

## **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.

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

## 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.

<b>Out-of-Pocket Maximum</b>	
For one Member	\$600
For an entire Family	\$1,200
<b>Deductible</b>	
For one Member	None
For an entire Family	None
<b>Lifetime Maximum</b>	None
<b>Outpatient Services</b>	<b>You Pay</b>
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
<b>Inpatient Hospital Services</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$50 per day, up to \$250 maximum per admission
<b>Ambulance Services</b>	<b>You Pay</b>
Per transport	\$75
<b>Chemical Dependency Services</b>	<b>You Pay</b>
Outpatient Services	\$5

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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
<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	\$5
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	\$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
<b>Outpatient Durable Medical Equipment</b>	<b>You Pay</b>
	\$0
<b>Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures</b>	<b>You Pay</b>
	\$0
<b>Outpatient Prescription Drugs, Supplies, and Supplements</b>	<b>You Pay</b>
No charge for diabetic supplies, insulin , and smoking cessation drugs when used in conjunction with an approved smoking cessation program	<b>\$0</b>

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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
<b>Rehabilitative Therapy</b>	<b>You Pay</b>
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
<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>
Prescription eyeglasses and contact lenses (up to \$200 every 24 months)	Charges in excess of \$200

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

<b>Student Out-of-area Coverage</b>	
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 <sup>th</sup> 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.

<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
<b>Lifetime Maximum</b>	None
<b>Outpatient Services</b>	<b>You Pay</b>
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

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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
<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 exam	\$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	\$50 per day up to \$250 maximum per admission
<b>Outpatient Durable Medical Equipment</b>	<b>You Pay</b>

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

	50%
	20% for diabetic supplies
<b>Outpatient Laboratory, X-ray, Imaging, and Special Diagnostic Procedures</b>	<b>You Pay</b>
	\$10
	\$0 for preventative
<b>Outpatient Prescription Drugs, Supplies, and Supplements</b>	<b>You Pay</b>
No charge smoking cessation drugs when used in conjunction with an approved smoking cessation program	<b>\$0</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
<b>Rehabilitative Therapy</b>	<b>You Pay</b>
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

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

	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
<b>Student Out-of-area Coverage</b>	
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 <sup>th</sup> 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><b>Questions? Call Membership Services (M-F, 8am – 6pm)</b>  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>	

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

## 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.

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

## 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
<b>Preventive Health Services</b>		
• 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%
<b>Women's Health Care Services (direct access, no referral required)</b>		
• Annual calendar year gynecological exams, Pap tests	\$0	30%
• Follow-up visits after annual gynecological exam	\$5/visit	30%
• Mammograms	\$0	30%
<b>Physician / Provider Services</b>		
• 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%
<b>Hospital and Inpatient Services, including</b>	\$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
<b>Maternity Services</b>		
• 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%

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

• Hospital service related to routine newborn nursery care	\$50/day, maximum of \$250/admission	30%
• Infertility services	50%	50%
<b>Medical Supplies</b> , including <i>Durable Medical Equipment</i> , appliances and prosthetic devices	15%	30%
<b>Diabetes Supplies</b>	\$0	\$0
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<b>Emergent/Urgent &amp; Ambulance Services</b> (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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<b>Other Covered Services</b>		
• 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%
<b>Mental Health / Chemical Dependency Services</b>		
• 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%

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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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.

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

## 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.**

<b>BENEFITS</b>	You Pay: IN-PLAN	You Pay: OUT-OF- PLAN
<b>Preventive Health Services</b>		
• 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%
<b>Women's Health Care Services (direct access, no referral required)</b>		
• Annual calendar year gynecological exams, Pap tests	\$0/visit	50%
• Follow-up visits after annual gynecological exam	\$30/visit	50%
• Mammograms	\$0	50%
<b>Physician / Provider Services</b>		
• 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%
<b>Hospital and Inpatient Services, including</b>	\$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
<b>Maternity Services</b>		
• Pre-natal visits, delivery and post-natal visits	\$0	50%

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

• <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%
<b>Medical Supplies</b> , including <i>Durable Medical Equipment</i> , appliances, and prosthetic devices	50%	50%
<b>Diabetes Supplies</b>	\$0	\$0
<b>Emergent/Urgent &amp; Ambulance Services</b> (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
<b>Other Covered Services</b>		
• 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%
<b>Mental Health / Chemical Dependency Services</b>		
• Outpatient <i>Services</i>	\$30/visit	50%
• Inpatient <i>Hospital Services</i> and Residential/Day <i>Services</i>	\$500/admission	50%

