

Section 2: Medical Benefits

Medical Plan Options

Each of PEBB's medical plans provides a member handbook (evidence of coverage, in the case of Kaiser Permanente). They are incorporated in this Summary Plan Description by reference here and are available for download as printable documents on PEBB's Web site. Carefully review the plans' member handbooks and service areas to see which one best fits your and your family's healthcare needs.

Prescription Drug Coverage. All the medical plans offered by PEBB include coverage for prescription drugs.

Routine Vision Care. Employees and others who enroll in full-time medical plans offered by PEBB receive coverage for routine vision care if they enroll in a PPO plan or through the HMO plan. See VSP Routine Vision Care for the summary of benefits; see the plan's Evidence of Coverage for details. See the HMO [*Discontinues Jan. 1, 2010* or POS] plan benefit summaries for information on routine vision care in those plans.

Employees and others who enroll in part-time and retiree plans do not have coverage for routine vision services. The exceptions are the part-time and retiree HMO plan [*Discontinues Jan. 1, 2010* and the HMO tier of the POS plan], which cover a routine vision exam.

Health Maintenance Organization Plans

Health maintenance organization (HMO) plans offer a high level of service and benefits with low out-of-pocket copayments. To get benefits, you must use the providers and facilities that are part of the plan. You select a primary care provider who guides your care. If you seek care elsewhere, the plan may not pay or may pay a reduced amount.

PEBB sponsors the **Kaiser Permanente** HMO plan for those who live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See the plan's member handbook (evidence of coverage) for a list of the ZIP codes in the service area.

Following are Benefit Summaries for the Kaiser Permanente HMO plans.

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Kaiser Permanente HMO Full-time Benefit Summary

This is a summary of the most frequently asked questions about benefits and the Copayments and Coinsurance. This chart does not describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), and for complete explanations, and for additional benefits that are not included in this summary, please refer to the “Copayments, Coinsurance, and Benefits,” “Exclusions and Limitations” and “Reductions” sections of the Evidence of Coverage.

Out-of-Pocket Maximum	
For one Member	\$600
For an entire Family	\$1,200
Deductible	
For one Member	None
For an entire Family	None
Lifetime Maximum	None
Outpatient Services	You Pay
Routine preventive physical exam (<i>includes adult and well child</i>)	\$0
Primary care visit, including urgent care	\$5
Specialty care visit	\$5
Scheduled prenatal care and first postpartum visit	\$0
Routine eye exam	\$5
All injections provided in the Nurse Treatment Area	\$5
Immunizations	\$0
Outpatient surgery visit	\$5
Breast, cervical, prostate, and colorectal cancer screenings	\$0
Chemotherapy/radiation therapy	\$5
Emergency department visit (waived if admitted)	\$75 plus any other charges that normally apply
Inpatient Hospital Services	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$50 per day, up to \$250 maximum per admission
Ambulance Services	You Pay
Per transport	\$75
Chemical Dependency Services	You Pay
Outpatient Services	\$5

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Inpatient hospital Services	\$50 per day, up to \$250 maximum per admission
Residential Services	\$50 per day, up to \$250 maximum per admission
Day treatment Services	\$5 per day
Dialysis Services	You Pay
Outpatient dialysis	\$0
Home dialysis	\$0
Inpatient hospital	\$0
Skilled nursing facility (up to 100 days per Calendar Year)	\$0
Hearing Aids	You Pay
Hearing exams	\$5
Hearing aids (up to \$4,000 every four years)	10%
Home Health Services	You Pay
\$0	
Hospice Services	You Pay
\$0	
Infertility Services	You Pay
Diagnosis, treatment, and artificial insemination	50%
Mental Health Services	You Pay
Outpatient and intensive outpatient Services	

Outpatient Services	\$5
Intensive outpatient Services	\$5 per day
Inpatient Hospital Services	\$50 per day, up to \$250 maximum per admission
Residential Services	\$50 per day up to \$250 maximum per admission
Outpatient Durable Medical Equipment	You Pay
	\$0
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	You Pay
	\$0
Outpatient Prescription Drugs, Supplies, and Supplements	You Pay
No charge for diabetic supplies, insulin , and smoking cessation drugs when used in conjunction with an approved smoking cessation program	\$0

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Generic drugs, supplies, or supplements for up to a 30-day supply	\$1
Brand-name drugs, supplies, or supplements for up to a 30-day supply	\$15
Generic drugs, supplies, or supplements from our Mail-Delivery Pharmacy	
for up to a 30-day supply	\$1
for 31-90 days supply	\$2
Brand-name drugs, supplies, or supplements from our Mail-Delivery Pharmacy	
for up to a 30-day supply	\$15
for 31-90 days supply	\$30
Medical foods and formulas	\$0
Oral chemotherapy medications used for the treatment of cancer	\$0
Post-surgical immunosuppressive drugs after covered transplant services	\$0
Rehabilitative Therapy	You Pay
Outpatient occupational therapy (up to 20 visits per Calendar Year)	\$5
Outpatient physical therapy (up to 20 visits per Calendar Year)	\$5
Outpatient speech therapy (up to 20 visits per Calendar Year)	\$5
Outpatient respiratory therapy	\$5
Multidisciplinary rehabilitation (up to a combined total of 60 days per condition per Calendar Year for inpatient and outpatient rehabilitation)	
Inpatient multidisciplinary rehabilitation	\$50 per day, up to \$250 maximum per admission
Outpatient multidisciplinary rehabilitation	\$5
Skilled Nursing Facility Care	You Pay
Up to 100 days per Calendar Year	\$0
Vision Services (Eyeglasses and contact lenses)	You Pay
Prescription eyeglasses and contact lenses (up to \$200 every 24 months)	Charges in excess of \$200

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Student Out-of-area Coverage	
Routine, continuing, and follow-up Services (up to \$1200 per Calendar Year)	20% of the allowed amount plus any fees that exceed the allowed amount. The allowed amount is the lesser of 1) the provider's actual fee, or 2) the 70 th percentile of the fees for the same or similar Service in the geographic area where the Service was received, according to the most current survey data published by Medicode's Ingenix UCR Database.
Questions? Call Membership Services (M-F, 8am – 6pm) Portland: 503-813-2000, outside Portland: 1-800-813-2000. TTY...1-800-735-2900. Language Interpretation Services, all areas...1-800-324-8010	
This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (or EOC) or call Membership Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.	

Kaiser Permanente HMO Part-time and Retiree Benefit Summary

This is a summary of the most frequently asked questions about benefits and the Copayments and Coinsurance. This chart does not describe benefits, the benefit limitations, or exclusions in full. To see what is covered for each benefit (including exclusions and limitations), and for complete explanations, and for additional benefits that are not included in this summary, please refer to the "Copayments, Coinsurance and Benefits," "Exclusions and Limitations" and "Reductions" sections of the Evidence of Coverage.

Out-of-Pocket Maximum	
For one Member	\$1,500
For an entire Family	\$3,000
Deductible	
For one Member	None
For an entire Family	None
Lifetime Maximum	None
Outpatient Services	You Pay
Routine preventive physical exam (<i>includes adult and well child</i>)	\$0
Primary care visit, including urgent care	\$30
Specialty care visit	\$30
Scheduled prenatal care and first postpartum visit	\$0
Routine eye exam	\$30
All injections provided in the Nurse Treatment Area	\$5
Immunizations	\$0

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Outpatient surgery visit	\$30
Breast, cervical, prostate, and colorectal cancer screenings	\$0
Chemotherapy/radiation therapy	\$30
Emergency department visit (waived if admitted)	\$100 plus any other charges that normally apply
Inpatient Hospital Services	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$500 per admission
Ambulance Services	You Pay
Per transport	\$75
Chemical Dependency Services	You Pay
Outpatient Services	\$30
Inpatient hospital Services	\$500 per admission
Residential Services	\$50 per day, up to \$250 maximum per admission
Day treatment Services	\$30 per day
Dialysis Services	You Pay
Outpatient dialysis	\$0
Home dialysis	\$0
Inpatient hospital	\$0
Skilled nursing facility (up to 100 days per Calendar Year)	\$0
Hearing Aids	You Pay
Hearing exam	\$30
Hearing aids (up to \$4,000 every four years)	10%
Home Health Services	You Pay
\$0	
Hospice Services	You Pay
\$0	
Infertility Services	You Pay
Diagnosis, treatment, and artificial insemination	50%
Mental Health Services	You Pay
Outpatient and intensive outpatient Services	
Outpatient Services	\$30
Intensive outpatient Services	\$30 per day
Inpatient Hospital Services	\$500 per admission
Residential Services	\$50 per day up to \$250 maximum per admission
Outpatient Durable Medical Equipment	You Pay

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	50%
	20% for diabetic supplies
Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures	You Pay
	\$10
	\$0 for preventative
Outpatient Prescription Drugs, Supplies, and Supplements	You Pay
No charge smoking cessation drugs when used in conjunction with an approved smoking cessation program	\$0
Generic drugs, supplies, or supplements for up to a 30-day supply	\$10
Brand-name drugs, supplies, or supplements for up to a 30-day supply	\$25
Generic drugs, supplies, or supplements from our Mail-Delivery Pharmacy	
for up to a 30-day supply	\$10
for 31-90 days supply	\$20
Brand-name drugs, supplies, or supplements from our Mail-Delivery Pharmacy	
for up to a 30-day supply	\$25
for 31-90 days supply	\$50
Medical foods and formulas	\$0
Oral chemotherapy medications used for the treatment of cancer	\$0
Post-surgical immunosuppressive drugs after covered transplant services	\$0
Rehabilitative Therapy	You Pay
Outpatient occupational therapy (up to 20 visits per Calendar Year)	\$30
Outpatient physical therapy (up to 20 visits per Calendar Year)	\$30
Outpatient speech therapy (up to 20 visits per Calendar Year)	\$30
Outpatient respiratory therapy	\$30
Multidisciplinary rehabilitation (up to a combined total of 60 days per condition per Calendar Year for inpatient and outpatient rehabilitation)	
Inpatient multidisciplinary rehabilitation	\$50 per day, up to \$250

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	maximum per admission
Outpatient multidisciplinary rehabilitation	\$30
Skilled Nursing Facility Care	You Pay
Up to 100 days per Calendar Year	\$0
Student Out-of-area Coverage	
Routine, continuing, and follow-up Services (up to \$1200 per Calendar Year)	20% of the allowed amount plus any fees that exceed the allowed amount. The allowed amount is the lesser of 1) the provider's actual fee, or 2) the 70 th percentile of the fees for the same or similar Service in the geographic area where the Service was received, according to the most current survey data published by Medicode's Ingenix UCR Database.
<p>Questions? Call Membership Services (M-F, 8am – 6pm) Portland: 503-813-2000, outside Portland: 1-800-813-2000. TTY...1-800-735-2900. Language Interpretation Services, all areas...1-800-324-8010</p>	
<p>This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (or EOC) or call Membership Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.</p>	

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Preferred Provider Organization Plans

Preferred provider organization (PPO) plans offer services and benefits at two coverage levels — from preferred providers and from non-preferred providers. You may use any doctors you wish. If you use doctors who are preferred (in-network), you pay less. If you use providers who are not preferred (out of network), you pay more. If you use providers who do not participate in the plan as preferred or non-preferred, the providers may bill you for amounts greater than allowed in the plan.

PEBB sponsors the following PPO plans:

- Providence Choice — for those who live or work in Multnomah, Clackamas, Washington and Yamhill counties
- [*Effective Jan. 1, 2010* PEBB's Statewide Plan — no matter where you live or work.]
- [*Discontinues Jan. 1, 2010* Regence BlueCross BlueShield of Oregon (BCBSO) — no matter where you live or work]

Each of these plans has a search function on its Web site to help you find out which doctors are preferred and non-preferred. The plans will also provide a printed copy of their list of preferred providers on request.

