

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

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

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PRESCRIPTION DRUG SUMMARY OF BENEFITS

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

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

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

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

Important Notes:

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