

Section 2: Medical Benefits

Medical Plan Options

Each of PEBB's medical plans provides a member handbook (evidence of coverage, in the case of Kaiser Permanente) and benefit summary. They are incorporated in this Summary Plan Description by reference and are available for download as printable documents on PEBB's Web site. Carefully review the plans' member handbooks and service areas to see which one best fits your and your family's healthcare needs. View Covered Service Areas by Plan www.oregon.gov/DAS/PEBB/2011Benefits/ServArea.shtml

- **Prescription Drug Coverage.** All the medical plans offered by PEBB include coverage for prescription drugs.
- **Routine Vision Care.** Employees and others who enroll in medical the plans offered by PEBB receive coverage for routine vision care except in the *part-time* versions of the plans, which do not have coverage for routine vision services. The exception is part-time HMO plan, which covers a routine vision exam with a \$30 copay. See the HMO plan benefit summaries for information on routine vision care in those plans. See VSP Routine Vision Care for the summary of benefits in the other plans.

Health Maintenance Organization Plans

Health maintenance organization (HMO) plans offer a high level of service and benefits with low out-of-pocket copayments. To get benefits, you must use the providers and facilities that are part of the plan. You select a primary care provider within the HMO who guides your care. If you seek care elsewhere, the plan may not pay or may pay a reduced amount.

PEBB sponsors the **Kaiser Permanente** HMO plan for those who live or work (at least 50 percent of the time) in the Kaiser Permanente service area. See the plan's member handbook (evidence of coverage) for details on this plan and coverage, long with a list of the ZIP codes in the service area.

Kaiser Permanente HMO Benefit Summary

This document is on the Web at http://my.kp.org/nw/pebb/benefits_nw_traditionalHMOPlan.html. It is incorporated here by reference. The summary includes routine vision services.

Kaiser Permanente HMO Part-time Benefit Summary

This document is on the Web at http://my.kp.org/nw/pebb/benefits_nw_traditionalHMOPlan.html. It is incorporated here by reference. The summary includes routine vision services.

Medical-home Plans

A medical home is a clinic staffed by health care professionals who work together as a team. Led by your primary provider, this team coordinates all of your health care, including referrals to outside providers or specialists when necessary. The team gives you connected health care by staying informed about and actively participating in all aspects of your care.

State of Oregon

Public Employees' Benefit Board Summary Plan Description

PEBB offers the Providence Choice medical-home model plan. You need to establish your medical home clinic to ensure you have access to the full benefits of your plan, including claims paid at the medical home benefit level and not the out-of-plan level.

Providence Choice Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBChoicePlanFT2012.pdf. It is incorporated here by reference. See the VSP benefit summary for routine vision services in this plan.

Providence Choice Part-time Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBChoicePlanPT2012.pdf. It is incorporated here by reference. This plan does not cover routine vision services.

Preferred Provider Organization Plans

Preferred provider organization (PPO) plans offer services and benefits at two coverage levels — from preferred providers and from non-preferred providers. PEBB offers the PEBB Statewide PPO plan in all parts of the state. You may use any doctors you wish. If you use doctors who are preferred (in-network), you pay less. If you use providers who are not preferred (out of network), you pay more. If you use providers who do not participate in the plan as preferred or non-preferred, the providers may bill you for amounts greater than allowed in the plan.

PEBB Statewide Plan Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBStatewidePlanFT2012.pdf. It is incorporated here by reference. See the VSP benefit summary for routine vision services in this plan.

PEBB Statewide Plan Part-time Benefit Summary

This document is on the Web at

www.providence.org/healthplans/pdfs/pebb/PEBBStatewidePlanPT2012.pdf. It is incorporated here by reference. This plan does not cover routine vision services.

Vision Service Plan

VSP provides vision coverage in the Providence Choice and PEBB Statewide plans. The part-time versions of these plans have no vision coverage. The VSP benefit summary is on the Web at www.oregon.gov/DAS/PEBB/2012Benefits/Docs/VSPBrochure.pdf. It is incorporated here by reference.

Health Improvement and Cost Containment Programs

The Board may institute health improvement and cost containment programs in the design of health plans. The goal of these programs is to assist the employer and employees improve employee health and contain costs for health benefits. See Appendix B.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Premium Rates

The state, as the employer, provides a monthly benefit amount for eligible employees. Payroll applies the amount to premiums for the core benefits of medical, dental and basic life insurance coverage. PEBB does not play a role in determining the employer's contribution. That is determined through a series of decisions made by the governor, legislature, Department of Administrative Services, other agencies and branches of government, and collective bargaining agreements.