Following are Benefit Summaries for the Providence Choice plan and [*Discontinues Jan. 1, 2010* Regence BCBSO] [*Effective Jan. 1, 2010* PEBB's Statewide] plan.

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Providence Choice Full-time Benefit Summary

IN-PLAN benefits apply to *Medically Necessary Services* provided by a *Medical Home Provider* or from a specialist in the *Providence Choice Network* when care is coordinated by the *Medical Home Provider*. OUT-OF-PLAN benefits apply to *Medically Necessary Services* provided by a *Non-Participating Provider* or when *Services* have not been coordinated by a *Medical Home Provider*. Many *Services* must be *Prior Authorized* (see section 3.6 for *Prior Authorization* requirements).

The annual (calendar year) Out-of-Pocket Maximum for IN-PLAN Covered Services is \$1000 per person / \$3000 per family and for OUT-OF-PLAN Covered Services it is \$ 2000 per person / \$ 6000 per family. Your *Copayments* or *Coinsurance* for the following *Services* do **not** count toward the *Out-of-Pocket Maximum*: Prescription drugs, hearing exams, hearing aids, infertility and alternative care. (See the definition of *Out-of-Pocket Maximum* for additional details.) **The Lifetime Maximum Benefit is \$2,000,000.**

Benefits	You Pay: IN-PLAN	You Pay: OUT-OF- PLAN
Preventive Health Services		
• Periodic health exams, well-baby and well child care (to age 19)	\$0	30%
• Routine immunizations/shots	\$0	0%
• Physical exam to obtain commercial driver's license (for employees only; see section 5.2.1 for voucher requirements)	\$0	30%
• Hearing screenings	\$0	30%
• Prostate cancer screening	\$0	30%
• Colorectal cancer screening (colonoscopy, sigmoidoscopy)	\$0	30%
Women's Health Care Services (direct access, no referral required)		
• Annual calendar year gynecological exams, Pap tests	\$0	30%
• Follow-up visits after annual gynecological exam	\$5/visit	30%
• Mammograms	\$0	30%
Physician / Provider Services		
• Office visits to a <i>Medical Home Provider</i>	\$5/visit	Not Applicable
• Office visits to other providers	\$5/visit	30%
• E-visits to a <i>Participating Provider</i>	\$5/visit	Not Covered
• E-visits to a <i>Medical Home Provider</i> for treatment of diabetes	\$0/visit	Not Covered
• Inpatient hospital visits, including surgery and anesthesia	\$0	30%
• Surgery and anesthesia performed in a provider's office	\$5/visit	30%
• Allergy shots, serums and injectable medications	\$5/visit	30%
• Family planning and related <i>Services</i>	\$5/visit	30%
• Alternative care visits from any <i>Qualified Practitioner</i> (limited to \$1000 per calendar year)	\$10/visit	\$10/visit
• Other office procedures	\$5/visit	30%
Hospital and Inpatient Services, including	\$50/day, maximum of \$250/admission	30%
• Acute care		
• Rehabilitative care (30 days per calendar year; 60 days for • head and spinal cord injuries)		
• <i>Skilled Nursing Facility</i> (180 days per admission)		
• Bariatric surgery (In-Plan coverage only)		Not Covered
Maternity Services		
• Pre-natal visits, delivery and post-natal visits	\$0/visit	30%
• <i>Hospital Services</i> related to delivery	\$50/day, maximum of \$250/admission	30%

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• Hospital service related to routine newborn nursery care	\$50/day, maximum of \$250/admission	30%
• Infertility services	50%	50%
Medical Supplies , including <i>Durable Medical Equipment</i> , appliances and prosthetic devices	15%	30%
Diabetes Supplies	\$0	\$0
<hr/>		
Emergent/Urgent & Ambulance Services (the <i>Copayment</i> shown is waived if admitted to <i>Hospital</i> within 24 hours)		
• Emergency services (for <i>Emergency Medical Conditions</i> only)	\$75	\$75
• Urgent care services (for non-life threatening illness/minor injury)	\$25/visit	30%
• <i>Ambulance Services</i> (for emergency transportation only)	\$75	\$75
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Other Covered Services		
• X-ray and lab <i>Services</i>	\$0	30%
• Outpatient rehabilitative <i>Services</i> (60 visits per calendar year)	\$5/visit	30%
• Outpatient surgery, dialysis, chemotherapy, radiation therapy and cardiac rehabilitation	\$5/visit	30%
• Temporomandibular joint (TMJ) <i>Services</i>	Same as other medical	Not Covered
• Home health care and home infusion <i>Services</i> (limited to 180 visits per calendar year)	<i>Services</i> \$5/visit	30%
• Hospice care	Covered in full	Covered in full
• Hearing exams	\$5/visit	30%
• Hearing aids (limited to \$4000 per person every 4 calendar years)	10%	10%
Mental Health / Chemical Dependency Services		
• Outpatient <i>Services</i>	\$5/visit	30%
• Inpatient <i>Hospital Services</i> and Residential/Day <i>Services</i>	\$50/day, maximum of \$250/admission	30%

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PRESCRIPTION DRUG SUMMARY OF BENEFITS

Retail: For prescriptions filled at a participating retail pharmacy, **for up to a 30-day supply:**

- Value drugs: \$0 *Copayment*
- **Generic drugs:** \$5 *Copayment*
- **Preferred (formulary) brand name drugs:** \$15 *Copayment*
- **Non-preferred (non-formulary) brand name drugs:** \$50 *Copayment* or 50% *Coinsurance*, whichever is greater,
when a generic equivalent is not available (see note below)

Mail Order: For prescriptions filled via the mail order provisions of this Plan, **for up to a 90-day supply:**

- Value drugs: \$0 *Copayment*
- **Generic drugs:** \$5 *Copayment*
- **Preferred (formulary) brand name drugs:** \$37.50 *Copayment* **when a generic equivalent is not available**
- **Non-preferred (non-formulary) brand name drugs:** \$125 *Copayment* or 50% *Coinsurance*, whichever is greater,
when a generic equivalent is not available (see note below)

Important Notes:

- An exception process is available if the prescribing provider believes that it is medically necessary for *You* to use a non-preferred (non-formulary) brand name drug instead of a preferred (formulary) brand name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by your provider to PHP. If the request is approved, the benefits for **preferred** (formulary) brand name drugs will apply. If the request is denied, the appeal rights described in section 9 will apply.
- If *You* request, or *Your* physician prescribes, a non-preferred (non-formulary) brand name drug when a generic equivalent is available, *You* will be responsible for the difference in cost between the non-preferred brand name drug and the generic drug, in addition to the non-preferred brand *Copayment*.
- *Copayments* and any difference in cost payments for covered prescription drugs do **not** apply to *Your* annual medical *Out-of-Pocket Maximum*.
- Bupropion and over-the-counter nicotine gum and patches are covered under the value copayment.
- Chantix is covered under the generic copayment.
- Value drugs are commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, asthma and other breathing disorders. These medications may be generic or brand-name and are considered first-line treatments for many conditions. The drugs can be found on the Providence Health Plans formulary.

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Providence Choice Part-time and Retiree Benefit Summary

IN-PLAN benefits are provided for medically necessary services when provided by a participating Medical Home provider or a participating specialist upon referral from a Medical Home provider. **OUT-OF-PLAN** benefits are provided when services are received from participating providers without referral authorization or non-participating providers. Benefits for non-participating providers are provided at usual, customary and reasonable (UCR) charges. Many services must be prior authorized or services will be denied.

The annual (calendar year) in-plan out-of-pocket maximum payable by you for any covered services is \$2,000 per person/\$6,000 per family; out-of-plan is \$4,000 per person/\$12,000 per family. Your Copayments or Coinsurance for the following Services do not count toward the Out-of-Pocket Maximum: Prescription drugs, hearing exams, hearing aids, infertility and alternative care. (See the definition of *Out-of-Pocket Maximum* for additional details.) **The lifetime maximum coverage for benefits is \$2,000,000.**

BENEFITS	You Pay: IN-PLAN	You Pay: OUT-OF- PLAN
Preventive Health Services		
• Periodic health exams, well-baby and well child care (to age 19 and including lab & x-ray)	\$0	50%
• Routine immunizations/shots	\$0	50%
• Physical exam to obtain commercial driver's license (for employees only; see section 5.2.1 for voucher requirements)	\$0	50%
• Hearing screenings	\$0	50%
• Prostate cancer screening	\$0	50%
• Colorectal cancer screening	\$0	50%
Women's Health Care Services (direct access, no referral required)		
• Annual calendar year gynecological exams, Pap tests	\$0/visit	50%
• Follow-up visits after annual gynecological exam	\$30/visit	50%
• Mammograms	\$0	50%
Physician / Provider Services		
• Office visits to a <i>Medical Home Provider</i>	\$30/visit	Not Applicable
• Office visits to other providers	\$30/visit	50%
• E-visits to a participating provider	\$30/visit	Not Covered
• E-visits to a <i>Medical Home Provider</i> for treatment of diabetes	\$0/visit	Not Covered
• Inpatient hospital visits, including surgery and anesthesia	\$30/visit	50%
• Surgery and anesthesia performed in a provider's office	\$30/visit	50%
• Allergy shots, serums and injectable medications	\$5/visit	50%
• Family planning and related <i>Services</i>	\$30/visit	50%
• Alternative care visits from any <i>Qualified Practitioner</i>	50%	50%
• Other office procedures	\$30/visit	50%
Hospital and Inpatient Services, including	\$500/admission	
• Acute care		50%
• Rehabilitative care (30 days per calendar year; 60 days for head and spinal cord injuries)		50%
• <i>Skilled Nursing Facility</i> (180 days per admission)		50%
• Bariatric surgery (In-Plan coverage only)		Not Covered
Maternity Services		
• Pre-natal visits, delivery and post-natal visits	\$0	50%

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• <i>Hospital Services</i> relating to delivery	\$500/admission	50%
• <i>Hospital service relating to</i> routine newborn nursery care	\$500/admission	50%
• Infertility services	50%	50%
Medical Supplies , including <i>Durable Medical Equipment</i> , appliances, and prosthetic devices	50%	50%
Diabetes Supplies	\$0	\$0
Emergent/Urgent & Ambulance Services (the <i>Copayment</i> shown is waived if admitted to <i>Hospital</i> within 24 hours)		
• Emergency services (for <i>Emergency Medical Conditions</i> only)	\$100	\$100
• Urgent care services (for non-life threatening illness/minor injury)	\$30/visit	50%
• <i>Ambulance Services</i> (for emergency transportation only)	\$75	\$75
Other Covered Services		
• X-ray and lab <i>Services</i>	20%	50%
• Outpatient rehabilitative <i>Services</i> (60 visits per calendar year)	\$30/visit	50%
• Outpatient surgery, dialysis, chemotherapy, radiation therapy and cardiac rehabilitation	\$30/visit	50%
• Temporomandibular joint (TMJ) <i>Services</i>	\$30/visit	Not Covered
• Home health care and home infusion <i>Service</i> (limited to 180 visits per calendar year)	\$30/visit	50%
• Hospice care	Covered in full	Covered in full
• Hearing exams	\$30/visit	50%
• Hearing aids (limited to \$4000 per person every 4 calendar years)	10%	10%
Mental Health / Chemical Dependency Services		
• Outpatient <i>Services</i>	\$30/visit	50%
• Inpatient <i>Hospital Services</i> and Residential/Day <i>Services</i>	\$500/admission	50%

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PRESCRIPTION DRUG SUMMARY OF BENEFITS

Retail: For prescriptions filled at a participating retail pharmacy, **for up to a 30-day supply:**

- Value drugs: \$0 *Copayment*
- **Generic drugs:** \$10 *Copayment*
- **Preferred (formulary) brand name drugs:** \$25 *Copayment*
- **Non-preferred (non-formulary) brand name drugs:** \$50 *Copayment* or 50% *Coinsurance*, whichever is greater, **when a generic equivalent is not available** (see note below)

Mail Order: For prescriptions filled via the mail order provisions of this Plan, **for up to a 90-day supply:**

- Value drugs: \$0 *Copayment*
- **Generic drugs:** \$25 *Copayment*
- **Preferred (formulary) brand name drugs:** \$62.50 *Copayment* **when a generic equivalent is not available**
- **Non-preferred (non-formulary) brand name drugs:** \$125 *Copayment* **when a generic equivalent is not available** (see note below)

Important Notes:

- An exception process is available if the prescribing provider believes that it is medically necessary for *You* to use a non-preferred (non-formulary) brand name drug instead of a preferred (formulary) brand name or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by your provider to PHP. If the request is approved, the benefits for **preferred** (formulary) brand name drugs will apply. If the request is denied, the appeal rights described in section 9 will apply.
- If *You* request, or *Your* physician prescribes, a non-preferred (non-formulary) brand name drug when a generic equivalent is available, *You* will be responsible for the difference in cost between the non-preferred brand name drug and the generic drug, in addition to the non-preferred brand *Copayment*.
- *Copayments* and any difference in cost payments for covered prescription drugs do **not** apply to *Your* annual medical *Out-of-Pocket Maximum* or to any applicable medical plan deductibles.
- Bupropion and over-the-counter nicotine gum and patches are covered under the value copayment.
- Chantix is covered under the generic copayment.
- Value drugs are commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, asthma and other breathing disorders. These medications may be generic or brand-name and are considered first-line treatments for many conditions. The drugs can be found on the Providence Health Plans formulary.

