Your Benefit Summary

for PEBB Statewide Part-Time Plan members

Providence Health Plan

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 / 20% (after deductible)	50% coinsurance (after deductible; UCR applies)	$3,200 per person $9,600 per family (3 or more)	$7,500 per person $22,500 per family (3 or more)	$500 per person $1,500 per family (3 or more)	$1,000 per person $3,000 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, 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 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	After you pay your calendar year deductible, then you pay the following for covered services:	
No deductible needs to be met prior to receiving this benefit.	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	50%
Routine immunizations/shots	Covered in full	50%
Hearing screenings	Covered in full	50%
Colorectal cancer screening: sigmoidoscopy, colonoscopy	Covered in full	50%
Prostate screening exam (calendar year)	Covered in full	50%
Nutritional counseling	Covered in full	50%
Physician / Provider Services		
Office visits to Primary Care Provider or Naturopath (deductible waived on first 4 visits in-network, per calendar year)	20%	50%
Office visits to specialist	20%	50%
Office visits for chronic conditions (i.e., asthma, diabetes, heart conditions)	Covered in full	50%
Office visits to Chiropractors and Acupuncturists	20%	50%
E-visits, telephone, video visits to a participating provider	Covered in full	Not covered
Allergy shots, serums, infusions and injectable medications	20%	50%
Surgery and anesthesia (in office)	20%	50%
Maternity services: prenatal	Covered in full	50%
Maternity services: delivery and postnatal	20%	50%
Doula services (limited to delivery plus 8 visits)	Covered in full	Covered in full
Inpatient hospital visits (including surgery and anesthesia)	20%	50%
Women's Health Services		
Gynecological exams (calendar year); Pap tests	Covered in full	50%
Mammograms	Covered in full	50%
Diagnostic and supplemental breast exam	Covered in full	50%

Copayment does not apply to out-of-pocket maximums.
Coinsurance does not apply to out-of-pocket maximums.
15% coinsurance at OHA certified Patient Centered Primary Care Homes

Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan Copay or Coinsurance
Mental Health / Chemical Dependency		
All in-network 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	20%	$500 then 50%
Day treatment, intensive outpatient and partial hospitalization services	20%	50%
Applied behavior analysis	20%	50%
Outpatient provider visits	20%	50%
Hospital Services		
Inpatient care	20%	$500 then 50%
Observation care	20%	$500 then 50%
Maternity care	20%	$500 then 50%
Routine newborn nursery care	20%	$500 then 50%
Rehabilitative care (30 days per calendar year; 60 days head or spinal cord injuries)	20%	$500 then 50%
Skilled nursing facility (180 days per calendar year)	20%	$500 then 50%
Bariatric surgery	20%	Not covered
Medical and Diabetes Supplies, Durable Medical Equipment, Appliances, Prosthetic and Orthotic Devices		
Durable medical equipment and supplies	20%	50%
Diabetic supplies and insulin	Covered in full	Covered in full
Prosthetic and orthotic devices (deductible waived on removable custom shoe orthotics)	20%	50%
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 20%	$150, then 20%
Urgent care visits (for non-life threatening illness/minor injury)	20%	20%
Emergency medical transportation	20%	20%
Other Covered Services		
• X-ray; lab services	20%	50%
• Imaging services (such as PET, CT, MRI)	$100, then 20%*	$100, then 50%*
• (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)	20%	50%
• Outpatient surgery	20%	$100 then 50%*
• Outpatient dialysis, infusion, chemotherapy, radiation therapy	20%	50%
• Cardiac rehabilitation	20%	50%
• Temporomandibular joint (TMJ) service	See handbook	Not covered
• Home health care (up to 180 visits per calendar year)	20%	50%
• Hospice care	Covered in full✓	Covered in full✓
• Respite Care (up to 120 hours)	20%	50%
• Hearing exam	15%✓	50%
• Hearing aids (one per ear every three calendar years)	10%✓	10%✓
• Sleep studies	$100, then 20%*	$100, then 50%*
• Chiropractic manipulation and acupuncture (up to 60 visits per calendar year)	20%○	50%○
• Massage therapy (Limited to $1,000 per calendar year)	20%○	50%○
• 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

* Copayment does not apply to out-of-pocket maximums.
○ Coinsurance does not apply to out-of-pocket maximums.
** 15% coinsurance at OHA certified Patient Centered Primary Care Homes

Benefit Highlights (continued)	In-Plan Copay or Coinsurance	Out-of-Plan 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.)		
Hammertoe surgery	$100, then 20%	$100, then 50%
Bunionectomy	$100, then 20%	$100, then 50%
Morton's neuroma	$100, then 20%	$100, then 50%
Spinal injections for pain	$100, then 20%	$100, then 50%
Upper GI endoscopy	$100, then 20%	$100, then 50%
Knee arthroscopy	$500, then 20%	$500, then 50%
Knee, hip replacement	$500, then 20%	$500, then 50%
Knee, hip resurfacing	$500, then 20%	$500, then 50%
Shoulder arthroscopy	$500, then 20%	$500, then 50%
Spine procedures	$500, then 20%	$500, then 50%
Sinus surgery	$500, then 20%	$500, then 50%
Bariatric surgery	$500, then 20%	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)

Copayment does not apply to out-of-pocket maximums.

Coinsurance does not apply to out-of-pocket maximums.

15% coinsurance at OHA certified Patient Centered Primary Care Homes

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.