

## PEBB Statewide Plan Part-time & Retiree

### 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%

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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
*Does not apply to out-of-pocket maximum		
<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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### **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).

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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.

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- Our formulary can help you and your physician choose less costly effective medications to minimize your out-of-pocket expense.
- Effective generic drug choices are available to treat most medical conditions. Visit [www.providence.org/healthplans](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.

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

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

### Brand-name drug

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

### Coinsurance

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

### Compounded drug

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

### Copay

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

### Formulary

A Formulary is a list of FDA-approved prescription drugs developed by physicians and pharmacists, designed to offer drug treatment choices for covered medical conditions. The Providence Health Plan Formulary includes both brand name and generic medications.

### Generic drug

Generic drugs have the same active-ingredient formula as the brand name drug and are tested by the FDA to be as safe and effective as brand-name drugs. Generic drugs are only available after the brand name patent expires. Visit [www.providence.org/healthplans](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)