

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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|--|--|
| Outpatient physical therapy (up to a total of 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  |
| <b>Skilled Nursing Facility Care</b>   | <b>You Pay</b>   |
| Up to 100 days per Calendar Year   | \$0  |
| <b>Vision Services (Eyeglasses and contact lenses)</b>   | <b>You Pay</b>   |
| Eye exams  | \$5  |
| Prescription eyeglasses and contact lenses (up to \$200 every 24 months)   | Charges in excess of \$200   |
| <b>Student Out-of-Area Coverage</b>  | <b>You Pay</b>   |
| Routine, continuing, and follow-up Services (up to \$1,200 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 70th 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. |

## 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.

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|--|---------|
| <b>Out-of-Pocket Maximum</b>   |         |
| For one Member   | \$1,500 |
| For an entire Family   | \$3,000 |
| <b>Deductible</b>  |         |
| For one Member   | None    |
| For an entire Family   | None    |
| Lifetime Maximum   | None    |
| <b>Outpatient Services</b>   |         |
| Routine preventive physical exam (includes adult and well child)   | \$0     |
| Primary care visit (includes OB/GYN visits, routine medical office visits, routine hearing exam appointments, Urgent Care visits, and diabetic outpatient self-management training and education, including medical nutrition therapy) | \$30    |

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| Specialty care visit (includes TMJ therapy and diabetic outpatient self-management training and education, including medical nutrition therapy) | \$30   |
| Scheduled prenatal care and first postpartum visit  | \$0  |
| Routine eye exam  | \$30   |
| All injections provided in the Nurse Treatment Area   | \$5  |
| Immunizations   | \$0  |
| Outpatient surgery visit  | \$30   |
| Breast, cervical, prostate, and colorectal cancer screenings  | \$0  |
| Emergency department visit  | \$100 plus any other charges that normally apply |
| <b>Inpatient Hospital Services</b>  | <b>You Pay</b>                                   |
| Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs   | \$500 per admission                              |
| <b>Ambulance Services</b>   | <b>You Pay</b>                                   |
| Per transport   | \$75   |
| <b>Chemical Dependency Services</b>   | <b>You Pay</b>                                   |
| 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                                     |
| <b>Dialysis Services</b>  | <b>You Pay</b>                                   |
| Outpatient dialysis   | \$0  |
| Home dialysis   | \$0  |
| Inpatient hospital  | \$0  |
| Skilled nursing facility (up to 100 days per Calendar Year)   | \$0  |
| <b>Hearing Aids</b>   | <b>You Pay</b>                                   |
| Hearing exams   | \$30   |
| Hearing aids (up to \$4,000 every four years)   | 10%  |
| <b>Home Health Services</b>   | <b>You Pay</b>                                   |
|   | \$0  |
| <b>Hospice Services</b>   | <b>You Pay</b>                                   |
|   | \$0  |
| <b>Infertility Services</b>   | <b>You Pay</b>                                   |
| Diagnosis, treatment, and artificial insemination   | 50%  |
| <b>Mental Health Services</b>   | <b>You Pay</b>                                   |
| Outpatient and intensive outpatient Services  |  |
| Outpatient Services   | \$30   |
| Intensive outpatient Services   | \$30 per day                                     |
| Inpatient Hospital Services   | \$500 per admission                              |
| Residential Services (up to 45 days per Calendar Year)  | \$50 per day up to \$250 maximum per admission   |

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| <b>Outpatient Durable Medical Equipment</b>  | <b>You Pay</b>                                  |
|  | 50%   |
| <b>Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures</b>  | <b>You Pay</b>                                  |
|  | \$10  |
| <b>Outpatient Prescription Drugs, Supplies, and Supplements</b>  | <b>You Pay</b>                                  |
| 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   |
| Diabetic supplies and insulin  | \$0   |
| <b>Rehabilitative Therapy</b>  | <b>You Pay</b>                                  |
| Chemotherapy/radiation therapy   | \$30  |
| Outpatient occupational therapy (up to 20 visits per Calendar Year)  | \$30  |
| Outpatient physical therapy (up to a total of 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 maximum per admission |
| Outpatient multidisciplinary rehabilitation  | \$30  |
| <b>Skilled Nursing Facility Care</b>   | <b>You Pay</b>                                  |
| Up to 100 days per Calendar Year   | \$0   |

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| Student Out-of-Area Coverage  | You Pay  |
|---|--|
| Routine, continuing, and follow-up Services (up to \$1,200 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 70th 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. |

**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
- 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 and Regence BCBSO plans.