PEBB Statewide Plan Full-time [Effective Jan. 1, 2010]

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for myProvidence at www.providence.org/php/getstarted.

- Not sure what a word or phrase means? See the back for definitions used in this summary.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Annual In-Plan Out-of-Pocket Maximum per person	\$1,000 per person
Annual In-Plan Out-of-Pocket Maximum per family (3 or more)	\$3,000 per family (3 or more)
Annual Out-of-Plan Out-of-Pocket Maximum per person	\$2,000 per person
Annual Out-of-Plan Out-of-Pocket Maximum per family (3 or more)	\$6,000 per family (3 or more)
Lifetime Maximum Benefit	\$2,000,000

PEBB Statewide Plan Benefit Highlights

You pay the following for covered services:

	In-Plan Cost (for participating provider)	Out-of-Plan Cost (for non-participating provider)
Physician / Provider Services		
• Office visits and procedures	15%	30%
• Periodic health exams, well-baby care (Covered according to plan schedule; includes related lab and x-ray.)	Covered in full	30%
• Routine immunizations, shots	Covered in full	Covered in full
• Colorectal cancer screenings	Covered in full	30%
• Prostate cancer screenings	Covered in full	30%
• Allergy shots, serums, injectable medications	15%	30%
• Inpatient hospital visits	15%	30%
• Surgery, anesthesia	15%	30%
• E-visits to a participating provider	Covered in full	Not covered
Women's Health Services		
• Annual gynecological exams (calendar year), Pap tests	Covered in full	30%
• Follow-up visits after annual gynecological exam	15%	30%
• Mammogram screening (according to schedule)	Covered in full	30%
Hospital Services		
• Inpatient care, observation, maternity care	15%	30%
• Rehabilitative care (30 days per calendar year; 60 days head/spinal cord injuries)	15%	30%
• Skilled nursing facility (180 days per calendar year)	15%	30%
• Bariatric surgery	15%	Not covered
Maternity		
• Prenatal and postnatal visits, delivery	15%	30%
• Routine newborn nursery care	15%	30%
Medical Supplies and Equipment		
• Durable medical equipment and supplies	15%	30%
• Diabetic supplies	Covered in full	Covered in full

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PEBB Statewide Plan Benefit Highlights (continued)	In-Plan Cost	Out-of-Plan Cost
Emergency / Urgent Care / Ambulance Services (Emergency/urgent care copay is waived if admitted to the hospital within 24 hours.)		
• Emergency services (for emergency medical conditions only)	15%	15%
• Urgent care services (non life-threatening illness/minor injury)	15%	30%
• Ambulance services (emergency transportation only)	15%	15%
Other Covered Services		
• X-ray, lab services	15%	30%
• Imaging services (PET, CT, MRI)	15%	30%
• Outpatient rehabilitative services (60 visits per calendar year)	15%	30%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	15%	30%
• Temporomandibular joint (TMJ) services	15%	30%
• Home health care (180 visits per calendar year)	15%	30%
• Hospice care	Covered in full	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy.)		
-Generic drugs	\$10	N/A
-Formulary brand-name drugs	\$50	N/A
-Non-formulary brand-name drugs	\$100	N/A
• Chiropractic, naturopathic, acupuncture*	30%	30%
• Infertility*	50%	50%
• Hearing aids* (Up to \$4,000 every four calendar years.)	10%	10%
• Hearing exam*	15%	30%
• Free & Clear [®] smoking cessation program	Covered in full	Covered in full
• Weight Watchers [®] program (Employees only; up to four programs per calendar year.)	Covered in full	Covered in full
<i>*Does not apply to out-of-pocket maximum</i>		
Mental Health / Chemical Dependency		
(To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
• Inpatient, residential and day treatment services	15%	30%
• Outpatient provider visits	15%	30%

Your guide to the words or phrases used to explain your benefits

Coinsurance

The percentage of the cost that you may need to pay for a covered service.

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 Member Handbook for details.

Copay

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

In-plan benefit

The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to the online directory at www.providence.org/php/providerdirectory.

Lifetime maximum benefit

The total dollar amount of benefits that you can receive from your plan during your lifetime.

Non-participating provider

Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-Plan

Refers to services you receive from a non-participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to the online directory at www.providence.org/php/providerdirectory.

Participating provider

A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, go to the online directory at www.providence.org/php/providerdirectory.

Prior authorization

Some services must be pre-approved. In-plan, your provider will request prior authorization. Out-of-plan, you are responsible for obtaining prior authorization, or coverage for services may be denied.

Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Usual, Customary & Reasonable (UCR)

Describes predefined charges established by your plan for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

Contact us

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TTY: 503-574-8702 or
1-888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:

www.providence.org/php/contactus.

Prescription Drug Plan – PEBB Statewide Plan Full-Time Employees

Important information about your plan

- This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, including your Member Handbook, register for myProvidence at www.providence.org/php/getstarted.
- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.providence.org/healthplans, or call us.
- You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty, or mail-order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.providence.org/healthplans, or call us.
- Not sure what a word or phrase means? See the back for definitions used in this summary.
- Copays, coinsurance and cost differences for prescription drugs do not apply to plan year medical plan out-of-pocket maximums or deductibles.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (up to a 34-day supply)	All Mail-Order and Preferred Retail Pharmacies (up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (up to a 30-day supply of specialty and self administered chemotherapy drugs)
Value drug	\$0	\$0	Does not apply
Generic drug	\$5	\$12.50	\$5
Formulary brand-name drug	\$15	\$37.50	\$15
Non-formulary brand-name drug	Greater of \$50 or 50% plus the difference in cost	Greater of \$125 or 50% plus the difference in cost	Greater of \$50 or 50% plus the difference in cost
Compounded drug	Greater of \$50 or 50%	Does not apply	Does not apply

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What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan. Some medications are less costly. If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If you or your physician requests a non-formulary brand-name drug when a generic equivalent is available, you will be responsible for paying the cost difference, in addition to your non-formulary brand-name drug copay.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain one FDA-approved drug.
- Specialty drugs are prescriptions requiring special delivery, handling, administration and monitoring by your pharmacist.
- An exception process is available if the prescribing provider believes it is medically necessary that a non-formulary brand-name drug be used instead of a formulary brand-name drug or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by your provider. If the request is approved, the benefits for formulary brand-name drugs will apply.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows the lowest out-of-pocket cost. Please see your medical benefit summary for more information.
- Bupropion and over-the-counter nicotine gum and patches are covered under the value copayment.
- Chantix is covered under the generic copayment.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information visit our Web site at www.providence.org/healthplans.
- Diabetes supplies may be obtained at your participating pharmacy and are subject to your group's medical supplies and devices benefits, limitations and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary

- The Providence Formulary is a list of FDA-approved prescription brand name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place or length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not on the formulary, please contact us.

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- Our formulary can help you and your physician choose effective less costly medications to minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.providence.org/healthplans for frequently asked questions about both generic drugs and our formulary.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.providence.org/healthplans.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy. If this occurs, you will need to pay full price for your prescription at the time of purchase.
- Reimbursement forms are available online. Reimbursement is subject to your plan's limitations and exclusions.

What you need to know about limitations and exclusions

- The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to www.providence.org/healthplans.

Limitations

- All drugs must be FDA approved, medically necessary, and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs are reviewed for safety and medical necessity within 12 months following FDA approval.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 34 consecutive day supply, whichever is less. Other dispensing limits may apply to medications requiring limited use and are listed on our formulary.
- Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through a designated specialty pharmacy. Due to the nature of these medications, they are not considered “maintenance” drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). “Specialty Medications” are noted in the formulary on our website.
- Self-injectable drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration and on our list of “Specialty Medications.”

Exclusions

- Drugs used in the treatment of the common cold. Over-the-counter (OTC) drugs, medications, or vitamins that may be purchased without a provider's written prescription, and prescription drugs available in an OTC therapeutically similar form.
- Fluoride, for members over the age of 10 years old.

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- Amphetamines and amphetamine derivatives, except when used to treat narcolepsy or hyperactivity in children and adults.
- Drugs used for the treatment of fertility or infertility. Intrauterine devices (IUDs), diaphragms and implantable contraceptives. (Some of these items may be covered under your medical benefits.) Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra[®]. Drugs required for, or as a result of, sexual transformation.
- Drugs used for weight loss or cosmetic purposes. Drugs to stimulate hair growth, including, but not limited to, Rogaine[®] (i.e., topical minoxidil) or other similar drug preparations. Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Drugs or prescribed medications not medically necessary or not provided according to our medical policy. Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Drugs or medications delivered, injected or administered for you by a health care provider or other trained person.
- Drugs prescribed by naturopathic physicians (N.D.). Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment. Drugs that are not FDA approved or are designated as “less than effective” by the FDA, also known as a “DESI” drug.
- Drugs placed on prescription-only status as required by state or local law.
- Replacement of lost or stolen medication.

Your guide to the words and phrases used to explain your benefits

Brand-name drug

Brand-name drugs are protected by U.S. patent laws for up to 17 years. The pharmaceutical company holding the patent has exclusive rights to produce and sell the drug.

Coinsurance

The percentage of the cost you pay to a participating pharmacy at the time of purchase for a covered prescription drug.

Compounded drug

The combining, mixing, or altering of covered drugs or other ingredients to create a customized prescription for an individual as prescribed by a licensed provider.

Copay

The fixed dollar amount you pay to a participating pharmacy at the time of purchase, for a covered prescription drug.

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.

Generic drug

Generic drugs have the same active-ingredient formula as the brand name drug. Generic drugs are tested by the FDA to be as safe and as effective as brand name drugs. Generic drugs are only available after the brand name patent expires. Visit www.providence.org/healthplans for frequently asked questions about generic drugs.

Maintenance drug

Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those you have received under our plan for at least 30 days and anticipate continuing to use in the future.

Out-of-pocket maximum

The limit on the dollar amount you will have to spend for covered non-formulary and compounded prescription drugs in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbooks 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 34-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 34-day supply of short-term prescriptions.
- **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.
- **Mail-order:** a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Prior authorization

The process used to request an exception to the Providence Health Plan Drug Formulary. This process is initiated by your doctor, or other prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit www.providence.org/healthplans for additional information.

Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Value drug

A specified list of commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, and asthma or other breathing disorders. These medications may be generic or brand name and are considered first-line treatments for many conditions. They are on our formulary and offered at your lowest copay or coinsurance.

Contact us

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Customer Service: 1-800-423-9470
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www.providence.org/php/contactus

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PEBB Statewide Plan Part-time & Retiree [Effective Jan. 1, 2010]

Important information about your plan

This summary provides only highlights of your benefits. **Please note: this plan pays 50 percent of the first \$1,000 of eligible expenses incurred from preferred and non-preferred providers per person, and \$3,000 per family each calendar year.** Benefits are then paid as indicated in the following summary. To view all your plan details, including your Member Handbook, register for myProvidence at www.providence.org/php/getstarted.

- Not sure what a word or phrase means? See the back for definitions used in this summary.
- Some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-plan services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Annual In-Plan Out-of-Pocket Maximum per person	\$2,000 per person
Annual In-Plan Out-of-Pocket Maximum per family (3 or more)	\$6,000 per family (3 or more)
Annual Out-of-Plan Out-of-Pocket Maximum per person	\$4,000 per person
Annual Out-of-Plan Out-of-Pocket Maximum per family (3 or more)	\$12,000 per family (3 or more)
Lifetime Maximum Benefit	\$2,000,000

PEBB Statewide Plan Benefit Highlights

You pay the following for covered services:

	In-Plan Cost (for participating provider)	Out-of-Plan Cost (for non-participating provider)
Physician / Provider Services		
• Office visits and procedures	20%	50%
• Periodic health exams, well-baby care (Covered according to plan schedule; includes related lab and x-ray.)	Covered in full	50%
• Routine immunizations, shots	Covered in full	50%
• Colorectal cancer screenings	Covered in full	50%
• Prostate cancer screenings	Covered in full	50%
• Allergy shots, serums, injectable medications	20%	50%
• Inpatient hospital visits	20%	50%
• Surgery, anesthesia	20%	50%
• E-visits to a participating provider	Covered in full	Not covered
Women's Health Services		
• Annual gynecological exams (calendar year), Pap tests	Covered in full	50%
• Follow-up visits after annual gynecological exam	20%	50%
• Mammogram screening (according to schedule)	Covered in full	50%
Hospital Services		
• Inpatient care, observation, maternity care	20%	50%
• Rehabilitative care (30 days per calendar year; 60 days head/spinal cord injuries)	20%	50%
• Skilled nursing facility (180 days per calendar year)	20%	50%
• Bariatric surgery	20%	Not covered
Maternity		
• Prenatal and postnatal visits, delivery	20%	50%
• Routine newborn nursery care	20%	50%

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PEBB Statewide Plan Benefit Highlights (continued)	In-Plan Cost	Out-of-Plan Cost
Medical Supplies and Equipment		
<ul style="list-style-type: none"> • Durable medical equipment and supplies • Diabetic supplies 	20% Covered in full	50% Covered in full
Emergency / Urgent Care / Ambulance Services (Emergency/urgent care copay is waived if admitted to the hospital within 24 hours.)		
<ul style="list-style-type: none"> • Emergency services (emergency medical conditions only) • Urgent care services (non life-threatening illness/minor injury) • Ambulance services (emergency transportation only) 	20% 20% 20%	20% 50% 20%
Other Covered Services		
<ul style="list-style-type: none"> • X-ray, lab services • Imaging services (PET, CT, MRI) • Outpatient rehabilitative services (60 visits per calendar year) • Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy • Temporomandibular joint (TMJ) services • Home health care • Hospice care • Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy.) <ul style="list-style-type: none"> -Generic drugs -Formulary brand-name drugs -Non-formulary brand-name drugs • Chiropractic, naturopathic, acupuncture* • Infertility* • Hearing aids* (up to \$4,000 every four calendar years) • Hearing exam* • Free & Clear® smoking cessation program • Weight Watchers® program (Employees only; up to four programs per calendar year.) 	20% 20% 20% 20% 20% 20% Covered in full \$10 \$50 \$100 50% 50% 10% 15% Covered in full Covered in full	50% 50% 50% 50% 50% 50% Covered in full N/A N/A N/A 50% 50% 10% 50% Covered in full Covered in full
*Does not apply to out-of-pocket maximum		
Mental Health / Chemical Dependency (To initiate services, you must call 1-800-711-4577. All inpatient, residential and day or partial hospitalization treatment services must be prior authorized.)		
<ul style="list-style-type: none"> • Inpatient, residential and day treatment services • Outpatient provider visits 	20% 20%	50% 50%

Your guide to the words or phrases used to explain your benefits

Coinsurance

The percentage of the cost that you may need to pay for a covered service.

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 Member Handbook for details.

Copay

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

In-plan benefit

The in-plan benefit is an extensive network of highly qualified physicians and health care providers, also known as participating providers, available to you by your plan. Generally, your out-of-pocket costs will be less when you receive covered services from participating providers. To find a participating provider, go to

www.providence.org/php/providerdirectory.

Lifetime maximum benefit

The total dollar amount of benefits that you can receive from your plan during your lifetime.

Non-participating provider

Any health care professional who does not participate in Providence Health Plan's network of participating physicians and providers of health care services.

Out-of-plan

Refers to services you receive from a non-participating provider. Your out-of-pocket costs are generally higher when you receive covered services from non-participating providers. To find a participating provider, go to the online directory at www.providence.org/php/providerdirectory.

Participating provider

A physician or provider of health care services who belongs to the Providence Health Plan participating provider network. To find a participating provider, go to the online directory at

www.providence.org/php/providerdirectory.

Prior authorization

Some services must be pre-approved. In-plan, your provider will request prior authorization. Out-of-plan, you are responsible for obtaining prior authorization, or coverage for services may be denied.

Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Usual, Customary & Reasonable (UCR)

Describes predefined charges established by your plan for services that you receive from an out-of-plan provider. When the cost of out-of-plan services exceeds UCR amounts, you are responsible for paying the provider any difference. These amounts do not apply to your out-of-pocket maximums.

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Prescription Drug Plan – PEBB Statewide Plan Part-Time Employees; Retirees

Important information about your plan

- This summary provides only highlights of your pharmacy benefits. Certain limitations and exclusions apply. To view all your plan details, including your Member Handbook, register for myProvidence at www.providence.org/php/getstarted.
- To find out how a drug is covered under your plan, view the complete formulary and pharmacy information available online at www.providence.org/healthplans, or call us.
- You have broad access to over 22,000 participating pharmacies and their services at discounted rates. Pharmacies are designated as participating retail, preferred retail, specialty, or mail order pharmacies.
- View a list of participating pharmacies, including specialty pharmacies, at www.providence.org/healthplans, or call us.
- Not sure what a word or phrase means? See the back for definitions used in this summary.
- Copays, coinsurance and cost differences for prescription drugs do not apply to plan year medical plan out-of-pocket maximums or deductibles. Out-of-pocket maximum for prescription drugs: \$1,000 per person per calendar year.

	Copay or Coinsurance		
Drug Coverage Category	All Participating and Preferred Retail Pharmacies (up to a 34-day supply)	All Mail Order and Preferred Retail Pharmacies (up to a 90-day supply of maintenance prescriptions)	All Participating Specialty Pharmacies (up to a 30-day supply of specialty and self-administered chemotherapy)
Value drug	\$0	\$0	Does not apply
Generic drug	\$10	\$25	\$10
Formulary brand-name drug	20%	\$62.50	20%
Non-formulary brand-name drug	Greater of \$50 or 50% plus the difference in cost	\$125 plus the difference in cost	50% plus the difference in cost
Compounded drug	Greater of \$50 or 50%	Does not apply	Does not apply

What you need to know about drug coverage categories

- Both generic and brand-name drugs are covered subject to the terms of your plan. Some medications are less costly. If the cost of your prescription is less than your copay, you will only be charged the cost of the prescription.
- If you or your physician request a non-formulary brand-name drug when a non-formulary generic equivalent is available, you will be responsible for paying the cost difference, in addition to your non-formulary brand-name drug copay.
- Compounded drugs are prescriptions that are custom prepared by your pharmacist. These prescriptions must contain one FDA-approved drug.
- Specialty drugs are prescriptions requiring special delivery, handling, administration and monitoring by your pharmacist.
- An exception process is available if the prescribing provider believes it is medically necessary that a non-formulary brand-name drug be used instead of a formulary brand-name drug or generic drug. A request for medical exception that explains why the drug substitution is medically appropriate may be submitted by your provider. If the request is approved, the benefits for formulary brand-name drugs will apply.
- Self-administered chemotherapy drugs are covered under your pharmacy benefits or your medical benefits, whichever allows the lowest out-of-pocket cost. Please see your medical benefit summary for more information.
- Bupropion and over-the-counter nicotine gum and patches are covered under the value copayment.
- Chantix is covered under the generic copayment.

Using your prescription drug benefit

- Your prescription drug benefit requires that you fill your prescriptions at a participating pharmacy.
- Be sure you present your current Providence Health Plan member identification card, along with your copay or coinsurance when you use a participating pharmacy.
- You may purchase up to a 90-day supply of maintenance drugs using a participating mail service or preferred retail pharmacy. Not all drugs are considered maintenance prescriptions, including compounded drugs and drugs from specialty pharmacies.
- Most specialty and chemotherapy drugs are only available at our designated specialty pharmacies. For more information visit our Web site at www.providence.org/healthplans.
- Diabetes supplies may be obtained at your participating pharmacy and are subject to your group's medical supplies and devices benefits, limitations and coinsurance. See your Member Handbook for details.

Using your prescription drug formulary

- The Providence Formulary is a list of FDA-approved prescription brand-name and generic drugs developed by physicians and pharmacists. It is designed to offer drug treatment choices for covered medical conditions.
- Some prescription drugs require prior authorization for medical necessity, place or length of therapy, step therapy, or number of doses. If a drug to treat your covered medical condition is not on the formulary, please contact us.

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- Our formulary can help you and your physician choose less costly effective medications to minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit www.providence.org/healthplans for frequently asked questions about both generic drugs and our formulary.

Ordering prescriptions by mail

- To order prescriptions by mail, your provider may call in the prescription or you can mail your prescription along with your member identification number to one of our participating mail-order pharmacies.
- To find participating mail-order pharmacy information visit us online at www.providence.org/healthplans.

If you use a non-participating pharmacy

- Urgent or emergency medical situations may require that you use a non-participating pharmacy. If this occurs, you will need to pay full price for your prescription at the time of purchase.
- Reimbursement forms are available online. Reimbursement is subject to your plan's limitations and exclusions.

What you need to know about limitations and exclusions

The following is a summary of the limitations and exclusions under your prescription drug plan. For complete descriptions go to www.providence.org/healthplans.

Limitations

- All drugs must be FDA-approved, medically necessary, and require by law a prescription to dispense. Not all FDA-approved drugs are covered by Providence Health Plan. Newly approved drugs are reviewed for safety and medical necessity within 12 months following FDA approval.
- Prescription dispensing limits: 1) topicals—up to 60 grams; 2) liquids—up to eight ounces; 3) tablets or capsules—up to 100 dosage units; and 4) multi-use or unit-of-use—up to one container or package; as prescribed, not to exceed a 34 consecutive day supply, whichever is less. Other dispensing limits may apply to medications requiring limited use and are noted in the Formulary.
- Specialty drugs are injectable, infused, oral or inhaled therapies that often require specialized delivery, handling, monitoring and administration, and are generally high cost. These drugs must be purchased through a designated specialty pharmacy. Due to the nature of these medications, they are not considered “maintenance” drugs and are limited to a 30-day supply (or minimum package size to approximate a 30-day supply). “Specialty Medications” are noted in the Formulary.
- Self-injectable drugs are only covered if they are intended for self-administration, labeled by the FDA for self-administration.