Table 1. 2012 Employee Medical Plan Monthly Premium Rates				
	Employees	Employee & Spouse/Partner	Employee & Children	Employee & Family
PEBB Statewide PPO¹	\$990.52	\$1,327.15	\$1,139.02	\$1,356.87
Providence Choice²	870.22	1,166.06	1,000.76	1,192.18
Kaiser HMO³	983.01	1,317.23	1,130.49	1,346.73
Kaiser Deductible³	903.83	1,211.11	1,039.40	1,238.24
PEBB Statewide Part-time PPO⁴	793.10	1,062.66	912.03	1,086.46
Providence Choice Part-time⁵	693.57	929.36	797.61	950.17
Kaiser HMO Part-time⁶	832.18	1,115.10	957.00	1,140.06
Kaiser Deductible Part-Time⁶	785.96	1,053.18	903.87	1,076.76

¹ Available to PEBB eligible full-time and part-time employees. VSP routine vision services.

² Available to PEBB eligible full-time and part-time employees in plan service area. VSP routine vision services.

³ Available to PEBB eligible full-time and part-time employees in plan service area. Kaiser routine vision services.

⁴ Additional option available to eligible part-time employees. No vision benefit.

⁵ Additional option available to eligible part-time employees in plan service area. No vision benefit.

⁶ Additional option available to eligible part-time employees in plan service area. Vision exam only.

2012 Retiree Medical Plan Monthly Premium Rates				
	Retiree	Retiree & Spouse/Partner	Retiree & Children	Retiree & Family
PEBB Statewide PPO¹	\$983.37	\$1,317.58	\$1,130.80	\$1,347.08
Providence Choice²	863.80	1,157.46	993.37	1,183.38
Kaiser³	975.97	1,307.80	1,122.39	1,337.09
Kaiser Deductible³	897.35	1,202.44	1,031.96	1,229.37
PEBB Statewide Part-Time PPO⁴	787.38	1,054.99	905.45	1,078.62
Providence Choice Part-Time⁵	688.57	922.65	791.85	943.31
Kaiser Part-Time⁶	826.22	1,107.12	950.15	1,131.90
Kaiser Deductible Part-Time⁶	780.34	1,045.64	897.40	1,069.05

¹ Available to PEBB eligible retirees. VSP routine vision services.

² Available to PEBB eligible retirees in plan service area. VSP routine vision services.

³ Available to PEBB eligible retirees in plan service area. Kaiser routine vision services.

⁴ Additional option available to eligible retirees. No vision benefit.

⁵ Additional option available to eligible retirees in plan service area. No vision benefit.

⁶ Additional option available to eligible retirees in plan service area. Vision exam only.

2012 Retiree Optional Vision Plan Monthly Premium Rates					
	Retiree	Retiree & Spouse/Partner	Retiree & Children	Retiree & Family	Child(ren) Only⁷
VSP Optional Part-time	\$12.90	\$25.80	\$25.80	\$30.31	\$12.90

State of Oregon
Public Employees' Benefit Board Summary Plan Description

2012 COBRA Medical Plan Monthly Premium Rates				
	Self	Self & Spouse/Partner	Self & Children	Self & Family
PEBB Statewide PPO¹	\$996.88	\$1,335.67	\$1,146.33	\$1,365.57
Providence Choice²	875.66	1,173.34	1,007.01	1,199.63
Kaiser³	989.50	1,325.93	1,137.95	1,355.62
Kaiser Deductible³	909.79	1,219.10	1,046.26	1,246.41
PEBB Statewide Part-Time PPO⁴	798.18	1,069.47	917.87	1,093.43
Providence Choice Part-Time⁵	698.02	935.31	802.72	956.26
Kaiser Part-Time⁶	837.67	1,122.47	963.32	1,147.59
Kaiser Deductible Part-Time⁶	791.15	1,060.14	909.83	1,083.87

¹ Available to PEBB eligible individuals. VSP routine vision services.

² Available to PEBB eligible individuals in plan service area. VSP routine vision services.

³ Available to PEBB eligible individuals in plan service area. Kaiser routine vision services.

⁴ Additional option available to PEBB eligible individuals. No vision benefit.

⁵ Additional option available to PEBB eligible individuals; in plan service area. No vision benefit.

⁶ Additional option available to PEBB eligible individuals; in plan service area. Vision exam only.

Medical Plans Comparison, Including Prescription and Vision Coverage

The tables on the following pages allow you to compare PEBB's health care plans on a side-by-side basis. **NOTE:** Full-time employees may not enroll in the part-time plans.

