Your Benefit Summary

for PEBB Statewide +100 Plan members

Administered by Providence Health Plan

What You Pay In-Network	What You Pay Out-of-Network	Calendar Year In-Network Out-of-Pocket Maximum (after deductible)	Calendar Year Out-of-Network Out-of-Pocket Maximum (after deductible)	Calendar Year In-Network Deductible	Calendar Year Out-of-Network Deductible	Calendar Year In-Network Maximum Cost Share
Covered in full / 15% (after deductible)	**30%** coinsurance (after deductible; UCR applies)	**$1,900** per person **$5,700** per family (3 or more)	**$4,800** per person **$14,400** per family (3 or more)	**$350** per person **$1,050** per family (3 or more)	**$600** per person **$1,800** per family (3 or more)	**$6,850** per person **$13,700** per family (2 or more)

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.ProvidenceHealthPlan.com/pebb.**
- Not sure what a word or phrase means? See the last page of this summary for definitions.
- Your deductibles, some services and penalties do not apply to out-of-pocket maximums.
- Benefits for out-of-network services are based on Usual, Customary & Reasonable charges (UCR).
- Limitations and exclusions apply to your benefits. See your Member Handbook for details.

Benefit Highlights

✓ No deductible needs to be met prior to receiving this benefit.

After you pay your calendar year deductible, then you pay the following for covered services:

	In-Plan Copay or Coinsurance (when you use a participating provider)	**Out-of-Plan Copay or Coinsurance** (when you use a non-participating provider)
Preventive Health and Wellness Services		
• Periodic health exams; well-baby care (from a Primary Care Provider only)	Covered in full✓	30%
• Routine immunizations/shots	Covered in full✓	30%
• Hearing screenings	Covered in full✓	30%
• Colorectal cancer screening: sigmoidoscopy, colonoscopy	Covered in full✓	30%
• Prostate screening exam (calendar year)	Covered in full✓	30%
• Nutritional counseling	Covered in full✓	30%
Physician / Provider Services		
• Office visits to Primary Care Provider (deductible waived on first 4 visits in-network, per calendar year)	15%**	30%
• Office visits to specialist	15%	30%
• Office visits for chronic conditions (i.e., asthma, diabetes, heart conditions)	Covered in full✓	30%
• Office visits to Naturopaths, Chiropractors and Acupuncturists	15%○	30%○
• E-visits, telephone, video visits to a participating provider	Covered in full✓	Not covered
• Allergy shots, serums, infusions and injectable medications	15%	30%
• Surgery and anesthesia (in office)	15%	30%
• Maternity services: prenatal	Covered in full✓	30%
• Maternity services: delivery and postnatal	15%	30%
• Inpatient hospital visits (including surgery and anesthesia)	15%	30%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	30%
• Mammograms	Covered in full✓	30%
Mental Health / Chemical Dependency		
All in-network chemical dependency services listed below are covered in full.		
Services except outpatient provider office visits must be prior authorized.		
• Inpatient, residential services	15%	$500 then 30%*
• Day treatment, intensive outpatient and partial hospitalization services	15%✓	30%
• Applied behavior analysis	15%✓	30%
• Outpatient provider visits	15%✓	30%

*Copayment does not apply to out-of-pocket maximums.
○Coinsurance does not apply to out-of-pocket maximums.
**10% coinsurance at OHA certified Patient Centered Primary Care Homes

Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Hospital Services		
• Inpatient care	15%	$500 then 40%*
• Observation care	15%	$500 then 40%*
• Maternity care	15%	$500 then 40%*
• Routine newborn nursery care	15%	$500 then 40%*
• Rehabilitative care (30 days per calendar year; 60 days head or spinal cord injuries)	15%	$500 then 40%*
• Skilled nursing facility (180 days per calendar year)	15%	$500 then 30%*
• Bariatric surgery	15%	Not covered
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices		
• Durable medical equipment and supplies	15%	30%
• Diabetic supplies and insulin	Covered in full✓	Covered in full✓
Emergency / Urgent Care / Emergency Medical Transportation (In-network deductible applies)		
• Emergency services (for emergency medical conditions only. If admitted to hospital, copayment is not applied; all services subject to inpatient benefits.)	$150, then 15%*	$150, then 15%*
• Urgent care visits (for non-life threatening illness/minor injury)	15% / visit	15% / visit
• Emergency medical transportation	15% / trip	15% / trip
Other Covered Services		
• X-ray; lab services	15%	30%
• Imaging services (such as PET, CT, MRI) (copayments do not apply to services related to cancer diagnosis and treatment)	$100, then 15%*	$100 then 30%*
• Outpatient rehabilitative services (60 visits per calendar year. Limits do not apply to Mental Health or Substance Abuse services)	15%	30%
• Outpatient surgery	15%	$100 then 40%*
• Outpatient dialysis, infusion, chemotherapy, radiation therapy	15%	30%
• Cardiac rehabilitation	15%	30%
• Temporomandibular joint (TMJ) service	See handbook	Not covered
• Home health care (up to 180 visits per calendar year)	15%	30%
• Hospice care	Covered in full✓	Covered in full✓
• Hearing exam	15%○	30%○
• Hearing aids (one per ear every three calendar years; in-plan deductible applies)	10%	10%
• Sleep studies	$100, then 15%*	$100 then 30%*
• Chiropractic manipulation and acupuncture (up to 60 visits per calendar year)	15%○	30%○
• Massage therapy (Limited to $1,000 per calendar year)	15%○	30%○
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	$10✓	Not covered
-Formulary brand-name drugs	$50✓	Not covered
-Non-formulary brand-name drugs	$100✓	Not covered
Additional Cost Tier (Inpatient or Outpatient) (Additional cost tier does not apply to services related to cancer diagnosis and treatment. These copayments/coinsurance apply to provider services only. Other services are covered at the applicable benefit level stated in this summary.)		
• Hammertoe surgery	$100, then 15%*	$100 then 30%*
• Bunionectomy	$100, then 15%*	$100 then 30%*
• Morton's neuroma	$100, then 15%*	$100 then 30%*
• Spinal injections for pain	$100, then 15%*	$100 then 30%*
• Upper GI endoscopy	$100, then 15%*	$100 then 30%*
• Knee arthroscopy	$500, then 15%*	$500 then 30%*
• Knee, hip replacement	$500, then 15%*	$500 then 30%*
• Knee, hip resurfacing	$500, then 15%*	$500 then 30%*
• Shoulder arthroscopy	$500, then 15%*	$500 then 30%*
• Spine procedures	$500, then 15%*	$500 then 30%*
• Sinus surgery	$500, then 15%*	$500 then 30%*
• Bariatric surgery	$500, then 15%*	Not covered

*Copayment does not apply to out-of-pocket maximums.
○Coinsurance does not apply to out-of-pocket maximums.
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Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Fertility Services		
Infertility diagnosis not required.		
• Assistive reproductive technology (All services except prescription drugs. Limited to $25,000 per calendar year)	Covered in full✓	Covered in full✓
• Artificial insemination (Limited to 6 cycles per lifetime)	Covered in full✓	Covered in full✓

*Copayment does not apply to out-of-pocket maximums.
°Coinsurance does not apply to out-of-pocket maximums.
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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.

Copay
The fixed dollar amount you pay to a health care provider for a covered service at the time care is provided.

Deductible
The dollar amount that an individual or family pays for prescription drug covered services before the plan pays any prescription drug benefits within a calendar year. The deductible is waived for generic drugs. The prescription drug deductible can be met by using participating providers. The following expenses do not apply to an individual or family deductible:

- Differences in cost between a brand name and generic drug when you or your physician requests the brand name medication when a generic is available,
- Copays or coinsurance for any medical benefits or other supplemental benefits provided by your employer, such as routine vision care,
- Services not covered by your plan,

Deductible carryover
A feature of your plan that allows for any portion of your deductible that is paid during the fourth quarter of a calendar year to be applied toward the next year's deductible.

In-Network
Refers to services received from an extensive network of highly qualified physicians, health care providers and facilities contracted by Providence Health Plan for your specific plan. Generally, your out-of-pocket costs will be less when you receive covered services from in-network providers. balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

In-Network provider
A physician or provider of health care services who belongs to the Providence Health Plan in-network provider panel. To find an in-network provider, refer to the directory available at www.ProvidenceHealthPlan.com/providerdirectory.

Maximum Cost Share
Maximum Cost Share means the annual limit on cost sharing for Essential Health Benefits as established by the Patient Protection and Affordable Care Act (ACA). Deductibles, copayments and coinsurance paid by the member for Essential Health Benefit covered services received in-network apply to the Maximum Cost Share.

Out-of-Network
Refers to services you receive from providers not in your plan's network. Your out-of-pocket costs are generally higher when you receive covered services outside of your plan's network. An out-of-network provider does not have contracted rates with Providence Health Plan and so balance billing may apply. To find an in-network provider, go to www.ProvidenceHealthPlan.com/providerdirectory.

Out-of-Network provider
Any health care professional who does not participate within Providence Health Plan's in-network panel of physicians and providers of health care services.

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.

