

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%

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• <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%

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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.