State of Oregon
Public Employees' Benefit Board Summary Plan Description
2012 Full-time Medical Plan

This information gives a high-level summary only. See plan documents for details.

Benefits apply without regard to HEM participation ¹	PEBB Statewide Plan		Providence Choice		Kaiser HMO	Kaiser Deductible Plan
Service Area	Statewide and Nationwide		Clackamas, Clark, Curry, Deschutes, Lane, Linn-Benton, Marion-Polk, Multnomah, Washington and Yamhill counties		Zip codes in Benton, Clackamas, Clark, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties	
Provider Status	In Network	Out of Network	In Network	Out of Network	Kaiser Permanente	Kaiser Permanente
Deductible²	\$250/individual \$750/family 4 primary care visits not subject	\$500/individual \$1500/family 4 primary care visits not subject	\$250/individual \$750/family 4 primary care visits not subject	\$500/individual \$1500/family 4 primary care visits not subject	\$0	\$250/individual \$750/family office visits and some services not subject
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum³	\$1500/individual \$4500/family	\$2500/individual \$7500/family	\$1500/individual \$4500/family	\$2500/individual \$7500/family	\$600/individual \$1200/family	\$1500/individual \$4500/family
Spouse/Domestic Partner Surcharge⁴	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month
Tobacco Surcharge⁵	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner
Primary Care	15%	30%	\$5	30%	\$5	\$5
Chronic Care Office Visit	0%	30% subject to deductible	\$0	30% subject to deductible	\$5	\$5
Specialty Care	15%	30%	\$5	30%	\$5	\$5
Mental Health	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services
Maternity/Childbirth Provider Services	15%	30%	\$0	30%	\$0/prenatal, \$50/day; up to \$250 maximum/admission	\$0/prenatal; \$50/day; up to \$250 maximum per admission. Prenatal not subject to deductible; deductible does apply to maternity/childbirth
Preventive	\$0	30%	\$0	30%	\$0	\$0
Lab & X-ray	15%	30%	\$0	30%	\$0	\$15
MRI, CT, PET, SPECT	15% + \$100	30% + \$100	\$100	30% + \$100	\$100	\$100
Sleep Study	15% + \$100	30% + \$100	\$100	30% + \$100	\$100	\$100
Inpatient Hospital	15%	30%	\$50/day; up to \$250 maximum per admission	30%	\$50/day; up to \$250 maximum per admission	\$50/day; up to \$250 maximum after deductible
Emergency Department	15% + \$100	15% + \$100	\$100	\$100	\$75	\$75, after deductible has been met
Durable Med Equipment	15%	30%	15%	30%	\$0	15%
Insulin/Diabetic Supplies	\$0	\$0	\$0	\$0	\$0	\$0
Prescription Drugs⁶	\$50 deductible (not applied to Value) \$0 Value \$10 generic \$30 preferred brand \$100 specialty 2.5X for 90-day No tier exceptions	Paid as if filled in network; Member pays difference between network & billed amt + coinsurance 2.5X for 90-day	\$50 deductible (not applied to Value) \$0 Value \$10 generic \$30 preferred brand \$100 specialty 2.5X for 90-day No tier exceptions	Paid as if filled in network; Member pays difference between network & billed amt + coinsurance 2.5X for 90-day	\$1 generic/\$15 brand \$1 generic 31-90 day maintenance mail order \$15 brand 31-90 day maintenance mail order	\$5 generic / \$25 brand \$50/50% whichever is greater for exception-approved non-formulary drugs \$5 generic 31-90 day maintenance mail order \$25 brand 31-90 day maintenance mail order
Vision	\$10 exam copay	VSP reimburses exam to \$50 office	\$10 exam copay	VSP reimburses exam to \$50	\$5 exam copay	\$5 exam copay