Patient-Centered Primary Care Home
A Patient-Centered Primary Care Home (PCPCH) is a health clinic that is recognized by the Oregon Health Authority for their commitment to patient-centered care.

Prior authorization
Some services must be pre-approved. In-network, your provider will request prior authorization. Out-of-network, you are responsible for obtaining prior authorization.

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 your plan's allowed charges for services that you receive from an out-of-network provider. When the cost of out-of-network 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.

Portland Metro Area: 503-574-7500
All other areas: 800-878-4445
TTY: 503-574-8702 or 888-244-6642

Have questions about your benefits and want to contact us via e-mail? Go to our Web site at:
www.ProvidenceHealthPlan.com/contactus

Non-discrimination Statement

Providence Health Plan and Providence Health Assurance comply with applicable Federal civil rights laws and do not discriminate on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex. Providence Health Plan and Providence Health Assurance do not exclude people or treat them differently because of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex.

Providence Health Plan and Providence Health Assurance:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, you can call us at 503-574-7500 or 1-800-878-4445 (TTY: 711).

If you believe that Providence Health Plan and Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, sexual orientation, religion, gender identity, marital status or sex, you can file a grievance with our Non-discrimination Coordinator by mail:

Providence Health Plan and Providence Health Assurance
Attn: Non-discrimination Coordinator
PO Box 4158
Portland, OR 97208-4158
Email: PHPAppealsandGrievances@providence.org

If you need help filing a grievance, call us at 503-574-7500 or 1-800-878-4445 (TTY:711) for assistance.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *https://ocrportal.hhs.gov/ocr/portal/lobby.jsf*, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue SW - Room 509F HHH Building
Washington, DC 20201
1-800-368-1019, 1-800-537-7697 (TTY)

Complaint forms are available at *http://www.hhs.gov/ocr/office/file/index.html*.

Members of Oregon Plans may file a complaint with the Division of Financial Regulation at 1-888-877-4894 or visit https://dfr.oregon.gov/Pages/index.aspx.

Language Access Information

ATTENTION: If you speak English, language assistance services, free of charge, are available to you. Call 1-800-878-4445 (TTY: 711).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-800-878-4445 (TTY: 711).

Russian: ВНИМАНИЕ: Если Вы говорите по-русски, то Вам доступны услуги бесплатной языковой поддержки. Звоните 1-800-878-4445 (телетайп: 711).

Vietnamese: CHÚ Ý: Nếu quý vị nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho quý vị. Xin gọi số 1-800-878-4445 (TTY: 711).

Traditional Chinese: 注意：如果您說中文，您可以免費獲得語言支援服務。請致電 1-800-878-4445 (TTY: 711)。

Kushite: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa 1-800-878-4445 (TTY: 711).

Farsi:

توجه: اگر به زبان فارسی صحبت می‌کنید، تسهیلات زبانی به صورت رایگان به شما ارائه می‌شود. با 1-800-878-4445 (TTY: 711) تماس بگیرید.

Ukrainian: УВАГА! Якщо Ви розмовляєте українською мовою, для Вас доступні безкоштовні послуги мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

Japanese: お知らせ: 日本語での通話をご希望の場合、言語支援サービスを無料でご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話ください。

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 1-800-878-4445 (TTY: 711) 번으로 전화해 주십시오

Nepali: ध्यान दिनुहोस्: तपाईंले नेपाली बोल्नुहुन्छ भने तपाईंले निम्न भाषा सहायता सेवाहरू निःशुल्क रूपमा उपलब्ध छन् । 1-800-878-4445 (TTY: 711) मा फोन गर्नुहोस् ।

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii gratuite de asistență lingvistică. Sunați 1-800-878-4445 (TTY: 711).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlose Sprachassistenzdienste zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

Hmong: LUS CEEB TOOM: Yog tias koj hais lus Hmoob, cov kev pab txhais lus, muaj kev pab dawb rau koj. Hu rau 1-800-878-4445 (TTY: 711).

Cambodian: កំណត់សម្គាល់៖ បើសិនជាអ្នកនិយាយភាសាខ្មែរ
អាចមានសេវាជំនួយផ្នែកភាសាដោយមិនគិតថ្លៃពីលោកអ្នក។ សូមហៅទូរស័ព្ទលេខ 1-800-878-4445 (TTY: 711)។

Laotian: ຊືນຊາບ: ຖ້າວ່າທ່ານເວົ້າພາສາລາວ, ຈະມີການຊ່ວຍເຫຼືອດ້ານພາສາ
ໂດຍບໍ່ເສຍຄ່າໃຫ້ທ່ານ. ໂທ 1-800-878-4445 (TTY: 711).