

St. Joseph Health System - Humboldt County PPO Health Plan Summary

Effective January 1, 2007

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 - SJHS facility	100%, no deductible		
Laboratory - non-SJHS facility	80% after deductible	50% of Medicare after deductible	
X-ray - SJHS facility	100%, no deductible		Humboldt Radiology is in-network
X-ray - non-SJHS facility	80% after deductible	50% of Medicare after deductible	MRCH is out-of-network
Hospital - Emergency - SJHS facility	\$50 copay, then 100%, no deductible		Copay waived if admitted
Hospital - Emergency - non-SJHS facility	\$100 copay, then 80% after deductible	\$100 copay, then 80% of MR after ded	Copay waived if admitted
Hospital - Inpatient - SJHS facility	100%, no deductible		
Hospital - Inpatient - non-SJHS facility	80% after deductible	50% of Medicare after deductible	MRCH is out-of-network
Hospital - Outpatient - SJHS facility	100%, no deductible		
Hospital - Outpatient - non-SJHS facility	80% after deductible	50% of Medicare after deductible	MRCH is out-of-network
Hospital - Urgent Care - SJHS facility	\$25 copay, then 100%, no deductible		Copay waived if admitted.
Hospital - Urgent Care - non-SJHS facility	80% after deductible	50% of Medicare after deductible	Copay waived if admitted. MRCH is out-of-network
Mental Health - Inpatient - SJHS facility	100%, no deductible		
Mental Health - Inpatient - non-SJHS 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			Up to 10 visits TOTAL of COMBINED acupuncture
Acupuncture/Acupressure	80% after deductible	50% of Medicare after deductible	chiropractic, PT, OT AND speech therapy visits
Chiropractic Services	80% after deductible	50% of Medicare after deductible	are covered without pre-authorization.
Physical/Occupational, Speech Therapy - SJHS facility	100%, no deductible		Maximum TOTAL covered (all types) is 30 visits/yr.
Physical/Occupational, Speech Therapy - non- SJHS facility	80% after deductible	50% of Medicare after deductible	Ponte PT is out-of-network
Durable Medical Equipment	80% after deductible	50% of Medicare after deductible	\$2,000 maximum/year. Included hearing aids
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 443-1303
Dental Services	See Delta Dental		Call 800-335-8227
Prescriptions	See American Health Care		Call 800-872-8276
Vision Services	See Vision Services Plan		Call 800-877-7195