State of Oregon
Public Employees' Benefit Board Summary Plan Description

Benefits apply without regard to HEM participation ¹	PEBB Statewide Plan		Providence Choice		Kaiser HMO	Kaiser Deductible Plan
	\$25 frame copay \$150 retail frame allowance Single and lined bifocal and trifocal lenses covered in full Progressive lenses available at a 35-40% discount. Or \$200 allowance for contacts and contacts fitting/evaluation	copay \$70 frame allowance \$50-\$125 single and lined bi or trifocal lenses allowance Progressive lenses available at a 35-40% discount Contact lenses covered in full to \$105 if elective, \$210 if necessary	\$25 frame copay \$150 retail frame allowance Single and lined bifocal and trifocal lenses covered in full Progressive lenses available at a 35-40% discount. Or \$200 allowance for contacts and contacts fitting/evaluation	\$70 frame allowance \$50-\$125 single and lined bi or trifocal lenses allowance Progressive lenses available at a 35-40% discount Contact lenses covered in full to \$105 if elective, \$210 if necessary	\$200 hardware allowance max/24 months	\$200 hardware allowance max/24 months
Chiropractic, Acupuncture, Naturopathic Services	30% coinsurance, applies to in-network deductible 60 visits/yr max		\$10 copay, applies to in-network deductible, limited to the lesser of \$1000 or 60 visits/yr		\$10 up to \$1000/yr	\$10 up to \$1000/yr
Additional-cost Tier (does not apply to cancer related services)						
Hip replacement Knee replacement Knee arthroscopy Shoulder arthroscopy Bariatric Surgery Spine pain procedures Sinus surgery Knee/Hip resurfacing Hip arthroplasty	15% + \$500	30% + \$500	\$500	30% + \$500	Copay same as other conditions	Copay same as other conditions
Upper endoscopy	15% + \$100	30% + \$100	\$100	30% + \$100 copay	Copay same as other conditions	Copay same as other conditions
Excluded Services⁷						
<p>¹ Benefits and HEM: The benefits shown here apply in or out of the Health Engagement Model (HEM) program. Employees (and spouses or domestic partners) who participate in HEM will have \$20 (or \$35) per month less deducted from their pay. NOTE: A PEBB-eligible employee <u>must</u> participate in the HEM program to allow a spouse or domestic partner to participate. A spouse or domestic partner of a PEBB-eligible employee may not participate in the HEM program as an individual if the employee does not.</p> <p>² Deductibles: In the Statewide and Providence Choice plans, the deductible does not apply to the first 4 visits to a primary care provider, preventive services, or the out-of-pocket maximum; however, the coinsurance applies even if the deductible does not. The deductible applies to all specialty visits and all lab and x-ray services. Once 3 members of family have met their individual deductible, all in-network services for all members of the family will be paid as if their individual in-network deductible has been met. Deductible amounts accumulate separately in these plans when using in-network and out-of-network providers. The Kaiser Health Maintenance Organization (HMO) plan has no deductible. In the Kaiser Deductible plan, office visits and some other services do not apply to the deductible. See the plan's evidence of coverage or call Kaiser Member Services. In this plan, once 3 members of family have met their individual deductible, all in-network services for all members of the family will be paid as if their individual in-network deductible has been met.</p> <p>³ Annual Out-of-Pocket (OOP) Maximums: In the Statewide and Providence choice plans, once 3 members of a family have met their individual \$1500 in-network OOP, all in-network services for all members of the family will be paid as if their individual in-network OOP has been met; once 3 members of a family have met their individual \$2500 out-of-network OOP, all out-of-network services for all members of the family will be paid as if their individual out-of-network OOP has been met. In the Kaiser HMO, once 2 members of a family have met their individual \$600 OOP, all in-plan services for all members of the family will be paid as if their individual in-network OOP has been met. In the Kaiser Deductible Plan, once 3 members of a family have met their individual \$1500 in-network OOP, all in-plan services for all members of the family will be paid as if their individual in-network OOP has been met.</p> <p>⁴ Spouse or Domestic Partner Coverage Surcharge: A \$50 monthly surcharge is applied if an employee's spouse or domestic partner has access to other non-Oregon-state-agency employer-based group health insurance and chooses not to enroll.</p> <p>⁵ Tobacco Surcharge: A \$25 monthly surcharge is applied to employees and covered spouses or domestic partners who use tobacco as stated when they enroll.</p> <p>⁶ Prescription Drugs: See the plans' formularies, which list drugs covered in the plan and how they are covered.</p> <p>⁷ Excluded Services: PEBB Statewide and Providence Choice (full- and part-time) plan members will pay 100% of the cost for excluded services. Beginning 2012, these include surgery for warts, varicose vein surgery (including radio frequency ablation), varicose vein stripping, TMJ surgery, surgery for ganglions of the wrist, surgery for Morton's neuroma, hammertoe surgery, bunionectomy surgery and breast reduction surgery. Surgery for certain varicose vein conditions may be considered for prior authorization. Kaiser HMO and Kaiser Deductible (full- and part-time) plan members will pay a copay, as for treatment of other conditions.</p>						

State of Oregon
Public Employees' Benefit Board Summary Plan Description

2012 Part-time Medical Plan. See footnotes on page 32.

This information gives a high-level summary only. See plan documents for details. See footnotes on page 32.

