

2009 PLAN YEAR

FOR RETIREE, SELF-PAY AND COBRA PARTICIPANTS

Checklist

- Read this!
- Review your benefit statement
- Certify dependents 19-24
- Make any benefit changes
- Have a great year!



PUBLIC EMPLOYEES'

PEBB

BENEFIT BOARD

BenefitHelp Solutions
Administrator

oregon.gov/das/pebb

New For You in 2009

Medical

Save on Prescriptions

You can save money on prescriptions for:

- Heart disease
- High cholesterol
- Diabetes
- Depression
- Asthma

The plans will cover certain generic drugs for these conditions at no cost. Kaiser will continue to cover generics for a \$1 copay. Each of the plans will also fully cover at least one brand-name inhaler for asthma (at the generic copay). Providence Choice will also fully cover certain brand-name drugs for some of these conditions.

Cancer Screens for Free

All the medical plans will cover screenings at no cost for cancer of the breast, cervix, colon and prostate on recommended schedules.

Lose Weight with a Plan

All the medical plans will reimburse members for successful participation in a commercial weight management program.

Eat Better to Live Better

Learn how to eat better through covered sessions with a registered dietitian. The Regence and Providence plans will cover up to four sessions per lifetime at your choice and up to four per year for chronic conditions and medical weight management. Kaiser covers

these services as prescribed.

Get No-cost Help to Quit

All the plans fully cover the Free & Clear™ tobacco cessation program. The program covers online and phone counseling, free patches or gum, and certain prescription drugs at low cost.

Samaritan Select

The Samaritan Select medical plan will not be offered for 2009. Current Samaritan members will be automatically enrolled in the comparable Regence BlueCross BlueShield of Oregon plan beginning Jan. 1, 2009. Samaritan members who live or work (at least 50 percent of the time) in the Kaiser Permanente or Providence Choice service area may enroll in those plans for 2009.

VSP Vision

If your medical plan includes vision benefits through VSP a routine exam will be covered every 12 months, no matter your age. Plus, you get a \$200 benefit every 12 months to use for lenses and frames or contacts. If you don't use the whole benefit at once, you can bank the balance to use later during the 12 months.

Kaiser Dental

If you have coverage in a Kaiser dental plan, you won't have a deductible before the plan starts paying benefits. Plus, periodontal dental cleanings will be covered the same as routine dental cleanings.

RESOURCES

BenefitHelp Solutions (BHS) (503) 765-3581, (800) 556-3137
www.benefithelp solutions.com

Medical Plans

Kaiser Permanente my.kp.org/nw/pebb

Providence Choice providence.org/pebb

Regence BCBSO or.regence.com/pebb

VSP (Vision Service Plan) vsp.com

Mail-order Prescriptions

PPS ppsrx.com

Walgreens walgreenshealth.com

Dental Plans

Kaiser Permanente my.kp.org/nw/pebb

ODS odscompanies.com/pebb

Willamette Dental willamettedental.com

Premium Rates

2009 PEBB Medical Plan Monthly Premium Rates For Retiree, Self-pay* and COBRA Participants

	Self			Self & Spouse/Partner			Self & Children			Self & Family		
	Retiree	Self-pay	COBRA	Retiree	Self-pay	COBRA	Retiree	Self-pay**	COBRA	Retiree	Self-pay	COBRA
Kaiser Permanente¹	\$759.47	\$766.76	\$770.75	\$1,017.70	\$1,023.97	\$1,032.81	\$873.40	\$880.24	\$886.37	\$1,040.48	\$1,046.66	\$1,055.93
Kaiser Added Choice¹	803.43	810.55	815.37	1,076.60	1,082.64	1,092.59	923.95	930.59	937.67	1,100.70	1,106.64	1,117.05
Providence Choice²	753.77	761.09	764.97	1,010.03	1,016.32	1,025.02	866.84	873.71	879.72	1,032.65	1,038.86	1,047.99
Regence BCBSO²	837.49	844.48	849.93	1,122.11	1,127.97	1,138.77	963.05	969.54	977.36	1,147.24	1,152.99	1,164.28
Kaiser PT&R³	642.93	NA	652.47	861.52	NA	874.31	739.36	NA	750.34	880.81	NA	893.89
Kaiser AC PT&R³	650.03	NA	659.68	871.03	NA	883.97	747.53	NA	758.63	890.54	NA	903.76
Providence PT&R⁴	595.85	NA	604.70	798.44	NA	810.29	685.23	NA	695.41	816.31	NA	828.44
Regence PT&R⁴	665.32	NA	675.20	891.44	NA	904.68	765.08	NA	776.44	911.42	NA	924.96