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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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](http://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	<b>\$1,000</b> per person
Annual In-Plan Out-of-Pocket Maximum per family (3 or more)	<b>\$3,000</b> per family (3 or more)
Annual Out-of-Plan Out-of-Pocket Maximum per person	<b>\$2,000</b> per person
Annual Out-of-Plan Out-of-Pocket Maximum per family (3 or more)	<b>\$6,000</b> per family (3 or more)
Lifetime Maximum Benefit	<b>\$2,000,000</b>

### PEBB Statewide Plan Benefit Highlights

**You pay the following for covered services:**

	<b>In-Plan Cost</b> (for participating provider)	<b>Out-of-Plan Cost</b> (for non-participating provider)
<b>Physician / Provider Services</b>		
• 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
<b>Women's Health Services</b>		
• 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%
<b>Hospital Services</b>		
• 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
<b>Maternity</b>		
• Prenatal and postnatal visits, delivery	15%	30%
• Routine newborn nursery care	15%	30%
<b>Medical Supplies and Equipment</b>		
• Durable medical equipment and supplies	15%	30%
• Diabetic supplies	Covered in full	Covered in full

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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 <sup>®</sup> smoking cessation program	Covered in full	Covered in full
• Weight Watchers <sup>®</sup> 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](http://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](http://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](http://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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Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:

[www.providence.org/php/contactus](http://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](http://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](http://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](http://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.

	<b>Copay or Coinsurance</b>		
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	<b>\$0</b>	<b>\$0</b>	<b>Does not apply</b>
Generic drug	<b>\$5</b>	<b>\$12.50</b>	<b>\$5</b>
Formulary brand-name drug	<b>\$15</b>	<b>\$37.50</b>	<b>\$15</b>
Non-formulary brand-name drug	<b>Greater of \$50 or 50% plus the difference in cost</b>	<b>Greater of \$125 or 50% plus the difference in cost</b>	<b>Greater of \$50 or 50% plus the difference in cost</b>
Compounded drug	<b>Greater of \$50 or 50%</b>	<b>Does not apply</b>	<b>Does not apply</b>

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

### **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](http://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.

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

- 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](http://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](http://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](http://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.

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

- 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<sup>®</sup>. 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<sup>®</sup> (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](http://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](http://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.

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### Contact us

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State of Oregon  
Public Employees' Benefit Board Summary Plan Description

## 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](http://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	<b>\$2,000</b> per person
Annual In-Plan Out-of-Pocket Maximum per family (3 or more)	<b>\$6,000</b> per family (3 or more)
Annual Out-of-Plan Out-of-Pocket Maximum per person	<b>\$4,000</b> per person
Annual Out-of-Plan Out-of-Pocket Maximum per family (3 or more)	<b>\$12,000</b> per family (3 or more)
Lifetime Maximum Benefit	<b>\$2,000,000</b>

### 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)
<b>Physician / Provider Services</b>		
• 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
<b>Women's Health Services</b>		
• 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%
<b>Hospital Services</b>		
• 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
<b>Maternity</b>		
• Prenatal and postnatal visits, delivery	20%	50%
• Routine newborn nursery care	20%	50%

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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

	<b>Copay or Coinsurance</b>		
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	<b>\$0</b>	<b>\$0</b>	<b>Does not apply</b>
Generic drug	<b>\$10</b>	<b>\$25</b>	<b>\$10</b>
Formulary brand-name drug	<b>20%</b>	<b>\$62.50</b>	<b>20%</b>
Non-formulary brand-name drug	<b>Greater of \$50 or 50% plus the difference in cost</b>	<b>\$125 plus the difference in cost</b>	<b>50% plus the difference in cost</b>
Compounded drug	<b>Greater of \$50 or 50%</b>	<b>Does not apply</b>	<b>Does not apply</b>

## **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](http://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.

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

- 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](http://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](http://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](http://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.

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

- 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](http://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](http://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](http://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]*

<b>Type of care or supplies*</b>	<b>Preferred provider coverage (amount you pay based on eligible charges)</b>	<b>Nonpreferred provider coverage (amount you pay based on eligible charges)</b>
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)**

<b>Type of care or supplies*</b>	<b>Preferred provider coverage (amount you pay based on eligible charges)</b>	<b>Nonpreferred provider coverage (amount you pay based on eligible charges)</b>
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)**

