

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:

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):
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.

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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%

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** 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.

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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):
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***	0%**	50%
Diagnostic x-ray and laboratory tests (not including Pap smears and mammograms)	20%	50%
Breast, cervical, prostate, and colorectal cancer screenings	0%**	50%

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** 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.

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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):
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%

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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):
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.

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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="width: 15%;"><u>Pharmacy</u></td> <td>\$10 generic</td> </tr> <tr> <td>(34-day supply)</td> <td>20% preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multi-source brands)</td> </tr> <tr> <td><u>Mail Order</u></td> <td>\$25 generic</td> </tr> <tr> <td>(90-day supply)</td> <td>\$62.50 preferred \$125 nonpreferred (plus difference between generic and brand for multi-source brands)</td> </tr> </table>	<u>Pharmacy</u>	\$10 generic	(34-day supply)	20% preferred Greater of \$50 or 50% nonpreferred (plus difference between generic and brand for multi-source brands)	<u>Mail Order</u>	\$25 generic	(90-day supply)	\$62.50 preferred \$125 nonpreferred (plus difference between generic and brand for multi-source brands)
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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.