Exclusions

- Drugs used in the treatment of the common cold. Over-the-counter (OTC) drugs, medications, or vitamins that may be purchased without a provider's written prescription, and prescription drugs available in an OTC therapeutically similar form.
- Fluoride, for members over the age of 10 years old.

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- Amphetamines and amphetamine derivatives, except when used to treat narcolepsy or hyperactivity in children and adults.
- Drugs used for the treatment of fertility or infertility. Intrauterine devices (IUDs), diaphragms and implantable contraceptives. (Some of these items may be covered under your medical benefits.) Drugs or medications used to treat sexual dysfunctions or disorders, in either men or women, such as Viagra®. Drugs required for, or as a result of, sexual transformation.
- Drugs used for weight loss or cosmetic purposes. Drugs to stimulate hair growth, including, but not limited to, Rogaine® (i.e., topical minoxidil) or other similar drug preparations. Drugs used in the treatment of fungal nail conditions.
- Drugs used in the treatment of drug induced fatigue, general fatigue and idiopathic hypersomnia.
- Devices, appliances, supplies and durable medical equipment, even if a prescription is required for purchase. These items may be covered under your medical benefits.
- Drugs or prescribed medications not medically necessary or not provided according to our medical policy. Medications prescribed that do not relate directly to the treatment of a covered illness or injury.
- Drugs or medications delivered, injected or administered for you by a health care provider or other trained person.
- Drugs prescribed by naturopathic physicians (N.D.). Experimental or investigational drugs or drugs used by a member in a research study or in another similar investigational environment. Drugs that are not FDA approved or are designated as “less than effective” by the FDA, also known as a “DESI” drug.
- Drugs placed on prescription-only status as required by state or local law.
- Replacement of lost or stolen medication.

Your guide to the words and phrases used to explain your benefits

Brand-name drug

Brand-name drugs are protected by U.S. patent laws for up to 17 years. The pharmaceutical company holding the patent has exclusive rights to produce and sell the drug.

Coinsurance

The percentage of the cost you pay to a participating pharmacy at the time of purchase for a covered prescription drug.

Compounded drug

The combining, mixing, or altering of covered drugs or other ingredients to create a customized prescription for an individual as prescribed by a licensed provider.

Copay

The fixed dollar amount you pay to a participating pharmacy at the time of purchase for a covered prescription drug.

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.

Generic drug

Generic drugs have the same active-ingredient formula as the brand name drug and are tested by the FDA to be as safe and effective as brand-name drugs. Generic drugs are only available after the brand name patent expires. Visit www.providence.org/healthplans for frequently asked questions about generic drugs.

Maintenance drug

Medications that are typically prescribed to treat long-term or chronic conditions, such as diabetes, high blood pressure and high cholesterol. Maintenance drugs are those you have received under our plan for at least 30 days and anticipate continuing to use in the future.

Out-of-pocket maximum

The limit on the dollar amount you will have to spend for covered non-formulary and compounded prescription drugs in a calendar year. Some services and expenses do not apply to the out-of-pocket maximum. See your Member Handbooks 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 34-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 34-day supply of short-term prescriptions.
- **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.
- **Mail order:** a participating pharmacy that allows up to a 90-day supply of maintenance prescriptions and specializes in direct delivery to your home.

For a complete description of the types of services provided by participating pharmacies, see your Member Handbook.

Prior authorization

The process used to request an exception to the Providence Health Plan Drug Formulary. This process is initiated by your doctor, or other prescriber of the medication. Some drugs require prior authorization for medical necessity, place of therapy, length of therapy, step therapy or number of doses. Visit www.providence.org/healthplans for additional information.

Self-administered chemotherapy

Oral, topical or self-injectable medications that are used to stop or slow the growth of cancerous cells.

Value drug

A specified list of commonly used medications for treating chronic conditions such as diabetes, high blood pressure, high cholesterol, heart disease, depression, and asthma or other breathing disorders. These medications may be generic or brand name and are considered first-line treatments for many conditions. They are on our formulary and offered at your lowest copay or coinsurance.

Contact us

Headquartered in Portland, our customer service professionals have been proudly serving our members since 1986.

Customer Service: 1-800-423-9470
TTY: 503-574-8702 or 1-888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.providence.org/php/contactus

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Regence BlueCross BlueShield of Oregon Full-time
[Discontinues Jan. 1, 2010]

Type of care or supplies*	Preferred provider coverage (amount you pay based on eligible charges)	Nonpreferred provider coverage (amount you pay based on eligible charges)
Hospital inpatient care	15% of semi-private room rate for unlimited days	30% of semi-private room rate for unlimited days
Medical care in skilled nursing facility in lieu of hospital	15% of semi-private room rate for up to 180 days per calendar year	30% of semi-private room rate for up to 180 days per calendar year
Hospital intensive care or isolation unit	15%	30%
Other hospital charges	15%	30%
Hospitalization for rehabilitation	30 days per calendar year at 15%	30 days per calendar year at 30%
Hospital outpatient care	15%	30%
Care in outpatient birthing center	15%	30%
Hospital emergency room**	15%	30%
Outpatient rehabilitation (refer to limitations on this benefit)	15% (60 visits maximum per calendar year)	30% (60 visits maximum per calendar year)
Surgeon	15%	30%
Assistant surgeon	15%	30%
Anesthesiologist	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Emergency benefits will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for PPO Plan (continued from previous page)

Type of care or supplies*	Preferred provider coverage (amount you pay based on eligible charges)	Nonpreferred provider coverage (amount you pay based on eligible charges)
Surgical supplies	15%	30%
Preadmission testing	15%	30%
Physician visits in hospital, home, or office for illness or injury	15%	30%
Maternity care professional services	15%	30%
Contraceptive services	15%	30%
Well-baby care	0%	30%
Immunizations	0%	0%
Durable medical equipment (we cover medically necessary durable medical equipment and supplies)	15%	30%
Therapeutic injections	15%	30%
Chemotherapy	15%	30%
Annual women's examinations	\$0 per visit	30%
Routine periodic health appraisals**	0%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Routine periodic health appraisals may not be eligible annually.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for PPO Plan (continued from previous page)

Type of care or supplies*	Preferred provider coverage (amount you pay based on eligible charges)	Nonpreferred provider coverage (amount you pay based on eligible charges)
Diagnostic x-ray and laboratory tests related to routine periodic health appraisals**	0%	30%
Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)	15%	30%
Breast, cervical, prostate, and colorectal cancer screenings	0%	30%
Scan and interpretation fee for Magnetic Resonance Imaging Services	15%	30%
X-ray, radioisotopic, and radium therapy	15%	30%
Infertility services: artificial insemination (includes related or supporting x-ray and laboratory services)	50%	50%
Outpatient diabetic instruction	0%	0%
Outpatient diabetic supplies	0%	0%
Home health care (maximum 180 visits per calendar year)	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Routine periodic health appraisals may not be eligible annually.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for PPO Plan (continued from previous page)

Type of care or supplies*	Preferred provider coverage (amount you pay based on eligible charges)	Nonpreferred provider coverage (amount you pay based on eligible charges)
Palliative hospice care	0%	0%
Home infusion therapy	15%	30%
Treatment of mental illness - Inpatient - Residential - Outpatient	15% 15% 15%	30% 30% 30%
Treatment of alcohol and medication abuse - Inpatient - Residential - Outpatient	15% 15% 15%	30% 30% 30%
Hearing examination	15% every 12 months	30% every 12 months
Hearing aid	10% up to \$4,000 maximum allowance every 4th year	10% up to \$4,000 maximum allowance every 4th year
Ambulance service to the nearest hospital (up to 500 miles per calendar year) **	15%	15%
Blood or blood plasma	15%	30%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

**Your coverage pays eligible charges based on community standards for local ground transportation as determined by Regence BlueCross BlueShield of Oregon.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for PPO Plan *(continued from previous page)*

Other Covered Expenses	Amount You Pay Based On Eligible Charges												
Vision care Vision services are provided through Vision Service Plan (VSP).	Not Covered												
Chiropractic care* Naturopathic care* Acupuncturist care*	30% 30% 30%												
Prescription medications NOTE: There is no copayment for covered diabetic supplies obtained either at the pharmacy or through a mail order supplier.	<table style="width: 100%; border: none;"> <tr> <td style="width: 15%;"><u>Pharmacy</u></td> <td>\$5 generic</td> </tr> <tr> <td>(34-day supply)</td> <td>\$15 preferred</td> </tr> <tr> <td></td> <td>Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multisource brands)</td> </tr> <tr> <td> <u>Mail Order</u></td> <td> \$12.50 generic</td> </tr> <tr> <td>(90-day supply)</td> <td>\$37.50 preferred</td> </tr> <tr> <td></td> <td>Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)</td> </tr> </table>	<u>Pharmacy</u>	\$5 generic	(34-day supply)	\$15 preferred		Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multisource brands)	 <u>Mail Order</u>	 \$12.50 generic	(90-day supply)	\$37.50 preferred		Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)
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(90-day supply)	\$37.50 preferred												
	Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)												
Surgical treatment of morbid obesity	Subject to plan limitations												

* Alternative care providers may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance. The patient is responsible for those balances.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Regence BlueCross BlueShield of Oregon Part-time & Retirees [*Discontinues Jan. 1, 2010*]

This plan pays 50 percent of the first \$1,000 of eligible expenses incurred from preferred and nonpreferred providers per person/\$3,000 per family each calendar year. Benefits are then paid as indicated in the following summary:

Type of care or supplies*	Preferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	Nonpreferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):
Hospital inpatient care	20% of semi-private room rate for unlimited days	50% of semi-private room rate for unlimited days
Medical care in skilled nursing facility in lieu of hospital	20% of semi-private room rate for up to 180 days per calendar year	50% of semi-private room rate for up to 180 days per calendar year
Hospital intensive care or isolation unit	20%	50%
Other hospital charges	20%	50%
Hospitalization for rehabilitation	30 days per calendar year at 20%	30 days per calendar year at 50%
Hospital outpatient care	20%	50%
Care in outpatient birthing center	20%	50%
Hospital emergency room**	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Emergency benefits will be reimbursed at the Preferred level as long as treatment meets the criteria of a true emergency medical condition.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for Regence PPO Part-Time and Retiree Plan (continued from previous page)

Type of care or supplies*	Preferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	Nonpreferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):
Outpatient rehabilitation (refer to limitations on this benefit)	20% (60 visits maximum per calendar year)	50% (60 visits maximum per calendar year)
Surgeon	20%	50%
Assistant surgeon	20%	50%
Anesthesiologist	20%	50%
Surgical supplies	20%	50%
Preadmission testing	20%	50%
Physician visits in hospital, home, or office for illness or injury	20%	50%
Maternity care professional services	20%	50%
Contraceptive services	20%	50%
Well-baby care	0% **	50%
Immunizations	0% **	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** These benefits are paid 100% and are not subject to the initial 50% of \$1,000 requirement when services are rendered by preferred professional providers.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for Regence PPO Part-Time and Retiree Plan (continued from previous page)

Type of care or supplies*	Preferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	Nonpreferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):
Durable medical equipment (we cover medically necessary durable medical equipment and supplies)	20%	50%
Therapeutic injections	20%	50%
Chemotherapy	20%	50%
Annual women's examinations	\$0 per visit**	50%
Routine periodic health appraisals***	0% **	50%
Diagnostic x-ray and laboratory tests related to routine periodic health appraisals*** Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms) Breast, cervical, prostate, and colorectal cancer screenings	0%** 20% 0%**	50% 50% 50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** These benefits are paid 100% and are not subject to the initial 50% of \$1,000 requirement when services are rendered by preferred professional providers.

