCH is out-of-network
Hospital – Outpatient – SJE/RMH facility	100%, no deductible		
Hospital – Outpatient – non-SJE/RMH facility	80% after deductible	50% of Medicare after deductible	MRCH is out-of-network
Hospital – Urgent Care – All locations	\$25 copay, then 100%, no deductible	\$25 copay, then 100%, no deductible	Copay waived if admitted. Includes MD fees.
Mental Health – Inpatient – SJE/RMH facility	100%, no deductible		
Mental Health – Inpatient – non-SJE/RMH facility	80% after deductible	50% of Medicare after deductible	
Mental Health – Outpatient/Office	\$20 copay, then 100%, no deductible	50% of Medicare after deductible	Maximum 30 visits/year
Mental Health – Serious Mental Illness	Covered under medical benefit	Covered under medical benefit	Covered under medical benefit
Rehabilitation Services – Combined Benefit			
Acupuncture/Acupressure	80% after deductible	50% of Medicare after deductible	Up to 10 visits TOTAL of COMBINED acupuncture, chiropractic, PT, OT AND speech therapy visits are covered without pre-authorization. Maximum TOTAL covered (all types) is 30 visits/year
Chiropractic Services	80% after deductible	50% of Medicare after deductible	
Physical/Occupational, Speech Therapy – SJE/RMH facility	100%, no deductible		
Physical/Occupational, Speech Therapy – non-SJE/RMH facility	80% after deductible	50% of Medicare after deductible	
Durable Medical Equipment	80% after deductible	50% of Medicare after deductible	\$2,000 maximum/year. Hearing aids included at 50%
Health Education	80% after deductible	50% of Medicare after deductible	
Home Health Care – SJHS agency	\$20 copay, then 100%, no deductible		Maximum 100 visits/year
Home Health Care – non-SJHS agency	80% after deductible	50% of Medicare after deductible	Maximum 100 visits/year
Hospice Care – Inpatient and Outpatient	80% after deductible	50% of Medicare after deductible	\$5,000/year. Other limits apply.
Skilled Nursing	80% after deductible	50% of Medicare after deductible	Maximum 100 visits/year
Employee Assistance Program	100%	not covered	Call 707-443-1303
Dental Services		See Delta Dental	Call 800-335-8227
Prescriptions: Copays \$10/20/35		See Express Scripts	Call 866-387-0448
Vision Services		See Vision Services Plan	Call 800-877-7195