

**MEDICAL AND PHARMACY BENEFIT INFORMATION**

	ODS Plan 3 w/ Rx Plan B Member Responsibility		ODS Plan 5 w/ Rx Plan B Member Responsibility		ODS Plan 8 w/ Rx Plan C Member Responsibility		Providence Plan 2 w/ Rx Plan 1 Member Responsibility	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
<b>Plan Year October 1 - September 30</b>								
Individual Deductible (plan year)	\$100	\$100	\$200	\$200	\$1,000	\$1,000	\$0.00	\$300
Family Deductible (plan year)	\$300	\$300	\$600	\$600	\$3,000	\$3,000	\$0.00	\$900
Individual Out-of-Pocket Maximum (plan year)	\$500	\$1,500	\$1,000	\$2,000	\$2,000	\$4,000	\$600	\$2,000
Family Out-of-Pocket Maximum (plan year)	N/A	N/A	N/A	N/A	N/A	N/A	\$1,200	\$4,000
Lifetime Maximum Benefit	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Member Coinsurance	10%	30%	20%	40%	20%	40%	0%	50%

**Physician & Professional Services**

Office, Home or Hospital visit	\$10	30%	\$20	40%	20%	40%	\$5	50%
Outpatient Rehabilitation (physical, occupational and speech therapy - 30/60 days per plan year)	\$10	30%	\$20	40%	20%	40%	\$5 (30 days per plan year)	50% (30 days per plan year)
Anesthesiologist	10%	30%	20%	40%	20%	40%	covered in full	50%

**Emergency & Urgent Care**

Emergency Room (waived if admitted)	\$100 per visit then 10%		\$100 per visit then 20%		\$100 copayment per visit then 20%		\$100	\$100*
RN Advice for minor illnesses	eDoc		eDoc		eDoc		Yes	Yes
Urgent Care Visits	\$10		\$20		20%		\$25	\$25*
Ambulance Transportation (\$5,000 annual maximum)	10% (ground or air)		20% (ground or air)		20% (ground or air)		\$100 (ground or air)	\$100* (ground or air)

**Hospital Benefit**

Inpatient Hospital - authorization required	10%	30%	20%	40%	20%	40%	covered in full	50%
Service Authorization Penalty Inpatient & Residential	50% up to \$2500	50% up to \$2500	50% up to \$2500	50% up to \$2500	50% up to \$2500	50% up to \$2500	N/A	50%, \$2500 max/occurrence
Inpatient Days Covered	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited
Inpatient Rehabilitative Hospital Care (30 days per plan year)	10%	30%	20%	40%	20%	40%	covered in full	50%
Skilled Nursing Facility	10% 60 days per year	30% 60 days per year	20% 60 days per year	40% 60 days per year	20% 60 days per year	40% 60 days per year	covered in full 30 days per year	50% 30 days per year

**Outpatient Hospital Services**

Outpatient Surgery	10%	30%	20%	40%	20%	40%	covered in full	50%
Diagnostic X-rays & Laboratory Tests	10%	30%	20%	40%	20%	40%	covered in full	50%
Chemotherapy	10%	30%	20%	40%	20%	40%	covered in full	50%
Radium, Radioisotopic, X-Ray Therapy & Kidney Dialysis	10%	30%	20%	40%	20%	40%	covered in full	50%
Imaging Procedures	10%	30%	20%	40%	20%	40%	covered in full	50%

**Health & Wellness**

Online Health & Lifestyle Information	Reference eDoc and MyOEBB.org						www.providence.org/healthplans	
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**Preventative Healthcare**

Well Child Exams (Newborn through age 17)	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50% (up to age 19)
Childhood Immunizations	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Adult Immunizations	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Routine Adult Physical Exams (Age 18 and above)	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Routine Mammograms (subject to schedule)	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Pap Smear	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Prostate Screening Age 50 and over	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Colon Cancer Screenings Age 50 and over (subject to schedule)	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Cardiovascular Screenings	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%
Hearing Evaluations	deductible waived	30%	deductible waived	40%	deductible waived	40%	covered in full	50%

**Family Planning**

Tubal Ligation	10%	30%	20%	40%	20%	40%	covered in full	50%
Vasectomy	10%	30%	20%	40%	20%	40%	covered in full	50%
Contraceptive Devices	10%	30%	20%	40%	20%	40%	covered in full	50%

**Maternity/Newborn Care**

Outpatient Maternity Care	10%	30%	20%	40%	20%	40%	\$50	50%
Midwife Delivery (only if also a licensed nurse practitioner)	10%	30%	20%	40%	20%	40%	inclusive in maternity care copay	50%
Inpatient Delivery	10%	30%	20%	40%	20%	40%		50%
Newborn Circumcision	10%	30%	20%	40%	20%	40%	covered in full	50%
Newborn Nursery Care	10%	30%	20%	40%	20%	40%	covered in full	50%

**Hospice Care & Home Health Care**

	(maximum benefit of \$20,000)								
Hospice Care	10%	30%	20%	40%	20%	40%	covered in full	covered in full*	
Home Health Care (daily limitations and 140 visits per year)	\$10	30%	\$20	40%	20%	40%	covered in full	50%	