*** Routine periodic health appraisals may not be eligible annually.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for Regence PPO Part-Time and Retiree Plan (continued from previous page)

Type of care or supplies*	Preferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	Nonpreferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):
Scan and interpretation fee for Magnetic Resonance Imaging Services	20%	50%
X-ray, radioisotopic, and radium therapy	20%	50%
Infertility services: artificial insemination (includes related or supporting x-ray and laboratory services)	50%	50%
Outpatient diabetic instruction	0%	0%
Outpatient diabetic supplies	0%	0%
Home health care (maximum 180 visits per calendar year)	20%	50%
Palliative hospice care	0%	0%
Home infusion therapy	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for Regence PPO Part-Time and Retiree Plan *(continued from previous page)*

Type of care or supplies*	Preferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	Nonpreferred Provider Coverage (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):
Treatment of mental illness - Inpatient - Residential - Outpatient	20% 20% 20%	50% 50% 50%
Treatment of alcohol and medication abuse - Inpatient - Residential - Outpatient	20% 20% 20%	50% 50% 50%
Hearing examination	15% every 12 months	50% every 12 months
Hearing aid	10% up to \$4,000 maximum allowance every 4th year	10% up to \$4,000 maximum allowance every 4th year
Ambulance service to the nearest hospital (up to 500 miles per calendar year)**	20%	20%
Blood or blood plasma	20%	50%

* Preferred and participating professional providers will not charge you or your insured dependents any balances for eligible charges over any applicable coinsurance amounts required under the plan. Nonparticipating providers, however, may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance.

** Your coverage pays eligible charges based on community standards for local ground transportation as determined by Regence BlueCross BlueShield of Oregon.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits for Regence PPO Part-Time and Retiree Plan (continued from previous page)

Other Covered Expenses	Amount You Pay Based On Eligible Charges				
Vision care	Not Covered				
Chiropractor care*	50%				
Naturopathic care*	50%				
Acupuncturist care*	50%				
Prescription medications NOTE: There is no copayment for covered diabetic supplies obtained either at the pharmacy or through a mail order supplier.	<table style="width: 100%; border-collapse: collapse;"> <tr> <td style="vertical-align: top;"><u>Pharmacy</u> (34-day supply)</td> <td style="vertical-align: top;">\$10 generic 20% preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multi-source brands)</td> </tr> <tr> <td style="vertical-align: top;"><u>Mail Order</u> (90-day supply)</td> <td style="vertical-align: top;">\$25 generic \$62.50 preferred \$125 nonpreferred (plus difference between generic and brand for multi-source brands)</td> </tr> </table>	<u>Pharmacy</u> (34-day supply)	\$10 generic 20% preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multi-source brands)	<u>Mail Order</u> (90-day supply)	\$25 generic \$62.50 preferred \$125 nonpreferred (plus difference between generic and brand for multi-source brands)
<u>Pharmacy</u> (34-day supply)	\$10 generic 20% preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multi-source brands)				
<u>Mail Order</u> (90-day supply)	\$25 generic \$62.50 preferred \$125 nonpreferred (plus difference between generic and brand for multi-source brands)				
Surgical treatment of morbid obesity	Subject to plan limitations				

* Alternative care providers may bill you for any balances over the maximum allowable charge in addition to any applicable coinsurance. The patient is responsible for those balances.

Point of Service Plans [*Discontinues Jan. 1, 2010*]

Point of Service (POS) plans have three tiers of providers: HMO, network, and out-of-network. You can seek care outside the HMO, but at reduced coverage levels. You must get prior authorization review before getting surgical or inpatient services.

PEBB sponsors the Kaiser Permanente Added Choice plans — for those who live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See the plan's member handbook (evidence of coverage) for a list of the ZIP codes in the service area.

Following are Benefit Summaries for the Kaiser Permanente Added Choice plans.

Kaiser Permanente Added Choice Full-Time Benefit Summary [Discontinues Jan. 1, 2010]

IN-NETWORK BENEFIT SUMMARY

This “In-Network Benefit Summary” is a summary of the most frequently asked questions about benefits of your In-Network benefits. Please refer to your “Out-of-Network Benefit Summary” for your out-of-network benefits. These charts do not describe benefits (including exclusions and limitations) for complete explanations and for additional benefits that are not included in this “In-Network Benefit Summary”, please refer to the “In-Network Copayments, Coinsurance and Benefits,” the “Exclusions and Limitations” and “Reductions” sections of this EOC.

	IN-NETWORK
Annual Out-Of-Pocket Maximum	
For one Member	\$600
For an entire Family Unit	\$1,200
Annual Deductible This plan does not have an annual deductible	
For one Member	None
For an entire Family Unit	None
Lifetime Maximum	
None	
Outpatient Care	
You Pay	
Routine preventive physical exam (includes adult and well child)	No charge
Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Services and Diabetic Outpatient self-management training and education, including medical nutrition therapy) The annual Benefit Maximum for preventive care is \$300 per member.	\$10
Specialty care visit (includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy; see Primary care for OB/GYN visits)	\$10
Scheduled prenatal care and first postpartum visit	No charge
Routine eye exam	\$10
All injections provided in the Nurse Treatment Area	\$5
Immunizations	No charge
Rehabilitative therapy visit	\$10
Outpatient surgery visit	\$10
Emergency Department visit	\$75 plus any other charges that normally apply
Breast, cervical, prostate, and colorectal cancer screenings	\$0
X-rays, imaging, laboratory, and special diagnostic procedures	No charge

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	IN-NETWORK
Hospital Inpatient Care	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$100 per day up to \$500 maximum per year
Outpatient prescription drugs, supplies, and supplements	You Pay
Per Prescription	\$5 for generic drugs. \$15 for brand drugs. No charge for diabetic supplies, insulin, and smoking cessation drugs when used in conjunction with an approved smoking cessation program. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two copayments.
Ambulance Services per transport	You Pay
	\$75 per transport
Durable Medical Equipment	You Pay
	No charge
Mental Health Services	You Pay
Outpatient Services	\$10
Intensive outpatient Services	\$10 per day
Inpatient Hospital Services	\$100 per day up to \$500 maximum per admission per year
Residential or day treatment Services Limited to 45 days per Calendar Year	\$100 per day up to \$500 maximum per admission per year
Chemical Dependency Services	You Pay
Outpatient Services	\$10
Inpatient Hospital Services	\$100 per day up to \$500 maximum per admission per year
Residential or day treatment Services Limited to 45 days per Calendar Year	\$100 per day up to \$500 maximum per admission per year
Home Health Services	You Pay
	No charge
Infertility Services	You Pay
	50% for diagnosis and treatment
Skilled Nursing Facility Care	You Pay
	No charge for up to 100 days per year
Hospice Care	You Pay
	No charge
Alternative Care	You Pay
	\$15 per chiropractor, acupuncture, or naturopath visit. \$1,000 benefit maximum per year
Hearing Aids	You Pay

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	IN-NETWORK
	10% up to a maximum of \$4,000 every four years
Vision hardware	You Pay
Prescription eyeglasses and contact lenses	Balance after \$200 credit is applied. Your benefit renews every 24 months

OUT-OF-NETWORK BENEFIT SUMMARY

This “Out-of-Network Benefit Summary” is a summary of the answers to the most frequently asked questions about benefits. Please refer to your “In-Network Benefit Summary” for your in-network benefits. These charts do not describe benefits (including exclusions and limitations) for complete explanations, and for additional benefits that are not included in this “Out-of-Network Benefit Summary”, please refer to the “Out-of-Network Copayments, Coinsurance, Benefits and Other Requirements” section and the “Emergency Services, Urgent Services, and Routine Services” section as well as “Exclusions and Limitations,” and “Reductions” sections of this EOC.

	PPO	OTHER PROVIDERS
Annual Out-Of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$1,500 per Calendar Year	\$2,500 per Calendar Year
Family Out-of-Pocket Maximum	\$4,500 per Calendar Year	\$7,500 per Calendar Year
Annual Deductible		
This plan does not have an annual Deductible		
Individual Deductible	None	None
Family Deductible	None	None
Lifetime Maximum	\$2,000,000	\$2,000,000
Outpatient Care	You Pay	You Pay
Routine preventive physical exam (includes adult and well child)	No charge	30%
Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Services and Diabetic Outpatient self-management training and education, including medical nutrition therapy) The annual Benefit Maximum for preventive care is \$300 per member.	\$20	30%
Specialty care visit (includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy; see Primary care for OB/GYN visits.)	15%	30%
Scheduled prenatal care and first postpartum visit	15%	30%
Routine eye exam	Not covered	Not covered

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	PPO	OTHER PROVIDERS
All injections provided in the Nurse Treatment Area	15%	30%
Immunizations	No charge	No charge
Rehabilitative therapy visit	15%	30%
Outpatient surgery visit	15%	30%
Urgent Care visit	\$20	30%
Emergency Department visit	In-network benefit applies: \$75 plus any other charges that normally apply	In-network benefit applies: \$75 plus any other charges that normally apply
X-rays, imaging, laboratory, and special diagnostic procedures	15%	30%
Hospital Inpatient Care	You Pay	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	15%	30%
Outpatient prescription drugs, supplies, and supplements	You Pay	You Pay
Per prescription	See "Other Providers"	\$20 for generic drugs at PBM-participating pharmacies. For brand drugs, you pay the difference in retail price between generic and brand plus \$20. No charge for diabetic supplies, insulin, and smoking cessation drugs when used in conjunction with an approved smoking cessation program. You get up to a 30-day supply.
Ambulance Services per transport	You Pay	You Pay
	See "Other Providers"	30%
Durable Medical Equipment	You Pay	You Pay
	In-network benefit applies: 0% coinsurance (No charge); available only through in-network providers.	
Mental Health Services	You Pay	You Pay
	15%	30%
Chemical Dependency Services	You Pay	You Pay
	15%	30%
Home Health Services	You Pay	You Pay
	15%	30%

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	PPO	OTHER PROVIDERS
Infertility Services	You Pay	You Pay
	50% for diagnosis; treatment not covered	50% for diagnosis; treatment not covered
Skilled Nursing Facility Care	You Pay	You Pay
	15%	30%

Kaiser Permanente Added Choice Part-time and Retiree Benefit Summary
[Discontinues Jan. 1, 2010]

IN-NETWORK BENEFIT SUMMARY

This “In-Network Benefit Summary” is a summary of the most frequently asked questions about benefits and their Deductibles, Copayments and Coinsurance for your in-network benefits. Please refer to your “Out-of-Network Benefit Summary” for your out-of-network benefits. These charts do not describe benefits (including exclusions and limitations) for complete explanations and for additional benefits that are not included in this “In-Network Benefit Summary”, please refer to the “In-Network Deductibles, Copayments, Coinsurance and Benefits,” the “Exclusions and Limitations” and “Reductions” sections of this EOC.

