Medical Plans

Kaiser Permanente NW Deductible

my.kp.org/pebb

Regional Service Area: Benton, Clackamas, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill; Clark, Cowlitz, Lewis, Skamania & Wahkiakum WA

	Full-time	Part-time
Standard deductible[2]	$250/individual, $750/family Some services not subject to deductible	$250/individual, $750/family Some services not subject to deductible
Additional non-HEM participant deductible[3]	Additional deductible: $100/individual, $300/family (applies to all services unless otherwise noted)	
Out-of-pocket max	$1500/individual $4500/family	$1500/individual, $4500/family
Providers	Kaiser Permanente network of providers	
Referrals	Referrals to non-Kaiser Permanente providers only from Kaiser provider	
Primary care visit	$5, deductible waived	$30, deductible waived
Chronic care visit[5]	$5, deductible waived	$30, deductible waived
Specialty visit	$5 w/referral, deductible waived	$30 w/referral, deductible waived
Mental health care	Costs same as medical services	
Substance abuse treatment	$0, deductible waived	$0, deductible waived
Prenatal, first postnatal visit	$0, deductible waived	$0, deductible waived
Delivery	Inpatient delivery subject to inpatient hospital charges	
Preventive	$0, deductible waived	$0, deductible waived
Lab & X-ray	$15, deductible waived	$20, deductible waived
Inpatient hospital per admission	$50/day up to $250 max	$500
Emergency department[6]	$75	$100
Durable medical equipment	15%, deductible waived	50%, deductible waived
Insulin & diabetic supplies	$0 or 0%, deductible waved	
Additional Cost Tier $100 copay[8]	$100 copay, deductible waived	$100 copay, deductible waived
Additional Cost Tier $500 copay	Standard copay only, applies to out of pocket maximum	Standard copay only, applies to out of pocket maximum
Alternative care provider visits[13]	$10, deductible waived	$30, with physician's authorization referral, deductible waived
Spinal manipulation, acupuncture services[13]	$10, deductible waived	$30 with physician's authorization referral, deductible waived
Prescription drugs	• No deductible • Copays accumulate to out-of-pocket maximum • $5 generic • $25 brand • 50% up to $100 max non-formulary brand • Mail order (31-90 day), $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	• No deductible • Copays accumulate to out-of-pocket maximum • $10 generic • $25 brand • Mail order 2 copays for up to 90-day supply

This is a summary only. See the plan's documents for details. In the case of a discrepancy between this summary and a plan document, the plan document will apply. See footnotes, pages 10-11.

Medical Plans (continued)

Kaiser Permanente NW HMO

my.kp.org/pebb

Regional Service Area: Benton, Clackamas, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill; Clark, Cowlitz, Lewis, Skamania & Wahkiakum WA

	Full-time	Part-time
Standard deductible	$0	$0
Additional HEM non-participant deductible[3]	Additional deductible: $100/individual, $300/family (applies to all services unless otherwise noted)	
Out-of-pocket max	$600/individual, $1200/family	$1500/individual, $3000/family
Providers	Kaiser Permanente Network of providers	
Referrals	Referrals to non-Kaiser Permanente providers only from Kaiser provider	
Primary care visit	$5	$30
Specialty visit	$5, with referral	$30, with referral
Mental health care	Same cost as physical health services	
Substance abuse treatment	$0	$0
Prenatal, first postnatal visit	$0	$0
Delivery	Inpatient delivery subject to inpatient hospital charges	
Preventive	$0	$0
Lab & X-ray	$0	$10
Inpatient hospital per admission	$50/day, up to $250 max	$500
Emergency department[6]	$75	$100
Durable medical equipment	$0	50%
Insulin & diabetic supplies	$0	
Additional Cost Tier $100 copay[8]	$100 copay	$100 copay
Additional Cost Tier $500 copay	Does not apply in this plan	Does not apply in this plan
Alternative care provider visits[13]	$10	$30, with physician's authorization approval
Spinal manipulation, acupuncture services[13]	$10	$30, with physician's authorization approval
Prescription drugs	• No deductible • Copays accumulate to out-of-pocket maximum • $1 generic • $15 brand • Mail order (31-90 day), $1 generic, $15 brand	• No deductible • Copays accumulate to out-of-pocket maximum • $10 generic • $25 brand • Mail order 2 copays for up to 90-day supply

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Medical Plans (continued)

Moda Summit, Synergy

Modahealth.com/pebb

Synergy Service Area: Benton, Clackamas, Clatsop, Columbia, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington, Yamhill, and Clark in Washington

