

Medical and Prescription Drug Plan Comparisons

The following pages allow you to compare PEBB's healthcare options on a side-by-side basis. Comparisons are presented in the following order:

- Full-time Medical and Prescription Drug plans available to full-time and part-time employees, retirees and other self-pay participants
- Part-time and Retiree Medical and Prescription Drug Plans available to part-time employees and retirees, and COBRA participants who were part-time employees when they elected COBRA continuation coverage

NOTE: Full-time employees may not enroll in the part-time and retiree plans.

State of Oregon
Public Employees' Benefit Board Summary Plan Description

2010 PEBB Full-time Medical Plans Comparison

[Effective Jan. 1, 2010]

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents as required in PEBB contracts, or applicable federal or state law or rule. See plan documents for details.

Type of Provider or System	PEBB Statewide		Kaiser Permanente ¹	Providence Choice ² (Portland Metro area)	
	In Network	Out of Network	HMO	In Network	Out of Network
Individual Out-of-pocket Maximum	\$1,000	\$2,000	\$600	\$1,000	\$2,000
Family Out-of-pocket Maximum	\$3,000	\$6,000	\$1,200	\$3,000	\$6,000
Individual Lifetime Maximum	\$2 million	\$2 million	No limit	\$2 million	\$2 million
	You pay	You pay	You pay	You pay	You pay
General Office Visit	15%	30%	\$5	\$5	30%
Specialist Office Visit	15%	30%	\$5	\$5	30%
Imaging and Labs	15%	30%	\$0	\$0	30%
Preventative Care					
Health Appraisal	\$0	30%	\$0	\$0	30%
Immunizations	\$0	\$0	\$0	\$0	\$0
Hearing Exams	15%	30%	\$5	\$5	30%
Cancer Screenings	\$0	30%	\$0	\$0	30%

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Hospital					
Ambulance	15%	15%	\$75	\$75	\$75
Hospital Inpatient/day	15%	30%	\$50 ³	\$50 ³	30%
Hospital Outpatient	15%	30%	\$5	\$5	30%
Hospital Emergency Dept.	15%	15%	\$75	\$75	\$75
Surgery					
Surgery Inpatient/day	15%	30%	\$50 ³	\$50 ³	30%
Surgery Outpatient Office	15%	30%	\$5	\$5	30%
Maternity Care					
Childbirth (prenatal, delivery, postpartum)	15%	30%	\$0	\$0	30%
Mental Health, Chemical Dependency					
Mental Health Inpatient & Residential/day	15%	30%	\$50 ³	\$50 ³	30%
Mental Health Outpatient	15%	30%	\$5	\$5	30%
Other Medical					
Diabetic Supplies, Insulin	\$0	\$0	\$0	\$0	\$0
Hearing Aids (\$4,000 once in 4 years)	10%	10%	10%	10%	10%
Durable Medical Equipment	15%	30%	\$0	15%	30%
Chiropractic, Acupuncture, Naturopathic	30%	30%	\$10 ⁴	\$10 ⁴	\$10 ⁴

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Physical Therapy	15%	30%	\$5	\$5	30%
Routine Vision Services	VSP		Kaiser Permanente¹	VSP	
Provider	VSP Network	Out of Network	Kaiser Providers Only	VSP Network	Out of Network
	You pay	You pay	You pay	You pay	You pay
Exam	\$10	\$10 + amount above \$42	\$5	\$10	\$10 + amount above \$42
Lenses and frames, contacts	Amount above \$200	Amount above \$200	Amount above \$200	Amount above \$200	Amount above \$200
Frequency	Every 12 months	Every 12 months	Every 24 months or with change of 0.5 diopter	Every 12 months	Every 12 months

¹ Available in Kaiser service area; plan pays nothing for non-emergency services accessed outside the HMO

² Referral required from Medical Home to receive in-plan benefits for professional services

³ \$250 max per admittance

⁴ Coverage limit \$1,000 per year

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2010 PEBB Part-time Medical Plans Comparison

[Effective Jan. 1, 2010]