**Alternative Care (combined maximum benefit of \$2,500)**

Chiropractic Care	10%	30%	20%	40%	20%	40%	\$5	N/A
Acupuncture	10%	30%	20%	40%	20%	40%	\$5	N/A
Naturopath	10%	30%	20%	40%	20%	40%	\$5	N/A
Massage Therapy	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

**Other Care, Services & Treatments**

Allergy Testing	10%	30%	20%	40%	20%	40%	covered in full	50%
Allergy Injections	10%	30%	20%	40%	20%	40%	covered in full	50%

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Cochlear Implants service authorization required	10%	30%	20%	40%	20%	40%	covered in full	50%
Cosmetic & Reconstructive Surgery medically necessary - authorization required	10%	30%	20%	40%	20%	40%	covered as any other surgery	50%
Infusion Therapy - authorization required	10%	30%	20%	40%	20%	40%	covered in full	50%
Injectible Medication (administered in provider's office)	10%	30%	20%	40%	20%	40%	covered in full	50%
Maxillofacial Prosthetic Services (medically necessary)	10%	30%	20%	40%	20%	40%	covered in full	50%
Medical Equipment (Durable), Supplies and Appliances	10%	30%	20%	40%	20%	40%	covered in full	50%
Orthotic & Prosthetic Appliances (medically necessary)	10%	30%	20%	40%	20%	40%	covered in full see limitations	50% see limitations
Podiatry Services (medically necessary)	10%	30%	20%	40%	20%	40%	\$5	50%
Temporomandibular Joint Syndrome (\$3000 lifetime maximum)	10%	30%	20%	40%	20%	40%	covered in full	50%
Therapeutic Injections	10%	30%	20%	40%	20%	40%	covered in full	50%
Transplants (\$250,000 lifetime maximum - authorization required)	\$0	30%	\$0	40%	\$0	40%	covered as any other surgery	N/A

**Chemical Dependency**

Deductible per Confinement	10%	30%	20%	40%	20%	40%	Prior authorization is required. Call (800) 711-4577. Individual & family annual deductibles apply. Call insurance carrier for more information on coverage details.
Deductible per Day	10%	30%	20%	40%	20%	40%	
Detoxification	10%	30%	20%	40%	20%	40%	
Inpatient Treatment	10%	30%	20%	40%	20%	40%	
Outpatient Office Visits	\$10	30%	\$20	40%	20%	40%	

**Mental Illness**

Deductible per Confinement	10%	30%	20%	40%	20%	40%	Prior authorization is required. Call (800) 711-4577. Individual & family annual deductibles apply. Call insurance carrier for more information on coverage details.
Deductible per Day	10%	30%	20%	40%	20%	40%	
Inpatient Treatment	10%	30%	20%	40%	20%	40%	
Outpatient Office Visits	\$10	30%	\$20	40%	20%	40%	
Group Therapy	\$10	30%	\$20	40%	20%	40%	
Mental Health Residential Care (45 days per plan year)	10%	30%	20%	40%	20%	40%	

N/A = No benefit

\*deductible does not apply

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### Pharmacy

Deductible	None	None	None	None	None	None	None	None	
Annual Copay/Out of Pocket Maximum	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	\$1,000	
Retail (31 day supply)									
Generic	\$5	\$5	\$5	\$5	50%	50%	50%	\$5	
Preferred	\$25	\$25	\$25	\$25	50%	50%	50%	\$15	
Non-Preferred	50%, \$50 max	50%, \$50 max	50%, \$50 max	50%, \$50 max	50%	50%	50%	50%	
Mail (90 day supply)									
Generic	\$10	\$10	\$10	\$10	50%	50%	50%	\$10	
Preferred	\$50	\$50	\$50	\$50	50%	50%	50%	\$30	
Non-Preferred	50%, \$100 max	50%, \$100 max	50%, \$100 max	50%, \$100 max	50%	50%	50%	50%	
Specialty	Contact BioScrip Specialty Pharmacy at (877) 316-8921 or online via <a href="http://www.bioscrip.com">www.bioscrip.com</a> for more info.							Contact Providence Specialty Pharmacy at (800) 772-7053, ext. 54535	
Compound	\$25	\$25	\$25	\$25	50%	50%	50%	50% (mail order not available)	

### DENTAL INFORMATION

	Insurance Pays Plan 1 - ODS	Insurance Pays Plan 5 - ODS	Insurance Pays Plan 7 - Willamette Dental
Deductible	None	\$50	none
Annual Maximum	\$2,200	\$1,500	none
Office Co-payment	None	None	\$5
Preventative Care	coverage begins at 70% increase of 10% yearly thereafter	100%	100%
Restorative Services	coverage begins at 70% increase of 10% yearly thereafter	80%	100%
Major Services	coverage begins at 70% increase of 10% yearly thereafter	50%	100%
Prosthodontics	coverage begins at 70% increase of 10% yearly thereafter	50%	100%
Orthodontia	80% to \$1500 lifetime max	80% to \$1500 lifetime max	100% after \$1500 copay+\$10/visit

### VISION INFORMATION

	Insurance Pays Plan 4 - ODS
Plan Maximum	\$600
Routine Eye Exam	100%
Exam Frequency	every 12 months
Lenses (every 12 months) either one pair of lenses or contacts	100%
Frames child: every 12 months adult: every 24 months	100%

This summary is not a guarantee of benefits. Additional details, requirements, limitations and exclusions may apply. Please contact your insurance carrier for any individual medical related benefit questions.