

Your Benefit Summary

PEBB Statewide Plan

Full-Time Employees



What You Pay In-Plan	What You Pay Out-of-Plan	Annual In-Plan Out-of-Pocket Maximum	Annual Out-of-Plan Out-of-Pocket Maximum	Lifetime Maximum Benefit
15% coinsurance	30% coinsurance (UCR applies)	\$1,000 per person \$3,000 per family (3 or more)	\$2,000 per person \$6,000 per family (3 or more)	\$2,000,000

Important information about your plan

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, register for myProvidence at 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.

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)
Physician / Provider Services <ul style="list-style-type: none"> • Office visits and procedures • Periodic health exams, well-baby care (Covered according to plan schedule; includes related lab and X-ray.) • Routine immunizations, shots • Colorectal cancer screenings • Prostate cancer screenings • Allergy shots, serums, injectable medications • Inpatient hospital visits • Surgery, anesthesia • E-visits to a participating provider 	15% Covered in full Covered in full Covered in full 15% 15% 15% Covered in full	30% 30% Covered in full 30% 30% 30% 30% 30% Not covered
Women's Health Services <ul style="list-style-type: none"> • Annual gynecological exams (calendar year), Pap tests • Follow-up visits after annual gynecological exam • Mammogram screening (according to schedule) 	Covered in full 15% Covered in full	30% 30% 30%
Hospital Services <ul style="list-style-type: none"> • Inpatient care, observation, maternity care • Rehabilitative care (30 days per calendar year; 60 days head/spinal cord injuries) • Skilled nursing facility (180 days per calendar year) • Bariatric surgery 	15% 15% 15% 15%	30% 30% 30% Not covered
Maternity <ul style="list-style-type: none"> • Prenatal and postnatal visits, delivery • Routine newborn nursery care 	15% 15%	30% 30%
Medical Supplies and Equipment <ul style="list-style-type: none"> • Durable medical equipment and supplies • Diabetic supplies 	15% Covered in full	30% Covered in full
Emergency / Urgent Care / Ambulance Services <ul style="list-style-type: none"> • Emergency services (emergency medical conditions only) • Urgent care services (non life-threatening illness/minor injury) • Ambulance services (emergency transportation only) 	15% 15% 15%	15% 30% 15%

PEBB Statewide Plan Benefit Highlights (continued)	In-Plan Cost	Out-of-Plan Cost
Other Covered Services		
• X-ray, lab services	15%	30%
• Imaging services (PET, CT, MRI)	15%	30%
• Outpatient rehabilitative services (60 visits per calendar year)	15%	30%
• Outpatient surgery, dialysis, infusion, chemotherapy, radiation therapy	15%	30%
• Temporomandibular joint (TMJ) services	15%	30%
• Home health care (180 visits per calendar year)	15%	30%
• Hospice care	Covered in full	Covered in full
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy.)		
-Generic drugs	\$10	N/A
-Formulary brand-name drugs	\$50	N/A
-Non-formulary brand-name drugs	\$100	N/A
• Chiropractic, naturopathic, acupuncture*	30%	30%
• Infertility*	50%	50%
• Hearing aids* (Up to \$4,000 every four calendar years.)	10%	10%
• Hearing exam*	15%	30%
• Free & Clear® smoking cessation program	Covered in full	Covered in full
• Weight Watchers® program (Employees only; up to four programs per calendar year.)	Covered in full	Covered in full
<i>*Does not apply to out-of-pocket maximum</i>		
Mental Health / Chemical Dependency		
(To initiate services, you must call 1-800-711-4577. All inpatient, residential, and day or partial hospitalization treatment services must be prior authorized.)		
• Outpatient services	15%	30%
• Inpatient hospital services and residential/day services (Residential services limited to 180 days per calendar year.)	15%	30%

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 the online directory at 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.

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.

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.

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.