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Medical Plan	PEBB Statewide		Kaiser Permanente ¹	Providence Choice ² (Portland Metro area)	
	Network	Out of Network	HMO	Medical Home	Out of Network
Deductible	50% of \$1,000 then 20%	50% of \$1,000 then 50%	\$0	\$0	\$0
Individual Out-of-Pocket Maximum	\$2,000	\$4,000	\$1,500	\$2,000	\$4,000
Family Out-of-Pocket Maximum	\$6,000	\$12,000	\$3,000	\$6,000	\$12,000
Individual lifetime maximum	\$2 million	\$2 million	No limit	\$2 million	\$2 million
	You pay	You pay	You pay	You pay	You pay
General office Visit	20%	50%	\$30	\$30	50%
Specialist office Visit	20%	50%	\$30	\$30	50%
Imaging and Labs	20%	50%	\$10	20%	50%
Preventative Care					
Health Appraisal	\$0	50%	\$0	\$0	50%
Immunizations	\$0	50%	\$0	\$0	50%

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Hearing exams	15%	50%	\$30	\$30	50%
Cancer screenings	\$0	50%	\$0	\$0	50%
Hospital					
Ambulance	20%	20%	\$75	\$75	\$75
Hospital Inpatient	20%	50%	\$500/admit	\$500/admit	50%
Hospital Outpatient	20%	50%	\$30	\$30	50%
Hospital Emergency Department	20%	20%	\$100	\$100	\$100
Surgery					
Surgery Inpatient	20%	50%	\$500/admit	\$30	50%
Surgery Outpatient Office	20%	50%	\$30	\$30	50%
Maternity Care					
Childbirth (prenatal, delivery, postpartum)	20%	50%	\$0	\$0	50%
Mental Health, Chemical Dependency					
Mental Health Inpatient	20%	50%	\$500/admit	\$500/admit	50%
Mental Health Residential	20%	50%	\$50/day ³	\$500/admit	50%
Mental Health Outpatient	20%	50%	\$30	\$30	50%
Other Medical					
Hearing Aids (\$4,000 once in 4 years)	10%	10%	10%	10%	10%

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Diabetic Supplies, Insulin	\$0	\$0	20%, \$0	\$0	\$0
Durable Medical Equipment	20%	50%	50% (except diabetic supplies)	50%	50%
Chiropractic, Acupuncture, Naturopathic	50%	50%	Not Covered	50%	50%
Physical Therapy	20%	50%	\$30	\$30	50%
Routine Vision Services	Not Covered	Not Covered	Exam only: \$30	Not Covered	Not Covered

¹ Available in Kaiser service area; plan pays nothing for non-emergency services accessed outside the HMO

² Referral required from Medical Home to receive in-plan benefits for professional services

³ \$250 max per admittance

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2010 Full-time & Part-time Prescription Drug Comparison [Effective Jan. 1, 2010]			
	PEBB Statewide¹ (FT/PT)	Kaiser Permanente (FT/PT)	Providence Choice¹ (FT/PT)
Month Supply	34-day	30-day	30-day
Provider	Retail Pharmacy	Kaiser Permanente	Retail Pharmacy
Generic	\$5/\$10	\$1/\$10	\$5/\$10
Formulary Brand	\$15/20%	\$15/\$25	\$15/\$25
Non-formulary	Greater of \$50 or 50% plus cost difference between generic and non-formulary brand	Not Covered	Greater of \$50 or 50% plus cost difference between generic and non-formulary brand
Extended Supply	90-day	90-day	90-day
Provider	Mail-order Pharmacy or Preferred Retail Pharmacy	Kaiser Permanente Mail-order Pharmacy	Mail-order Pharmacy or Preferred Retail Pharmacy
Generic	\$12.50/\$25	\$2/\$20	\$5/\$25
Formulary Brand	\$37.50/\$62.50	\$30/\$50	\$37.50/\$62.50
Non-formulary	Greater of \$125 or 50% plus cost difference between generic and non-formulary brand/\$125	Not Covered	Greater of \$125 or 50% plus cost difference between generic and non-formulary brand/ \$125

¹ Plan covers "Value Drugs" on the formulary at zero co-pay

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Full-time Medical Plans Comparison [Discontinues Jan. 1, 2010]

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents or applicable federal or state law or rule.