<b>Type of care or supplies*</b>	<b>Preferred provider coverage (amount you pay based on eligible charges)</b>	<b>Nonpreferred provider coverage (amount you pay based on eligible charges)</b>
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="vertical-align: top;"><u>Pharmacy</u> (34-day supply)</td> <td style="vertical-align: top;">\$5 generic \$15 preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multisource brands)</td> </tr> <tr> <td style="vertical-align: top;"><u>Mail Order</u> (90-day supply)</td> <td style="vertical-align: top;">\$12.50 generic \$37.50 preferred Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)</td> </tr> </table>	<u>Pharmacy</u> (34-day supply)	\$5 generic \$15 preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multisource brands)	<u>Mail Order</u> (90-day supply)	\$12.50 generic \$37.50 preferred Greater of \$125 or 50% nonpreferred (plus difference between generic and brand for multisource brands)
<u>Pharmacy</u> (34-day supply)	\$5 generic \$15 preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multisource brands)				
<u>Mail Order</u> (90-day supply)	\$12.50 generic \$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:

<b>Type of care or supplies*</b>	<b>Preferred Provider Coverage</b> (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	<b>Nonpreferred Provider Coverage</b> (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)

<b>Type of care or supplies*</b>	<b>Preferred Provider Coverage</b> (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	<b>Nonpreferred Provider Coverage</b> (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)

<b>Type of care or supplies*</b>	<b>Preferred Provider Coverage</b> (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	<b>Nonpreferred Provider Coverage</b> (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)***

<b>Type of care or supplies*</b>	<b>Preferred Provider Coverage</b> (You pay 50% of first \$1,000 then amount shown below, based on eligible charges):	<b>Nonpreferred Provider Coverage</b> (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
<b>Annual Out-Of-Pocket Maximum</b>	
For one Member	\$600
For an entire Family Unit	\$1,200
<b>Annual Deductible</b> This plan does not have an annual deductible	
For one Member	None
For an entire Family Unit	None
<b>Lifetime Maximum</b>	
<b>None</b>	
<b>Outpatient Care</b>	
<b>You Pay</b>	
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

	<b>IN-NETWORK</b>
<b>Hospital Inpatient Care</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	\$100 per day up to \$500 maximum per year
<b>Outpatient prescription drugs, supplies, and supplements</b>	<b>You Pay</b>
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.
<b>Ambulance Services per transport</b>	<b>You Pay</b>
	\$75 per transport
<b>Durable Medical Equipment</b>	<b>You Pay</b>
	No charge
<b>Mental Health Services</b>	<b>You Pay</b>
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
<b>Chemical Dependency Services</b>	<b>You Pay</b>
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
<b>Home Health Services</b>	<b>You Pay</b>
	No charge
<b>Infertility Services</b>	<b>You Pay</b>
	50% for diagnosis and treatment
<b>Skilled Nursing Facility Care</b>	<b>You Pay</b>
	No charge for up to 100 days per year
<b>Hospice Care</b>	<b>You Pay</b>
	No charge
<b>Alternative Care</b>	<b>You Pay</b>
	\$15 per chiropractor, acupuncture, or naturopath visit. \$1,000 benefit maximum per year
<b>Hearing Aids</b>	<b>You Pay</b>

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

	<b>IN-NETWORK</b>
	10% up to a maximum of \$4,000 every four years
<b>Vision hardware</b>	<b>You Pay</b>
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.

	<b>PPO</b>	<b>OTHER PROVIDERS</b>
<b>Annual Out-Of-Pocket Maximum</b>		
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
<b>Annual Deductible</b>		
This plan does not have an annual Deductible		
Individual Deductible	None	None
Family Deductible	None	None
<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)	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

	<b>PPO</b>	<b>OTHER PROVIDERS</b>
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%
<b>Hospital Inpatient Care</b>	<b>You Pay</b>	<b>You Pay</b>
Room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs	15%	30%
<b>Outpatient prescription drugs, supplies, and supplements</b>	<b>You Pay</b>	<b>You Pay</b>
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.
<b>Ambulance Services per transport</b>	<b>You Pay</b>	<b>You Pay</b>
	See "Other Providers"	30%
<b>Durable Medical Equipment</b>	<b>You Pay</b>	<b>You Pay</b>
	In-network benefit applies: 0% coinsurance (No charge); available only through in-network providers.	
<b>Mental Health Services</b>	<b>You Pay</b>	<b>You Pay</b>
	15%	30%
<b>Chemical Dependency Services</b>	<b>You Pay</b>	<b>You Pay</b>
	15%	30%
<b>Home Health Services</b>	<b>You Pay</b>	<b>You Pay</b>
	15%	30%

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

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
<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

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

<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%

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

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

State of Oregon  
Public Employees' Benefit Board Summary Plan Description

<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.