	IN-NETWORK
Annual Out-Of-Pocket Maximum	
For one Member	\$2,000 per Calendar Year
For an entire Family Unit	\$6,000 per Calendar Year
Annual Deductible	
Deductible amounts do not apply toward your Annual Out-of-Pocket Maximum	
For one Member	\$250 per Calendar Year
For an entire Family Unit	\$750 per Calendar Year
Lifetime Maximum	None
Outpatient Care	You Pay
Routine preventive physical exam (includes adult and well child)	\$30
Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Services and Diabetic Outpatient self-management training and education, including medical nutrition therapy) The annual Benefit Maximum for preventive care is \$300 per member.	\$30; urgent services visits subject to deductible
Specialty care visit (includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy; see Primary care for OB/GYN visits)	\$30
Scheduled prenatal care and first postpartum visit	\$30

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Routine eye exam	\$30
All injections provided in the Nurse Treatment Area	\$5
Immunizations	No charge
Rehabilitative therapy visit	\$30
Outpatient surgery visit	20% after deductible
Breast, cervical, prostate, and colorectal cancer screenings	\$0
Emergency Department visit	20% after deductible
X-rays, imaging, laboratory, and special diagnostic procedures	20% after deductible
Hospital Inpatient Care	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	20% after deductible
Outpatient prescription drugs, supplies, and supplements	You Pay
Per Prescription	\$10 for generic drugs. \$25 for brand drugs. No charge for smoking cessation drugs when used in conjunction with an approved smoking cessation program. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two copayments.
Ambulance Services per transport	You Pay
	20% coinsurance
Durable Medical Equipment	You Pay
	50% coinsurance
Mental Health Services	You Pay
Outpatient Services	\$30
Intensive outpatient Services	\$30 per day
Inpatient Hospital Services	20% after deductible
Residential or day treatment Services Limited to 45 days per Calendar Year	20% after deductible
Chemical Dependency Services	You Pay
Outpatient Services	\$30
Inpatient Hospital Services	20% after deductible
Residential or day treatment Services Limited to 45 days per Calendar Year	20% after deductible
Home Health Services	You Pay
Benefit Maximum – up to 130 visits per Calendar Year for part-time or intermittent home services.	20% after deductible
Infertility Services	You Pay
	50% after deductible for diagnosis and treatment
Skilled Nursing Facility Care	You Pay
	20% after deductible for up to 100 days per year

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Hospice Care	You Pay
	No charge
Hearing Aids	You Pay
	10% up to a maximum of \$4,000 every four years

OUT-OF-NETWORK BENEFIT SUMMARY

This “Out-of-Network Benefit Summary” is a summary of the answers to the most frequently asked questions about benefits and their Deductibles, Copayments and Coinsurance for your out-of-network benefits. Please refer to your “In-Network Benefit Summary” for your in-network benefits. These charts do not describe benefits (including exclusions and limitations) for complete explanations, and for additional benefits that are not included in this “Out-of-Network Benefit Summary”, please refer to the “Out-of-Network Deductibles, Copayments, Coinsurance, Benefits and Other Requirements” section and the “Emergency Services, Urgent Services, and Routine Services” section as well as “Exclusions and Limitations,” and “Reductions” sections of this EOC.

	PPO	OTHER PROVIDERS
Annual Out-Of-Pocket Maximum		
Individual Out-of-Pocket Maximum	\$3,000 per Calendar Year	\$4,500 per Calendar Year
Family Out-of-Pocket Maximum	\$9,000 per Calendar Year	\$13,500 per Calendar Year
Annual Deductible		
(Deductible amounts do not apply towards your Annual Out-of-Pocket Maximum)		
Individual Deductible	\$750 per Calendar Year	\$1,000 per Calendar Year
Family Deductible	\$2,250 per Calendar Year	\$3,000 per Calendar Year
Lifetime Maximum	\$2,000,000	\$2,000,000
Outpatient Care	You Pay	You Pay
Routine preventive physical exam (includes adult and well child)	30%	50%
Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, and Urgent Services and Diabetic Outpatient self-management training and education, including medical nutrition therapy) The annual Benefit Maximum for preventive care is \$300 per member.	30%	50%
Specialty care visit (includes TMJ therapy and Diabetic Outpatient self-management training and education, including medical nutrition therapy;	30%	50%

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see Primary care for OB/GYN visits.)		
Scheduled prenatal care and first postpartum visit	30%	50%
Routine eye exam	Not covered	Not covered
All injections provided in the Nurse Treatment Area	30%	50%
Immunizations	No charge	No charge
Rehabilitative therapy visit	30%	50%
Outpatient surgery visit	30%	50%
Urgent Care visit	30%	50%
Emergency Department visit	In-network benefit applies: 20% after deductible	In-network benefit applies: 20% after deductible
X-rays, imaging, laboratory, and special diagnostic procedures	30%	50%
Hospital Inpatient Care	You Pay	You Pay
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	30%	50%
	PPO	OTHER PROVIDERS
Outpatient prescription drugs, supplies, and supplements	You Pay	You Pay
Per prescription	See "Other Providers"	\$30 for generic drugs at PBM-participating pharmacies. For brand drugs, you pay the difference in retail price between generic and brand plus \$30. No charge for smoking cessation drugs when used in conjunction with an approved smoking cessation program. You get up to a 30-day supply.
Ambulance Services per transport	You Pay	You Pay
	See "Other Providers"	50%
Durable Medical Equipment	You Pay	You Pay
	In-network benefit applies: 50% coinsurance; available only through in-network providers.	
Mental Health Services	You Pay	You Pay
	30%	50%
Chemical Dependency Services	You Pay	You Pay
	30%	50%
Home Health Services	You Pay	You Pay
	30%	50%
Infertility Services	You Pay	You Pay
	50% for diagnosis; treatment not covered	50% for diagnosis; treatment not covered

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Public Employees' Benefit Board Summary Plan Description

Skilled Nursing Facility Care	You Pay	You Pay
	30%	50%

**VSP Routine Vision Care
Summary of Benefits (only in full-time PPO plans)**

This is a summary only. See the plan's Evidence of Coverage for details.

Routine Vision Services	VSP Provider¹	Non-VSP Providers²
Provided once each calendar year	You Pay	
Eye exam	\$10	Full amount; reimbursement to \$42
\$200 for prescription lenses and frames and contact lenses	Charges in excess of \$200	Full amount; reimbursement to \$200

¹ VSP guarantees services from VSP doctors only. VSP Providers also offer discounts.

² You pay the provider in full and have six months to submit a claim to VSP for partial reimbursement less copays.

Premium Rates [Effective Jan. 1, 2010]

The state, as the employer, provides a monthly benefit amount for employees. The employer's payroll administration applies the amount to premiums for the core benefits of medical, dental and basic life insurance coverage. PEBB does not play a role in determining the benefit amount. The amount is determined through a series of decisions made by the governor, legislature, Department of Administrative Services, other agencies and branches of government, and collective bargaining agreements.

2010 Employee Medical Plan Monthly Premium Rates				
	Employee	Employee & Spouse/Partner	Employee & Children	Employee & Family
PEBB's Statewide Plan¹	\$892.19	\$1,195.39	\$1,025.95	\$1,222.17
Kaiser Permanente²	835.16	1,119.11	960.45	1,144.17
Providence Choice¹	771.69	1,034.03	887.45	1,057.20
PEBB's Statewide Plan: Part-time³	710.42	951.87	816.94	973.21
Kaiser Permanente: Part-time⁴	707.01	947.39	813.05	968.60
Providence Choice: Part-time³	611.04	818.78	702.71	837.12

¹ Routine vision services through VSP.

² Kaiser Permanente routine vision services.

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³ No vision benefit.

⁴ Vision exam only.

2010 COBRA Medical Plan Monthly Premium Rates					
	Self	Self & Spouse/ partner	Self & Children	Self & Family	Child(ren) Only⁵
PEBB's Statewide Plan¹	\$909.76	\$1,218.93	\$1,046.15	\$1,246.24	\$468.53
Kaiser Permanente²	851.76	1,141.36	\$979.54	1,166.92	434.39
Providence Choice¹	786.89	1,054.39	904.92	1,078.02	410.15
PEBB's Statewide Plan Part-time³	724.40	970.61	833.02	992.36	372.91
Kaiser Permanente Part-time⁴	721.06	966.23	829.21	987.85	367.74
Providence Choice Part-time³	623.07	834.90	716.54	853.60	317.76

¹ Routine vision services through VSP.

² Kaiser Permanente routine vision services.

³ No vision benefit.

⁴ Vision exam only.

⁵ Child(ren) Only coverage is available only to COBRA & Retiree participants.

2010 Retiree Medical Plan Monthly Premium Rates					
	Retiree	Retiree & Spouse/ Partner	Retiree & Children	Retiree & Family	Child(ren) Only⁵
PEBB's Statewide Plan¹	\$895.70	\$1,200.11	\$1,029.99	\$1,226.98	\$461.30
Kaiser Permanente²	838.48	1,123.56	964.27	1,148.72	427.61
Providence Choice¹	774.73	1,038.11	890.94	1,061.36	403.81
PEBB's Statewide Plan Retiree³	713.21	955.62	820.15	977.04	367.15
Kaiser Permanente Retiree⁴	709.82	951.16	816.28	972.45	362.00
Providence Choice Retiree³	613.45	822.01	705.47	840.42	312.85

¹ Routine vision services through VSP.

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² Kaiser Permanente routine vision services.

³ No vision benefit.

⁴ Vision exam only.

⁵ Child(ren) Only coverage is available only to COBRA & Retiree participants.

2010 Self-pay Medical Plan Monthly Premium Rates				
	Self	Self & Spouse/ Partner	Self & Children	Self & Family
PEBB's Statewide Plan¹	\$902.49	\$1,205.69	\$1,036.25	\$1,232.47
Kaiser Permanente HMO²	845.46	1,129.41	970.75	1,154.47
Providence Choice¹	781.99	1,044.33	897.75	1,067.50

¹ Routine vision services through VSP

² Kaiser Permanente HMO routine vision services

Premium Rates [Discontinues Jan. 1, 2010]

The state, as the employer, provides a monthly benefit amount for employees. The employer's payroll administration applies the amount to premiums for the core benefits of medical, dental and basic life insurance coverage. PEBB does not play a role in determining the benefit amount. The amount is determined through a series of decisions made by the governor, legislature, Department of Administrative Services, other agencies and branches of government, and collective bargaining agreements.

2009 Employee Medical Plan Monthly Premium Rates				
	Employees	Employee & Spouse/Partner	Employee & Children	Employee & Family
Kaiser Permanente HMO¹	\$756.46	\$1,013.67	\$869.94	\$1,036.36
Kaiser Permanente Added Choice POS¹	800.25	1,072.34	920.29	1,096.34
Providence Choice PPO²	750.79	1,006.02	863.41	1,028.56
Regence BCBSO PPO²	834.18	1,117.67	959.24	1,142.69
Kaiser Permanente Part-time & Retiree³	640.38	858.11	736.43	877.32
Kaiser Added Choice Part-time & Retiree³	647.45	867.58	744.57	887.01
Providence Choice Part-time & Retiree³	593.49	795.27	682.52	813.08
Regence BCBSO Part-time & Retiree⁴	662.68	887.91	762.05	907.81

¹ Kaiser Permanente HMO routine vision services
² Routine vision services through VSP.
³ Vision exam only.
⁴ No vision benefit.

Medical and Prescription Drug Plan Comparisons

The following pages allow you to compare PEBB's healthcare options on a side-by-side basis. Comparisons are presented in the following order:

- Full-time Medical and Prescription Drug plans available to full-time and part-time employees, retirees and other self-pay participants
- Part-time and Retiree Medical and Prescription Drug Plans available to part-time employees and retirees, and COBRA participants who were part-time employees when they elected COBRA continuation coverage

NOTE: Full-time employees may not enroll in the part-time and retiree plans.

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2010 PEBB Full-time Medical Plans Comparison

[Effective Jan. 1, 2010]

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.

