Providence Choice

http://Providence healthplan.com/PEBB

Service Area: Baker, Benton, Clackamas, Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Grant, Harney, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Morrow, Multnomah, Polk, Tillamook, Umatilla, Union, Wallowa, Wasco, Wheeler, Yamhill; Clark and Walla Walla, WA; Payette, ID

	Full-time		Part-time	
Providers	**In Medical home[1]**	**Out of medical home[1]**	**In Medical home[1]**	**Out of medical home[1]**
Standard deductible[2]	$250/individual $750/ family, 4 visits not subject	$500/individual $1500/ family	$500/individual $1500/ family, 4 visits not subject	$1000/individual $3000/ family
Additional non-HEM participant deductible[3]	$100/individual, $300/family applies to all services unless otherwise noted			
Out-of-pocket max (some deductibles, copays, services don't apply)	$1500/individual, $4500/family	$4000/individual, $12,000/family	$2500/individual, $7500/family	$6000/individual, $18,000/family
Primary care visit	$10, first 4 visits deductible waived	30%	$40, first 4 visits deductible waived	50%
Chronic care visit[5]	$0, deductible waived	30%	$0, deductible waived	50%
Specialty visit	$10, with referral	30%	$40, with referral	50%
Outpatient mental health care	$10, deductible waived	30%	$40, deductible waived	50%
Substance abuse treatment	$0, deductible waived	30%	$0, deductible waived	50%
Maternity, & childbirth services provider	$0, deductible waived	30%	$0, deductible waived	50%
Delivery	Inpatient delivery subject to inpatient hospital charges			
Preventive	$0, deductible waived	30%	$0, deductible waived	50%
Lab & x-ray	$0, deductible waived	30%	20%, deductible applies	50%
Inpatient hospital per admission	$50/day to $250 max	$500 + 40%	$500	$500 + 50%
Outpatient surgery in a hospital setting	$50/day to $250 max	$100 + 40%		
Urgent care	$25	$25	$40	$40
Emergency department[6]	$100	$100	$100	$100
Durable medical equip.	15%	30%	20%	50%
Insulin, diabetic supplies	$0, deductible waived			
Additional Cost Tier $100 copay[7]	$100	$100 + 30%	$100	$100 + 50%
Additional Cost Tier $500 copay[9]	$500	$500 + 30%	$500	$500 + 50%
Alternative care provider visits	$10	30%	$40	50%
Spinal manipulation, acupuncture services[13]	$10/visit, up to $1000/yr max combined. Not applied to out-of-pocket max.	30%, up to $1000/yr max combined. Not applied to out-of-pocket max.	$40/visit, up to $1000/yr max combined. Not applied to out-of-pocket max	50% up to $1000/yr max combined. Not applied to out-of-pocket max.

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	Full-time		Part-time	
Prescription drugs	• $50/individual, $150/ family deductible[10] • $1000 out-of-pocket maximum[11] • $0 Value, not subject to deductible[12] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country. • In-network deductible, out-ofpocket maximum apply. • Reimbursed as if filled in-network; member pays difference between in-network rate and billed amount.	• $50/individual, $150/ family deductible[10] • $1000 out-of- pocket maximum[11] • $0 Value, not subject to deductible[12] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country. • In-network deductible, out-ofpocket maximum apply. • Reimbursed as if filled in-network; member pays difference between in-network rate and billed amount.

This is a summary only. See the plan documents for details. In the case of a discrepancy, the plan document will apply. See footnotes, page 10.

Medical plans footnotes

1 *To receive In-Medical Home benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or from providers referred by their medical home. Otherwise, benefits typically have higher costs or may not be covered. See the list of medical homes on the plan's website.*

2 *All medical plans have a standard plan deductible (except Kaiser HMO). This is the amount a member must pay for covered services before the plan begins to pay its share for medically necessary covered services. Deductibles apply per individual, or the family deductible will apply when there are three or more individuals within a family, based on the employee's choice of coverage tier. Payments toward the deductible accumulate separately for services in-network and out-of-network, and In- Medical Home and Out-of-Medical Home (see 1 above). Certain in-network services are not subject to the deductible. Examples: first four visits per individual to a primary care provider; insulin and diabetic supplies; visits for care of asthma, diabetes, cardiovascular disease or congestive heart failure; and preventive services. On the Kaiser deductible plans, the deductible is waived on additional services; please see the benefit summary for additional details.*

3 *See Health Engagement Model (HEM), page 14.*

4 *PEBB Statewide plan members whose in-network provider has been recognized by the Oregon Health Authority as a Patient- Centered Primary Care Home will have the lower coinsurance.*

5 *These are visits for care of asthma, diabetes, cardiovascular disease and congestive heart failure. Not subject to deductible in-network.*

6 *Copay amounts for use of a hospital emergency department are waived if the member is admitted directly to the hospital for inpatient treatment. This does not include admittance for observation. Copay does not apply to out-of-pocket maximum except in Kaiser plans. In-plan deductible applies.*

7 *These procedures are MRI, CT, PET and SPECT scans; sleep studies; spinal injections; upper endoscopy; bunionectomy; surgery for hammertoe and Morton's neuroma; and knee viscosupplementation. Copay does not apply to out-of-pocket maximum. Not applied to cancer-related procedures. These procedures may be overused compared with their risks and benefits.*

8 *Applies only to MRI, CT, PET and SPECT scans, and sleep studies in Kaiser plans. Additional copay applies to out of pocket maximum.*

9 *These are surgical procedures for hip or knee replacement or resurfacing; knee or shoulder arthroscopy; bariatric surgery; spine procedures; and sinus surgery. Copay does not apply to out-of- pocket maximum. Not applied to cancer-related procedures. These procedures may have alternatives that provide equal or better outcomes with lower risks and costs.*

10 *The prescription drug deductible is $50 per person or $150 for families with three or more members. It applies separately from the medical deductible.*

11 *The prescription drug out-of-pocket maximum is $1,000 per person, with a family maximum of $3,000. It accrues separately from the medical out-of-pocket maximum.*

12 *All plans have formularies that list covered drugs. Value drugs typically are generic drugs that are used in treating most common chronic conditions. (EHB stands for Essential Health Benefits.)*

13 *Limited to $1,000/year (combined in Kaiser plans). Limited to 60 visits/year in PEBB Statewide plan max. Copays and coinsurance do not apply to out-of-pocket maximum.*