

Your Benefit Summary

for PEBB Providence Choice Plan Members

POWERED BY **Collective Health**

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)	\$250 per person \$750 per family (3 or more)	\$500 per person \$1,500 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 who coordinate your care. You may 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 <http://join.collectivehealth.com/pebb-php>.

This summary provides only highlights of your benefits. To view all your plan details, including your Member Handbook, <http://join.collectivehealth.com/pebb-php>

Not sure what a word or 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		After you pay your calendar year deductible, then you pay the following for covered services:	
		In-Network Copay or Coinsurance (when you use a participating provider)	Out-of-Network Copay or Coinsurance (when you use a non-participating provider)
No deductible needs to be met prior to receiving this benefit.			
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 or Naturopath (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 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%
Doula services (limited to delivery plus 8 visits)		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%
Diagnostic and supplemental breast exam		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. For all services except outpatient provider visits and applied behavior analysis, PHP must be notified as soon as reasonably possible following the onset of treatment for coverage to continue.		
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%
Diabetic supplies and insulin	Covered in full	Covered in full
Prosthetic and orthotic devices (deductible waived on removable custom shoe orthotics)	15%	30%
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
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
Other Covered Services • X-ray; lab services • Imaging services (such as PET, CT, MRI) (copayments do not apply to services related to cancer diagnosis and treatment) • Outpatient rehabilitative services(60 visits per calendar year. Limits do not apply to Mental Health or Substance Use Disorder services) • Outpatient surgery • Outpatient dialysis, infusion, chemotherapy, radiation therapy • Cardiac rehabilitation • Temporomandibular joint (TMJ) service • Home health care (up to 180 visits per calendar year) • Hospice care • Respite Care (Up to 120 hours) • Hearing exam • Hearing aids (one per ear every three calendar years) • Sleep studies • Chiropractic manipulation (Limited to 20 visits per calendar year) • Acupuncture (Limited to 12 visits per calendar year) • Massage Therapy (Limited to \$1,000 per calendar year) • Self-administered chemotherapy (Up to a 30-day supply from a designated participating pharmacy) -Generic drugs -Formulary brand-name drugs -Non-formulary brand-name drugs	Covered in full✓ \$100* \$10 / visit \$10 / visit \$10 / visit \$10 / visit See handbook \$10 / visit Covered in full✓ \$10 / visit \$10 / visit✓ 10%✓ \$100* \$10 / visit* \$10 / visit* \$10 / visit* \$5✓ \$5✓ \$5✓	30% \$100 then 30%* 30% \$100 then 40%* 30% 30% Not covered 30% Covered in full✓ 30% 30% 10%✓ \$100 then 30%* 30% 30% 30% Not covered Not covered 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.) • Bunionectomy • Hammertoe surgery • Morton's neuroma • Spinal injections for pain • Upper GI endoscopy • Knee arthroscopy • Knee, hip replacement • Knee, hip resurfacing • Shoulder arthroscopy • Sinus surgery • Spine procedures • Bariatric surgery	\$100* \$100* \$100* \$100* \$100* \$500* \$500* \$500* \$500* \$500* \$500* \$500* \$500*	\$100 then 30%* \$100 then 30%* \$100 then 30%* \$100 then 30%* \$100 then 30%* \$500 then 30%* \$500 then 30%* \$500 then 30%* \$500 then 30%* \$500 then 30%* \$500 then 30%* \$500 then 30%* Not covered
Fertility Services • Fertility treatments are administered through Progyny. Please call (833) 233-0843 to activate benefit. Infertility diagnosis is not required. (Limited to 1 Progyny Smart Cycle per calendar year, with option to restart the cycle if the first is unsuccessful)	Covered in full✓	Not covered (call Progyny to find a provider)

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

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 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 and coinsurance for services that do not apply to the deductible

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 and find details on establishing a medical home, go to <http://join.collectivehealth.com/pebb-php>

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 <http://join.collectivehealth.com/pebb-php>

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 health care professionals who do not participate in Providence Health Plan's network of participating physicians and providers of health care services.

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.



(855) 284-1368



Have questions about your benefits and want to contact us via e-mail? Go to our Web site at: <http://my.collectivehealth.com>