Benefits apply without regard to HEM participation ¹	Part-Time PEBB Statewide Plan		Part-Time Providence Choice		Part-Time Kaiser HMO	Part-Time Kaiser Deductible Plan
Service Area	Statewide and Nationwide		Clackamas, Clark, Curry, Deschutes, Lane, Linn-Benton, Marion-Polk, Multnomah, Washington and Yamhill counties		Zip codes in Benton, Clackamas, Clark, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties	
Provider Status	In Network (Medical home)	Out of Network	In Network	Out of Network	Kaiser Permanente	Kaiser Permanente
Deductible ²	\$500/individual, \$1500/ family' 4 primary care visits not subject	\$1000/individual, \$3000/family; 4 primary care visits not subject	\$500/individual, \$1500/ family; 4 primary care visits not subject	\$1000/individual, \$3000/family; 4 primary care visits not subject	\$0	\$250/individual, \$750/Family; office visits & some services not subject
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum ³	\$2500/individual, \$7500/family	\$4500/individual, \$13500/family	\$2500 individual, \$7500/family	\$4500/individual, \$13500/family	\$1500/individual, \$3000/family	\$1500/individual, \$4500/family
Spouse/Partner Surcharge ⁴	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month	\$50/month
Tobacco Surcharge ⁵	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner	\$25/month/employee \$25/spouse/domestic partner
Primary Care	20%	50%	\$30	50%	\$30	\$30
Chronic Care Office Visit	\$0	50% subject to deductible	\$0	50% subject to deductible	\$30	\$30
Specialty Care	20%	50%	\$30	50%	\$30	\$30
Mental Health	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services
Maternity/Childbirth Provider Services	20%	50%	\$0	50%	\$0/prenatal; up to \$500 maximum per admission	\$0/prenatal (not subject); \$500/admit. deductible doesn't apply
Preventive	0%	50%	\$0	50%	\$0	\$0
Lab & X-ray	20%	50%	20%	50%	\$10	\$20
MRI, CT, PET, SPECT	20% + \$100	50% + \$100	20% + \$100	50% + \$100	\$100	\$100
Sleep Study	20% + \$100	50% + \$100	20% + \$100	50% + \$100	\$100	\$100
Inpatient Hospital	20%	50%	\$500/admission	50%	\$500 per admission	\$500/admit after deductible
Emergency Department	20% + \$100	20% + \$100	\$100	\$100	\$100	\$100, after deductible
Durable Med Equipment	20%	50%	20%	50%	50%	50%
Insulin/Diabetic Supplies	\$0	\$0	\$0	\$0	Both Plans: 20% (insulin covered as prescription drug)	
Prescription Drugs ⁶	\$50 deductible (not applied to Value drugs); \$0 Value; \$20 generic/\$40 preferred brand; \$100 specialty 2.5X for 90-day; No tier exceptions	PD as if filled in network; Member pays difference between network & billed amt + coinsurance; 2.5X for 90-day	\$50 deductible (not applied to Value drugs); \$0 Value; \$20 generic/\$40 preferred brand; \$100 specialty 2.5X for 90-day; No tier exceptions	PD as if filled in network; Member pays difference between network & billed amt + coinsurance; 2.5X for 90-day	\$10 generic; \$25 brand; \$20 generic and \$50 brand 31-90 day maintenance mail order	\$10 generic; \$25 brand \$20 generic and \$50 brand 31-90 day maintenance mail order
Vision	The VSP full time vision plan is available to retirees enrolled in these plans as a separate policy. Vision not covered for all other enrollees			These plans have a \$30 exam copay; hardware not covered		
Chiropractic, Acupuncture, Naturopathic	50% coinsurance, applies to in-network deductible 60 visits/yr max		50% copayment, applies to in-network deductible, limited to the lesser of \$1000 or 60 visits/yr		not covered	not covered
Additional-cost Tier (does not apply to cancer related services) Applies to Hip and Knee replacement, Knee and shoulder arthroscopy. Bariatric Surgery. Spine pain procedures Sinus surgery, Knee/Hip resurfacing, Hip arthroplasty						
	20% + \$500	50% + \$500	\$500	50% + \$500	Copay same as other conditions	Copay same as other conditions
Upper endoscopy	20% + \$100	50% + \$100	\$100 copay	50% + \$100 copay	Copay same as other conditions	Copay same as other conditions
Excluded Services⁷						