¹ Kaiser Permanente HMO routine vision services

² Routine vision services through VSP

³ Vision exam only.

⁴ No vision benefit

*Self-pay = Blind Business Enterprise agents, Certified Foster Parents, OLCC Employees, JI Visa Holders, University Post-docs.

**Corrected as of 9/16/08

2009 PEBB Dental Plan Monthly Premium Rates For Retiree, Self-pay and COBRA Participants

	Self			Self & Spouse/Partner			Self & Children			Self & Family		
	Retiree	Self-pay	COBRA	Retiree	Self-pay	COBRA	Retiree	Self-pay	COBRA	Retiree	Self-pay	COBRA
Kaiser	\$70.15	\$69.88	\$71.20	\$94.01	\$93.64	\$95.41	\$80.68	\$80.36	\$81.88	\$96.11	\$95.73	\$97.54
ODS Preferred	68.72	68.45	69.74	92.09	91.73	93.46	79.02	78.71	80.20	94.15	93.78	95.55
ODS Traditional	74.40	74.10	75.50	99.70	99.30	101.18	85.56	85.22	86.83	101.93	101.53	103.44
Willamette	75.12	74.83	76.24	100.67	100.27	102.16	86.40	86.05	87.68	102.92	102.51	104.45
Kaiser PT&R	52.30	52.09	53.07	70.07	69.80	71.11	60.14	59.90	61.03	71.65	71.37	72.71
ODS PT&R	53.53	53.32	54.33	71.74	71.46	72.81	61.57	61.33	62.48	73.35	73.06	74.44

NOTES:

PT&R = Part-time & Retiree Plan

COBRA Participants: Only COBRA participants who were part-time employees when they moved to COBRA status may select a part-time and retiree plan. Blind Business Enterprise Employees may enroll for medical coverage, only.

2009 PEBB Full-time Medical Plans Comparison

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents as required in PEBB contracts, or applicable federal or state law or rule. See plan documents for details.

	Kaiser		Kaiser Added Choice		Providence Choice		Regence BCBSO	
Provider Type	HMO	HMO	Network	OON*	Network	OON*	Network	OON*
Ind. OOP** max	\$600	\$600	\$1,500	\$2,500	\$1,000	\$2,000	\$1,000	\$2,000
Family OOP max	\$1,200	\$1,200	\$4,500	\$7,500	\$3,000	\$6,000	\$3,000	\$6,000
Ind. lifetime max	No limit	No limit	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million
Type of Service	You pay	You pay	You pay	You pay	You pay	You pay	You pay	You pay
General office	\$5	\$10	\$20	30%	\$5	30%	15%	30%
Specialist office	\$5	\$10	15%	30%	\$5	30%	15%	30%
X-ray and lab	\$0	\$0	15%	30%	\$0	30%	15%	30%
Preventive Care¹								
Health appraisal	\$0	\$0	\$0	30%	\$0	30%	\$0	30%
Immunizations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Hearing exams	\$5	\$10	15%	30%	\$5	30%	15%	30%
Cancer screens	\$0	\$0	15%	30%	\$0	30%	\$0	30%
Hospital²								
Ambulance	\$75	\$75	30%	30%	\$75	\$75	15%	15%
Inpatient/day max	\$50 (\$250/admit)	\$100 (\$500/yr)	15%	30%	\$50 (\$250/admit)	30%	15%	30%
Outpatient	\$5	\$10	15%	30%	\$5	30%	15%	30%
Emergency dept	\$75	\$75	\$75	\$75	\$75	50%	15%	30%
Surgery²								
Inpatient/day max	\$50 (\$250/admit)	\$100 (\$500/yr)	15%	30%	\$50 (\$250/admit)	30%	15%	30%
Outpatient office	\$5	\$10	15%	30%	\$5	30%	15%	30%
Maternity Care								
Prenatal, delivery, postpartum	\$0	\$0	15%	30%	\$0	30%	15%	30%
Mental Health, Chemical Dependency²								
Inpatient & resident/day max	\$50 (\$250/admit)	\$100 (\$500/yr)	15%	30%	\$50 (\$250/admit)	30%	15%	30%
Outpatient	\$5	\$10	15%	30%	\$5	30%	15%	30%
Other Medical³								
Hearing aids	10%	10%	10%	10%	10%	10%	10%	10%
Diabetic supplies, insulin	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Durable medical equipment	\$0	\$0	\$0	\$0	15%	30%	15%	30%
Alternative Care	\$10	\$15	\$15	\$15	\$10	\$10	30%	30%
Physical Therapy	\$5	\$10	15%	30%	\$5	30%	15%	30%
Routine Vision								
Exam	\$5	\$10	15%	30%	VSP Provider \$10: Non-VSP provider \$10 + amount above \$42 ⁴			
Eyewear	Kaiser facilities only: Amount above \$200				Amount above \$200 ⁴			

