Your Benefit Summary

for PEBB Providence Choice +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 / $10 (after deductible)	30% coinsurance (after deductible; UCR applies)	$1,500 per person $4,500 per family (3 or more)	$4,000 per person $12,000 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 is a medical home plan. You choose a medical home clinic, staffed by a team of health care professionals led by your primary care provider. This team coordinates your care, including referrals when needed. You have higher out-of-pocket costs when you use services not coordinated through your medical home. You can enroll in this plan if you live or work (at least 50 percent of the time) in the plan's service area. Learn how to establish your medical home at www.ProvidenceHealthPlan.com/pebb.

- 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 of phrase means? See the last page of this summary for definitions.
- Your deductibles, some copayments and services, and penalties do not apply to your 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-Network Copay or Coinsurance (Medical Home provider or with referral)	Out-of-Network Copay or Coinsurance (Non-Medical Home provider or without referral)
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)	$10 / visit	30%
• Office visits to specialist	$10 / visit	30%
• Office visits for chronic conditions (i.e., asthma, diabetes, heart conditions)	Covered in full✓	30%
• Office visits to Naturopaths, Chiropractors and Acupuncturists	$10 / visit*	30%○
• E-visits, telephone, video visits to a participating provider	Covered in full✓	Not covered
• Allergy shots, serums, infusions, and injectable medications	$10 / visit	30%
• Surgery and anesthesia (in office)	$10 / visit	30%
• Maternity services: prenatal	Covered in full✓	30%
• Maternity services: delivery and postnatal	Covered in full✓	30%
• Fertility services	Covered in full✓	Covered in full✓
• Inpatient hospital visits (including surgery and anesthesia)	Covered in full✓	30%
Women's Health Services		
• Gynecological exams (calendar year); Pap tests	Covered in full✓	30%
• Mammograms	Covered in full✓	30%

* Copayment does not apply to out-of-pocket maximums.
○ Coinsurance does not apply to out-of-pocket maximums.
** Copayment does not apply to out-of-pocket maximums. Not cancer related.

Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
Mental Health / Chemical Dependency		
All in-plan chemical dependency services listed below are covered in full.		
Services except outpatient provider office visits must be prior authorized.		
• Inpatient, residential services	$50 per day, up to $250 per admission	$500 then 30%*
• Day treatment, intensive outpatient and partial hospitalization services	$10 / visit✓	30%
• Applied behavior analysis	$10 / visit✓	30%
• Outpatient provider visits	$10 / visit✓	30%
Hospital Services		
• Inpatient care	$50 per day, up to $250 per admission	$500 then 40%*
• Observation care	$50 per day, up to $250 per admission	$500 then 40%*
• Maternity care	$50 per day, up to $250 per admission	$500 then 40%*
• Routine newborn nursery care	$50 per day, up to $250 per admission	$500 then 40%*
• Rehabilitative care (30 days per calendar year; 60 days head or spinal cord injuries)	$50 per day, up to $250 per admission	$500 then 40%*
• Skilled nursing facility (180 days per calendar year)	$50 per day, up to $250 per admission	$500 then 30%*
• Bariatric surgery	$50 per day, up to $250 per admission	Not covered
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices		
• Durable medical equipment and supplies	15%	30%
• Prosthetic and orthotic devices (removable custom shoe orthotics are limited to $200 per calendar year, deductible waived)	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 / visit*	$150 / visit*
• Urgent care visits (for non-life threatening illness/minor injury)	$25 / visit	$25 / visit
• Emergency medical transportation	$75 / trip	$75 / trip
Other Covered Services		
• X-ray; lab services	Covered in full✓	30%
• Imaging services (such as PET, CT, MRI) (copayments do not apply to services related to cancer diagnosis and treatment)	$100*	$100 then 30%*
• Outpatient rehabilitative services (60 visits per calendar year)	$10 / visit	30%
• Outpatient surgery	$10 / visit	$100 then 40%*
• Outpatient dialysis, infusion, chemotherapy, radiation therapy	$10 / visit	30%
• Cardiac rehabilitation	$10 / visit	30%
• Temporomandibular joint (TMJ) service	See handbook	Not covered
• Home health care (up to 180 visits per calendar year)	$10 / visit	30%
• Hospice care	Covered in full✓	Covered in full✓
• Hearing exam	$10 / visit*	30%○
• Hearing aids (one per ear every three calendar years; in-plan deductible applies)	10%	10%
• Sleep studies	$100*	$100 then 30%*
• Chiropractic manipulation (Limited to 20 visits per calendar year)	$10 / visit*	30%○
• Acupuncture (Limited to 12 visits per calendar year)	$10 / visit*	30%○
• Massage Therapy (Limited to $1,000 per calendar year)	$10 / visit*	30%○
• Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy)		
-Generic drugs	$5✓	Not covered
-Formulary brand-name drugs	$5✓	Not covered
-Non-formulary brand-name drugs	$5✓	Not covered