Plan	Kaiser	Kaiser Added Choice		Providence Choice		Regence BCBSO		
Provider Type	HMO	HMO	Network	OOO*	Network	OOO*	Network	OOO*
Ind. OOP** max	\$600	\$600	\$1,500	\$2,500	\$1,000	\$2,000	\$1,000	\$2,000
Family OOP max	\$1,200	\$1,200	\$4,500	\$7,500	\$3,000	\$6,000	\$3,000	\$6,000
Ind. lifetime max	No limit	No limit	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million
Type of Service	You pay	You pay	You pay	You pay	You pay	You pay	You pay	You pay
General office	\$5	\$10	\$20	30%	\$5	30%	15%	30%
Specialist office	\$5	\$10	15%	30%	\$5	30%	15%	30%
X-ray and lab	\$0	\$0	15%	30%	\$0	30%	15%	30%
Preventive Care ¹								
Health appraisal	\$0	\$0	\$0	30%	\$0	30%	\$0	30%
Immunizations	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Hearing exams	\$5	\$10	\$20	30%	\$5	30%	15%	30%
Cancer screens	\$0	\$0	15%	30%	\$0	30%	\$0	30%
Hospital ²								
Ambulance	\$75	\$75	30%	30%	\$75	\$75	15%	15%
Inpatient/day max	\$50	\$100	15%	30%	\$50	30%	15%	30%
	(\$250/admit)	(\$500/y)			(\$250/admit)			
Outpatient	\$5	\$10	15%	30%	\$5	30%	15%	30%
Emergency dept	\$75	\$75	\$75	\$75	\$75	50%	15%	30%
Surgery ²								
Inpatient/day Max	\$50	\$100	15%	30%	\$50	30%	15%	30%
	(\$250/admit)	(\$500/y)			(\$250/admit)			
Outpatient office	\$5	\$10	15%	30%	\$5	30%	15%	30%
Maternity Care								
Prenatal, delivery, postpartum	\$0	\$0	15%	30%	\$0	30%	15%	30%
Mental Health, Chemical Dependency ²								
Inpatient & resident/day max	\$50	\$100	15%	30%	\$50	30%	15%	30%
	(\$250/admit)	(\$500/y)			(\$250/admit)			
Outpatient	\$5	\$10	15%	30%	\$5	30%	15%	30%
Other Medical ³								
Hearing aids	10%	10%	10%, Rx & Aid only thru HMO		10%	10%	10%	10%
Diabetic supplies, insulin	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0
Durable medical equipment	\$0	\$0	Access thru Kaiser HMO		15%	30%	15%	30%
Alternative Care	\$10	\$15	\$15	\$15	\$10	\$10	30%	30%

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Plan	Kaiser	Kaiser Added Choice			Providence Choice		Regence BCBSO	
Provider Type	HMO	HMO	Network	OON*	Network	OON*	Network	OON*
Physical Therapy	\$5	\$10	15%	30%	\$5	30%	15%	30%
Vision	Kaiser Vision Benefit (every 24 months)				VSP Vision Benefit (every 12 months)			
Exam	\$5	\$10	15%	30%	VSP provider \$10 Non-VSP provider \$10 + amount above \$42			
Eyewear	Kaiser facilities only. Amount above \$200				Amount above \$200			
* OON = Out of Network **OOP = Out of Pocket								
¹ Plans cover preventive services on recommended schedules								
² Plans may require prior authorization								
³ Plans may place limits on type, number, frequency, source or maximum coverage of services or devices								
⁴ Benefits provided every 12 months								

Full-time Plans Prescription Drug Comparison [Discontinues Jan. 1, 2010]

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Coverage	Kaiser	Kaiser Added Choice			Providence	Regence
		HMO	Network	OON		
Retail supply	30-day	30-day	30-day	30-day	30-day	34-day
Pharmacies	Kaiser Only	Kaiser Only	MedImpact ¹	MedImpact ¹	Participating	Any
Generic	\$1	\$5	\$20	\$20	\$5	\$5
Brand	\$15	\$15	\$20 ²	\$20 ²	\$15	\$15
Non Formulary	Not Covered (NC)		\$20 ²	\$20 ²	>\$50 or 50% ³	>\$50 or 50% ³
90-day Mail Supply⁴						
Generic	\$1	\$10	\$10	\$10	\$5	\$12.50
Brand	\$15	\$30	\$30 ²	\$30 ²	\$37.50	\$37.50
Non Formulary	Not Covered				>\$125 or 50% ³	>\$125 or 50% ³
¹ May use Kaiser mail-order if drug is in stock and in formulary						
² Plus the difference between generic and formulary brand						
³ Plus the difference between generic and brand for brands not on the formulary						
⁴ Only "Maintenance drugs" in Kaiser						

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Part-time & Retiree Medical Plans Comparison [Discontinues Jan. 1, 2010]