*OON = out of network **OOP = out of pocket

¹ Plans cover preventive services on recommended schedules

² Plans may require prior authorization

³ Plans may place limits on type, number, frequency, source or maximum coverage of services or devices

⁴ Benefits provided every 12 months

2009 PEBB Part-time & Retiree Medical Plans Comparison

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents as required in PEBB contracts, or applicable federal or state law or rule. See plan documents for details.

	Kaiser	Kaiser Added Choice			Providence Choice		Regence BCBSO	
Provider Type	HMO	HMO	Network	OON*	Network	OON*	Network	OON*
Deductible (Individual; Family)	\$0	(\$250; \$750)	(\$750; \$2,250)	(\$1,000; \$3,000)	\$0	\$0	50% of \$1,000 then 20%	50% of \$1,000 then 50%
Ind. OOP** max	\$1,500	\$2,000	\$3,000	\$4,500	\$2,000	\$4,000	\$2,000	\$4,000
Family OOP max	\$3,000	\$6,000	\$9,000	\$13,500	\$6,000	\$12,000	\$6,000	\$12,000
Ind. lifetime max	No limit	No limit	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million
Type of Service	You pay	You pay	You pay	You pay	You pay	You pay	You pay	You pay
General office	\$30	\$30	30%	50%	\$30	50%	20%	50%
Specialist office	\$30	\$30	30%	50%	\$30	50%	20%	50%
X-ray and lab	\$10	20%	30%	50%	20%	50%	20%	50%
Preventive Care¹								
Health appraisal	\$0	\$30	30%	50%	\$0	50%	\$0	50%
Immunizations	\$0	\$0	30%	50%	\$0	50%	\$0	50%
Hearing exams	\$30	\$30	30%	50%	\$30	50%	20%	50%
Cancer screens	\$0	20%	30%	50%	\$0	50%	\$0	50%
Hospital²								
Ambulance	\$75	20%	50%	50%	\$75	\$75	20%	20%
Inpatient	\$500/admit	20%	30%	50%	\$500/admit	50%	20%	50%
Outpatient	\$30	\$30	30%	50%	\$30	50%	20%	50%
Emergency dept	\$100	20%	20%	20%	\$100	50%	20%	50%
Surgery²								
Inpatient	\$0	20%	30%	50%	\$30	50%	20%	50%
Outpatient office	\$30	20%	30%	50%	\$30	50%	20%	50%
Maternity Care								
Prenatal, delivery, postpartum	\$0	\$30	30%	50%	\$0	50%	20%	50%
Mental Health, Chemical Dependency²								
Inpatient	\$500/admit	20%	30%	50%	\$500/admit	50%	20%	50%
Residential	\$50/day, \$250/admit	20%	30%	50%	\$500/admit	50%	20%	50%
Outpatient	\$30	\$30	30%	50%	\$30	50%	20%	50%
Other³								
Routine vision	\$30 - exam only			Not Covered				
Hearing aids	10%	10%	10%	10%	10%	10%	10%	10%
Diabetic supplies, insulin	Covered as durable medical equipment & prescription drugs				\$0	\$0	\$0	\$0
Durable medical equipment	50%	50%	50%	50%	50%	50%	20%	50%
Alternative Care	Not Covered				50%		50%	
Physical Therapy	\$30	\$30	30%	50%	\$30	50%	20%	50%

*OON = out of network **OOP = out of pocket

¹ Plans cover preventive services on recommended schedules.