Type of Provider or System	PEBB Statewide		Kaiser Permanente ¹	Providence Choice ² (Portland Metro area)	
	In Network	Out of Network	HMO	In Network	Out of Network
Individual Out-of-pocket Maximum	\$1,000	\$2,000	\$600	\$1,000	\$2,000
Family Out-of-pocket Maximum	\$3,000	\$6,000	\$1,200	\$3,000	\$6,000
Individual Lifetime Maximum	\$2 million	\$2 million	No limit	\$2 million	\$2 million
	You pay	You pay	You pay	You pay	You pay
General Office Visit	15%	30%	\$5	\$5	30%
Specialist Office Visit	15%	30%	\$5	\$5	30%
Imaging and Labs	15%	30%	\$0	\$0	30%
Preventative Care					
Health Appraisal	\$0	30%	\$0	\$0	30%
Immunizations	\$0	\$0	\$0	\$0	\$0
Hearing Exams	15%	30%	\$5	\$5	30%
Cancer Screenings	\$0	30%	\$0	\$0	30%

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Hospital					
Ambulance	15%	15%	\$75	\$75	\$75
Hospital Inpatient/day	15%	30%	\$50 ³	\$50 ³	30%
Hospital Outpatient	15%	30%	\$5	\$5	30%
Hospital Emergency Dept.	15%	15%	\$75	\$75	\$75
Surgery					
Surgery Inpatient/day	15%	30%	\$50 ³	\$50 ³	30%
Surgery Outpatient Office	15%	30%	\$5	\$5	30%
Maternity Care					
Childbirth (prenatal, delivery, postpartum)	15%	30%	\$0	\$0	30%
Mental Health, Chemical Dependency					
Mental Health Inpatient & Residential/day	15%	30%	\$50 ³	\$50 ³	30%
Mental Health Outpatient	15%	30%	\$5	\$5	30%
Other Medical					
Diabetic Supplies, Insulin	\$0	\$0	\$0	\$0	\$0
Hearing Aids (\$4,000 once in 4 years)	10%	10%	10%	10%	10%
Durable Medical Equipment	15%	30%	\$0	15%	30%
Chiropractic, Acupuncture, Naturopathic	30%	30%	\$10 ⁴	\$10 ⁴	\$10 ⁴

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Physical Therapy	15%	30%	\$5	\$5	30%
Routine Vision Services	VSP		Kaiser Permanente¹	VSP	
Provider	VSP Network	Out of Network	Kaiser Providers Only	VSP Network	Out of Network
	You pay	You pay	You pay	You pay	You pay
Exam	\$10	\$10 + amount above \$42	\$5	\$10	\$10 + amount above \$42
Lenses and frames, contacts	Amount above \$200	Amount above \$200	Amount above \$200	Amount above \$200	Amount above \$200
Frequency	Every 12 months	Every 12 months	Every 24 months or with change of 0.5 diopter	Every 12 months	Every 12 months

¹ Available in Kaiser service area; plan pays nothing for non-emergency services accessed outside the HMO

² Referral required from Medical Home to receive in-plan benefits for professional services

³ \$250 max per admittance

⁴ Coverage limit \$1,000 per year

State of Oregon
Public Employees' Benefit Board Summary Plan Description

2010 PEBB Part-time Medical Plans Comparison

[Effective Jan. 1, 2010]

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.

Medical Plan	PEBB Statewide		Kaiser Permanente ¹	Providence Choice ² (Portland Metro area)	
	Network	Out of Network	HMO	Medical Home	Out of Network
Deductible	50% of \$1,000 then 20%	50% of \$1,000 then 50%	\$0	\$0	\$0
Individual Out-of-Pocket Maximum	\$2,000	\$4,000	\$1,500	\$2,000	\$4,000
Family Out-of-Pocket Maximum	\$6,000	\$12,000	\$3,000	\$6,000	\$12,000
Individual lifetime maximum	\$2 million	\$2 million	No limit	\$2 million	\$2 million
	You pay	You pay	You pay	You pay	You pay
General office Visit	20%	50%	\$30	\$30	50%
Specialist office Visit	20%	50%	\$30	\$30	50%
Imaging and Labs	20%	50%	\$10	20%	50%
Preventative Care					
Health Appraisal	\$0	50%	\$0	\$0	50%
Immunizations	\$0	50%	\$0	\$0	50%

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Hearing exams	15%	50%	\$30	\$30	50%
Cancer screenings	\$0	50%	\$0	\$0	50%
Hospital					
Ambulance	20%	20%	\$75	\$75	\$75
Hospital Inpatient	20%	50%	\$500/admit	\$500/admit	50%
Hospital Outpatient	20%	50%	\$30	\$30	50%
Hospital Emergency Department	20%	20%	\$100	\$100	\$100
Surgery					
Surgery Inpatient	20%	50%	\$500/admit	\$30	50%
Surgery Outpatient Office	20%	50%	\$30	\$30	50%
Maternity Care					
Childbirth (prenatal, delivery, postpartum)	20%	50%	\$0	\$0	50%
Mental Health, Chemical Dependency					
Mental Health Inpatient	20%	50%	\$500/admit	\$500/admit	50%
Mental Health Residential	20%	50%	\$50/day ³	\$500/admit	50%
Mental Health Outpatient	20%	50%	\$30	\$30	50%
Other Medical					
Hearing Aids (\$4,000 once in 4 years)	10%	10%	10%	10%	10%

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Public Employees' Benefit Board Summary Plan Description

Diabetic Supplies, Insulin	\$0	\$0	20%, \$0	\$0	\$0
Durable Medical Equipment	20%	50%	50% (except diabetic supplies)	50%	50%
Chiropractic, Acupuncture, Naturopathic	50%	50%	Not Covered	50%	50%
Physical Therapy	20%	50%	\$30	\$30	50%
Routine Vision Services	Not Covered	Not Covered	Exam only: \$30	Not Covered	Not Covered

¹ Available in Kaiser service area; plan pays nothing for non-emergency services accessed outside the HMO

² Referral required from Medical Home to receive in-plan benefits for professional services

³ \$250 max per admittance

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2010 Full-time & Part-time Prescription Drug Comparison [Effective Jan. 1, 2010]			
	PEBB Statewide¹ (FT/PT)	Kaiser Permanente (FT/PT)	Providence Choice¹ (FT/PT)
Month Supply	34-day	30-day	30-day
Provider	Retail Pharmacy	Kaiser Permanente	Retail Pharmacy
Generic	\$5/\$10	\$1/\$10	\$5/\$10
Formulary Brand	\$15/20%	\$15/\$25	\$15/\$25
Non-formulary	Greater of \$50 or 50% plus cost difference between generic and non-formulary brand	Not Covered	Greater of \$50 or 50% plus cost difference between generic and non-formulary brand
Extended Supply	90-day	90-day	90-day
Provider	Mail-order Pharmacy or Preferred Retail Pharmacy	Kaiser Permanente Mail-order Pharmacy	Mail-order Pharmacy or Preferred Retail Pharmacy
Generic	\$12.50/\$25	\$2/\$20	\$5/\$25
Formulary Brand	\$37.50/\$62.50	\$30/\$50	\$37.50/\$62.50
Non-formulary	Greater of \$125 or 50% plus cost difference between generic and non-formulary brand/\$125	Not Covered	Greater of \$125 or 50% plus cost difference between generic and non-formulary brand/ \$125

¹ Plan covers "Value Drugs" on the formulary at zero co-pay

State of Oregon
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Full-time Medical Plans Comparison [Discontinues Jan. 1, 2010]

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents or applicable federal or state law or rule.

Plan	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 Care ¹								
Health appraisal	\$0	\$0	\$0	30%	\$0	30%	\$0	30%
Immunizations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Hearing exams	\$5	\$10	\$20	30%	\$5	30%	15%	30%
Cancer screens	\$0	\$0	15%	30%	\$0	30%	\$0	30%
Hospital ²								
Ambulance	\$75	\$75	30%	30%	\$75	\$75	15%	15%
Inpatient/day max	\$50	\$100	15%	30%	\$50	30%	15%	30%
	(\$250/admit)	(\$500/y)			(\$250/admit)			
Outpatient	\$5	\$10	15%	30%	\$5	30%	15%	30%
Emergency dept	\$75	\$75	\$75	\$75	\$75	50%	15%	30%
Surgery ²								
Inpatient/day Max	\$50	\$100	15%	30%	\$50	30%	15%	30%
	(\$250/admit)	(\$500/y)			(\$250/admit)			
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 Dependency ²								
Inpatient & resident/day max	\$50	\$100	15%	30%	\$50	30%	15%	30%
	(\$250/admit)	(\$500/y)			(\$250/admit)			
Outpatient	\$5	\$10	15%	30%	\$5	30%	15%	30%
Other Medical ³								
Hearing aids	10%	10%	10%, Rx & Aid only thru HMO		10%	10%	10%	10%
Diabetic supplies, insulin	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Durable medical equipment	\$0	\$0	Access thru Kaiser HMO		15%	30%	15%	30%
Alternative Care	\$10	\$15	\$15	\$15	\$10	\$10	30%	30%

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Public Employees' Benefit Board Summary Plan Description

Plan	Kaiser	Kaiser Added Choice			Providence Choice		Regence BCBSO	
Provider Type	HMO	HMO	Network	OON*	Network	OON*	Network	OON*
Physical Therapy	\$5	\$10	15%	30%	\$5	30%	15%	30%
Vision	Kaiser Vision Benefit (every 24 months)				VSP Vision Benefit (every 12 months)			
Exam	\$5	\$10	15%	30%	VSP provider \$10 Non-VSP provider \$10 + amount above \$42			
Eyewear	Kaiser facilities only. Amount above \$200				Amount above \$200			
* 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								

Full-time Plans Prescription Drug Comparison [Discontinues Jan. 1, 2010]

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents or applicable federal or state law or rule.

Coverage	Kaiser	Kaiser Added Choice			Providence	Regence
		HMO	Network	OON		
Retail supply	30-day	30-day	30-day	30-day	30-day	34-day
Pharmacies	Kaiser Only	Kaiser Only	MedImpact ¹	MedImpact ¹	Participating	Any
Generic	\$1	\$5	\$20	\$20	\$5	\$5
Brand	\$15	\$15	\$20 ²	\$20 ²	\$15	\$15
Non Formulary	Not Covered (NC)		\$20 ²	\$20 ²	>\$50 or 50% ³	>\$50 or 50% ³
90-day Mail Supply⁴						
Generic	\$1	\$10	\$10	\$10	\$5	\$12.50
Brand	\$15	\$30	\$30 ²	\$30 ²	\$37.50	\$37.50
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 Only "Maintenance drugs" in Kaiser						

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Part-time & Retiree Medical Plans Comparison [Discontinues Jan. 1, 2010]

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents or applicable federal or state law or rule.

	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
Indiv. 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								
Vision	Exam only	Not Covered						
Hearing aids	10%	10%	10%, Rx & Aid only thru HMO		10%	10%	10%	10%
Diabetic supplies, insulin	Covered as durable medical equipment & prescription drugs				\$0	\$0	\$0	\$0
Durable medical equipment	50%	50%	Access thru Kaiser HMO		50%	50%	20%	50%

State of Oregon
Public Employees' Benefit Board Summary Plan Description

	Kaiser	Kaiser Added Choice			Providence Choice		Regence BCBSO	
Provider Type	HMO	HMO	Network	OON*	Network	OON*	Network	OON*
Alternative Care	Not Covered				50%		50%	
Physical Therapy	\$30	\$30	30%	50%	\$30	50%	20%	50%
* OON = Out of Network								
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								

Part-time & Retiree Plans Prescription Drug Comparison [Discontinues Jan. 1, 2010]

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents or applicable federal or state law or rule.

Coverage	Kaiser	Kaiser Added Choice			Providence	Regence
		HMO	Network	OON		
Retail supply	30-day	30-day	30-day	30-day	30-day	34-day
Pharmacies	Kaiser Only	Kaiser Only	MedImpact ¹	MedImpact ¹	Participating	Any
Generic	\$10	\$10	\$30	\$30	\$10	\$10
Brand	\$25	\$25	\$30 ²	\$30 ²	\$25	\$25
Non Formulary	Not Covered (NC)		\$20 ²	\$20 ²	>\$50 or 50% ³	>\$50 or 50% ³
90-day Mail Supply⁴						
Generic	\$1	\$20	\$20	\$20	\$25	\$37.50
Brand	\$50	\$50	\$50 ²	\$50 ²	\$62.50	\$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 Only "maintenance drugs" in Kaiser						