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	Kaiser	Kaiser Added Choice		Providence Choice		Regence BCBSO		
Provider Type	HMO	HMO	Network	OON*	Network	OON*	Network	OON*
Deductible (Individual; Family)	\$0	(\$250; \$750)	(\$750; \$2,250)	(\$1,000; \$3,000)	\$0	\$0	50% of \$1,000 then 20%	50% of \$1,000 then 50%
Ind. OOP** max	\$1,500	\$2,000	\$3,000	\$4,500	\$2,000	\$4,000	\$2,000	\$4,000
Family OOP max	\$3,000	\$6,000	\$9,000	\$13,500	\$6,000	\$12,000	\$6,000	\$12,000
Indiv. lifetime max	No limit	No limit	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million	\$2 million
Type of Service	You pay	You pay	You pay	You pay	You pay	You pay	You pay	You pay
General office	\$30	\$30	30%	50%	\$30	50%	20%	50%
Specialist office	\$30	\$30	30%	50%	\$30	50%	20%	50%
X-ray and lab	\$10	20%	30%	50%	20%	50%	20%	50%
Preventive Care¹								
Health appraisal	\$0	\$30	30%	50%	\$0	50%	\$0	50%
Immunizations	\$0	\$0	30%	50%	\$0	50%	\$0	50%
Hearing exams	\$30	\$30	30%	50%	\$30	50%	20%	50%
Cancer screens	\$0	20%	30%	50%	\$0	50%	\$0	50%
Hospital²								
Ambulance	\$75	20%	50%	50%	\$75	\$75	20%	20%
Inpatient	\$500/admit	20%	30%	50%	\$500/admit	50%	20%	50%
Outpatient	\$30	30%	30%	50%	\$30	50%	20%	50%
Emergency dept	\$100	20%	20%	20%	\$100	50%	20%	50%
Surgery²								
Inpatient	\$0	20%	30%	50%	\$30	50%	20%	50%
Outpatient office	\$30	20%	30%	50%	\$30	50%	20%	50%
Maternity Care								
Prenatal, delivery, postpartum	\$0	\$30	30%	50%	\$0	50%	20%	50%
Mental Health, Chemical Dependency²								
Inpatient	\$500/admit	20%	30%	50%	\$500/admit	50%	20%	50%
Residential	\$50/day, \$250/admit	20%	30%	50%	\$500/admit	50%	20%	50%
Outpatient	\$30	\$30	30%	50%	\$30	50%	20%	50%
Other³								
Vision	Exam only	Not Covered						
Hearing aids	10%	10%	10%, Rx & Aid only thru HMO		10%	10%	10%	10%
Diabetic supplies, insulin	Covered as durable medical equipment & prescription drugs				\$0	\$0	\$0	\$0
Durable medical equipment	50%	50%	Access thru Kaiser HMO		50%	50%	20%	50%

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	Kaiser	Kaiser Added Choice			Providence Choice		Regence BCBSO	
Provider Type	HMO	HMO	Network	OON*	Network	OON*	Network	OON*
Alternative Care	Not Covered				50%		50%	
Physical Therapy	\$30	\$30	30%	50%	\$30	50%	20%	50%
* OON = Out of Network								
¹ Plans cover preventive services on recommended schedules								
² Plans may require prior authorization, precertification or a treatment plan								
³ Plans may place limits on type, number, frequency, source or maximum coverage of services or devices								

Part-time & Retiree Plans Prescription Drug Comparison [Discontinues Jan. 1, 2010]

This is a summary, only. Any error or omission here is unintentional and will be resolved in favor of plan documents or applicable federal or state law or rule.

Coverage	Kaiser	Kaiser Added Choice			Providence	Regence
		HMO	Network	OON		
Retail supply	30-day	30-day	30-day	30-day	30-day	34-day
Pharmacies	Kaiser Only	Kaiser Only	MedImpact ¹	MedImpact ¹	Participating	Any
Generic	\$10	\$10	\$30	\$30	\$10	\$10
Brand	\$25	\$25	\$30 ²	\$30 ²	\$25	\$25
Non Formulary	Not Covered (NC)		\$20 ²	\$20 ²	>\$50 or 50% ³	>\$50 or 50% ³
90-day Mail Supply⁴						
Generic	\$1	\$20	\$20	\$20	\$25	\$37.50
Brand	\$50	\$50	\$50 ²	\$50 ²	\$62.50	\$62.50
Non Formulary	Not Covered				>\$125 or 50% ³	>\$125 or 50% ³
¹ May use Kaiser mail-order if drug is in stock and in formulary						
² Plus the difference between generic and formulary brand						
³ Plus the difference between generic and brand for brands not on the formulary						
⁴ Only "maintenance drugs" in Kaiser						