² Plans may require prior authorization, precertification or a treatment plan.

³ Plans may place limits on type, number, frequency, source or maximum coverage of services or devices.

2009 PEBB Full-time/Part-time & Retiree Dental Plans Coverage Comparison

Plan Type	Kaiser Traditional		Willamette	ODS			
	FT	PT&R		Traditional	PT&R	Preferred	
Type of Providers	Kaiser	Kaiser	Willamette	Any	Any	Preferred	Nonpreferred
Annual/person max	\$1,750	\$1,250	None	\$1,750	\$1,250	\$1,750	\$1,750
Type of Service – You Pay							
Annual deductible (individual; family)	None	None	None	\$50; \$150	\$50/ind.	\$50; \$150	\$50; \$150
Diagnostic & preventive (cleaning, X-ray) ¹	0%	\$0	\$0	0%	\$0	0%	10%
Basic & maintenance (filling, root canal, oral surgery)	20%	50%	\$0	20%	50%	20% ²	30%
Crowns	25%	50%	\$190 ³	25%	50%	25%	25%
Implants	50%	Not covered	75%	50%	Not covered	50%	50%
Dentures	50%	50%	\$190	50%	50%	50%	50%
Orthodontia	50% ⁴	Not covered	\$1,200 ⁵	50% ⁴	Not covered	50% ⁴	50% ⁴

¹ Routine cleaning covered once per year for patients with no risks; up two four cleanings per year covered based on dentist's assessment of patient's risks and health indicators. X-rays covered on age-based schedule.

² Decreases by 10% per calendar year if you visit preferred dentist at least once per year

³ Co-payment per tooth for crowns and bridges, per upper or lower for dentures

⁴ Limited to lifetime maximum of \$1,500/person

⁵ Requires \$150 co-payment prior to the start of orthodontic treatment, which applies to \$1,200 out-of-pocket maximum.

2009 Full-time/Part-time & Retiree Prescription Drug Comparison

Coverage	Kaiser (FT/PT&R)	Kaiser Added Choice			Providence (FT/PT&R)	Regence (FT/PT&R)
		HMO (FT/PT&R)	Network (FT/PT&R)	OON (FT/PT&R)		
Retail supply	30-day	30-day	30-day	30-day	30-day	34-day
Pharmacies	Kaiser Only	Kaiser Only	MedImpact ¹	MedImpact ¹	Participating	
Generic	\$1 / \$10	\$5 / \$10	\$20 / \$30	\$20 / \$30	\$5 / \$10	\$5 / \$10
Brand	\$15 / \$25	\$15 / \$25	\$20 ² / \$30 ²	\$20 ² / \$30 ²	\$15 / \$25	\$15 / 20%
Non Formulary	Not Covered (NC)		\$20 ² / NC	\$20 ² / NC	>\$50 or 50% ³	>\$50 or 50% ³
90-day Mail Supply⁴						
Generic	\$1 / \$20	\$10 / \$20	\$10 / \$20	\$10 / \$20	\$12.50 / \$25	\$12.50 / \$25
Brand	\$15 / \$50	\$30 / \$50	\$30 ² / \$50 ²	\$30 ² / \$50 ²	\$37.50 / \$62.50	\$37.50 / \$62.50
Non Formulary	Not Covered				>\$125 or 50% ³	>\$125 or 50% ³

¹ May use Kaiser mail-order if drug is in stock and in formulary

² Plus the difference between generic and formulary brand

³ Plus the difference between generic and brand for brands not on the formulary

⁴ "Maintenance drugs" only in Kaiser

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