

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

	<b>PPO</b>	<b>OTHER PROVIDERS</b>
<b>Infertility Services</b>	<b>You Pay</b>	<b>You Pay</b>
	50% for diagnosis; treatment not covered	50% for diagnosis; treatment not covered
<b>Skilled Nursing Facility Care</b>	<b>You Pay</b>	<b>You Pay</b>
	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.

	<b>IN-NETWORK</b>
<b>Annual Out-Of-Pocket Maximum</b>	
For one Member	\$2,000 per Calendar Year
For an entire Family Unit	\$6,000 per Calendar Year
<b>Annual Deductible</b>	
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
<b>Lifetime Maximum</b>	<b>None</b>
<b>Outpatient Care</b>	<b>You Pay</b>
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

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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
<b>Hospital Inpatient Care</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	20% after deductible
<b>Outpatient prescription drugs, supplies, and supplements</b>	<b>You Pay</b>
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.
<b>Ambulance Services per transport</b>	<b>You Pay</b>
	20% coinsurance
<b>Durable Medical Equipment</b>	<b>You Pay</b>
	50% coinsurance
<b>Mental Health Services</b>	<b>You Pay</b>
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
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Outpatient Services	\$30
Inpatient Hospital Services	20% after deductible
Residential or day treatment Services Limited to 45 days per Calendar Year	20% after deductible
<b>Home Health Services</b>	<b>You Pay</b>
Benefit Maximum – up to 130 visits per Calendar Year for part-time or intermittent home services.	20% after deductible
<b>Infertility Services</b>	<b>You Pay</b>
	50% after deductible for diagnosis and treatment
<b>Skilled Nursing Facility Care</b>	<b>You Pay</b>
	20% after deductible for up to 100 days per year

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<b>Hospice Care</b>	<b>You Pay</b>
	No charge
<b>Hearing Aids</b>	<b>You Pay</b>
	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.

	<b>PPO</b>	<b>OTHER PROVIDERS</b>
<b>Annual Out-Of-Pocket Maximum</b>		
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
<b>Annual Deductible</b>		
(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
<b>Lifetime Maximum</b>	<b>\$2,000,000</b>	<b>\$2,000,000</b>
<b>Outpatient Care</b>	<b>You Pay</b>	<b>You Pay</b>
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%
<b>Hospital Inpatient Care</b>	<b>You Pay</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	30%	50%
	<b>PPO</b>	<b>OTHER PROVIDERS</b>
<b>Outpatient prescription drugs, supplies, and supplements</b>	<b>You Pay</b>	<b>You Pay</b>
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.
<b>Ambulance Services per transport</b>	<b>You Pay</b>	<b>You Pay</b>
	See "Other Providers"	50%
<b>Durable Medical Equipment</b>	<b>You Pay</b>	<b>You Pay</b>
	In-network benefit applies: 50% coinsurance; available only through in-network providers.	
<b>Mental Health Services</b>	<b>You Pay</b>	<b>You Pay</b>
	30%	50%
<b>Chemical Dependency Services</b>	<b>You Pay</b>	<b>You Pay</b>
	30%	50%
<b>Home Health Services</b>	<b>You Pay</b>	<b>You Pay</b>
	30%	50%
<b>Infertility Services</b>	<b>You Pay</b>	<b>You Pay</b>
	50% for diagnosis; treatment not covered	50% for diagnosis; treatment not covered

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<b>Skilled Nursing Facility Care</b>	<b>You Pay</b>	<b>You Pay</b>
	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.

<b>Routine Vision Services</b>	<b>VSP Provider<sup>1</sup></b>	<b>Non-VSP Providers<sup>2</sup></b>
Provided once each calendar year	<b>You Pay</b>	
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

<sup>1</sup> VSP guarantees services from VSP doctors only. VSP Providers also offer discounts.

<sup>2</sup> 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.

<b>2010 Employee Medical Plan Monthly Premium Rates</b>				
	<b>Employee</b>	<b>Employee &amp; Spouse/Partner</b>	<b>Employee &amp; Children</b>	<b>Employee &amp; Family</b>
<b>PEBB's Statewide Plan<sup>1</sup></b>	\$892.19	\$1,195.39	\$1,025.95	\$1,222.17
<b>Kaiser Permanente<sup>2</sup></b>	835.16	1,119.11	960.45	1,144.17
<b>Providence Choice<sup>1</sup></b>	771.69	1,034.03	887.45	1,057.20
<b>PEBB's Statewide Plan: Part-time<sup>3</sup></b>	710.42	951.87	816.94	973.21
<b>Kaiser Permanente: Part-time<sup>4</sup></b>	707.01	947.39	813.05	968.60
<b>Providence Choice: Part-time<sup>3</sup></b>	611.04	818.78	702.71	837.12

<sup>1</sup> Routine vision services through VSP.

<sup>2</sup> Kaiser Permanente routine vision services.