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Benefit Highlights (continued)	In-Network Copay or Coinsurance	Out-of-Network Copay or Coinsurance
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.)		
• Bunionectomy	$100*	$100 then 30%*
• Hammertoe surgery	$100*	$100 then 30%*
• Morton's neuroma	$100*	$100 then 30%*
• Spinal injections for pain	$100*	$100 then 30%*
• Upper GI endoscopy	$100*	$100 then 30%*
• Knee arthroscopy	$500*	$500 then 30%*
• Knee, hip replacement	$500*	$500 then 30%*
• Knee, hip resurfacing	$500*	$500 then 30%*
• Shoulder arthroscopy	$500*	$500 then 30%*
• Sinus surgery	$500*	$500 then 30%*
• Spine procedures	$500*	$500 then 30%*
• Bariatric surgery	$500*	Not covered

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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.

What you need to know about drug coverage categories
The dollar amount an individual or family pays for covered services before your plan pays any benefits within a calendar year. Your plan has both in-network and an out-of-network deductibles. These deductibles accumulate separately and are not combined. The following expenses do not apply to an individual or family deductible:

- Services not covered by your plan
- Fees that exceed usual, customary and reasonable (UCR) charges as established by your plan
- Penalties incurred if you do not follow your plan's prior authorization requirements
- Copays or coinsurance for any supplemental benefits provided by your employer, such as prescription drugs, or routine vision care

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 and health care providers in the Providence Choice Medical Home network, available to you by your plan. Generally, your out-of-pocket cost will be less when you establish a medical home and receive covered services coordinated by your medical home. To find an in-network provider, go to www.ProvidenceHealthPlan.com/pebbmedicalhomes. For details on establishing a medical home go to www.ProvidenceHealthPlan.com/pebb.

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.

Medical home provider
A full service health care clinic within the Providence Choice Network which provides and coordinates members' medical care.

Out-of-network
Refers to services received without a referral or from a non-network provider. Your out-of-pocket costs are generally higher when you receive covered services from non-network providers. To find a participating 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.

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 predefined charges established by your plan 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 coinsurance 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, 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, or sex.

Providence Health Plan and Providence Health Assurance:

- Provide 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)
- Provide free language services to people whose primary language is not English, such as:
    - Qualified interpreters
    - Information written in other languages

If you are a Medicare member who needs these services, call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. Hearing impaired members may call our TTY line at 711.

If you believe that Providence Health Plan or Providence Health Assurance has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, 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

If you need help filing a grievance, and you are a Medicare member call 503-574-8000 or 1-800-603-2340. All other members can call 503-574-7500 or 1-800-878-4445. (TTY line at 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*.

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).

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

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

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-878-4445 (TTY: 711).

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 1-800-878-4445 (телетайп: 711).

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

УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером 1-800-878-4445 (телетайп: 711).

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。1-800-878-4445 (TTY: 711) まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 1-800-878-4445 (رقم هاتف الصم والبكم: 711 (TTY).

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

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ 1-800-878-4445 (TTY: 711)។

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

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 1-800-878-4445 (TTY: 711).

دیریبگ. شما یبرا گانیرا بصورت یزبان لاتیتسه ،دیکن یم گفتگو یفارس زبان به اگر :توجه
ف یم باشد. با (TTY: 711) 1-800-878-4445 تماس

ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 1-800-878-4445 (ATS : 711).

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร 1-800-878-4445 (TTY: 711)