Summit Service Area: Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wheeler

	Full-time		Part-time	
Providers	**In Medical home[1]**	**Out of network[1]**	**In Medical home[1]**	**Out of network[1]**
Standard deductible[2]	$250/individual, $750/family	$500/individual, $1500/family	$500/individual, $1500/family	$1000/individual, $3000/family
Additional non-HEM participant deductible[3]	$100/individual, $300/family (applies to all services unless otherwise noted)			
Out-of-pocket max (some deductibles, copays, services don't apply)	$1500/individual, $4500/family	$2500/individual $7500/family	$2500/individual $7500/family	$4500/individual, $13500/family
Primary care visit	$5, first 4 visits deductible waived	30%	$30, first 4 visits deductible waived	50%
Chronic care visit[5]	$0, deductible waived	30%	$0, deductible waived	50%
Specialty visit	$5, with referral	30%	$30, with referral	50%
Mental health care	Cost same as medical services			
Substance abuse treatment	$0, deductible waived	Cost same as medical services	$0, deductible waived	Cost same as medical services
Maternity, & childbirth services provider	$0, deductible waived	$30	$0, deductible waived	50%
Delivery	Inpatient delivery subject to inpatient hospital charges			
Preventive	$0, deductible waived	30%	$0, deductible waived	50%
Lab & x-ray	$0, deductible waived	30%	$0, Quest provider, deductible waived, or 20%	50%
Inpatient hospital per admission	$50/day to $250 max	30%	$500	50%
Emergency department[6]	$100	$100	$100	$100
Durable medical equip.	15%	30%	20%	50%
Insulin, diabetic supplies	$0, deductible waived			
Additional Cost Tier $100 copay[7]	$100	$100 + $30	$100	$100 + 50%
Additional Cost Tier $500 copay[9]	$500	$500 + 30%	$500	$500 + 50%
Alternative care provider visits	$5	30%	$30	50%
Spinal manipulation, acupuncture services[13]	$5 up to $1,000/yr max combined. Not applied to out-of-pocket max.	30% up to $1,000/yr max combined. Not applied to out-of-pocket max.	$30 up to $1000/yr max combined. Not applied to out-of-pocket max.	50% up to $1000/yr max combined. Not applied to out-of-pocket max.
Prescription drugs	• $50/individual, $150/ family deductible[10] • $1000 out-of-pocket maximum[11] • $0 Value, not subject to deductible[12] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• In-network deductible, out-of-pocket max apply • $0 Value, not subject to deductible[12] • $20 generic • $50 preferred brand • $100 specialty • Copay x 2.5 for 90-day • Member pays difference between in-network rate and billed amount	• $50/individual, $150/ family deductible[10] • $1000 out-of- pocket maximum[11] • $0 Value, not subject to deductible[12] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• In-network deductible, out-of-pocket max apply • $0 Value, not subject to deductible[12] • $20 generic • $50 preferred brand • $100 specialty. • Copay x 2.5 for 90-day • Member pays difference between in-network rate and billed amount

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Medical Plans (continued)

PEBB Statewide

Regional Service Area: Statewide and Nationwide

Providence.org/pebb

	Full-time		Part-time	
Providers	**In Network**	**Out of Network**	**In Network**	**Out of Network**
Standard deductible[2]	$250/individual, $750/family Four primary care visits not subject	$500/individual, $1500/family	$500/individual, $1500/family Four primary care visits not subject	$1000/individual, $3000/family
Additional non-HEM participant deductible[3]	$100/individual, $300/family (applies to all services unless otherwise noted)			
Out-of-pocket max (some deductibles, copays, services don't apply)	$1500/individual $4500/family	$2500/individual $7500/family	$2500/individual $7500/family	$4500/individual $13500/family
Primary care visit	15% or 10%[4], deductible waived	30%	20% or 15%[4], deductible waived	50%
Chronic care visit[5]	0%, deductible waived	30%	0%, deductible waived	50%
Specialty visit	15%	30%	20%	50%
Mental health care	Cost same as medical services			
Substance abuse treatment	0%, deductible waived	30%	0%, deductible waived	50%
Pre-natal	0%, deductible waived	30%	0%, deductible waived	50%
Delivery and postnatal	15%	30%	20%	50%
Preventive	0%, deductible waived	30%	0%, deductible waived	50%
Lab & x-ray	15%	30%	20%	50%
Inpatient hospital per admission	15%	30%	20%	50%
Emergency department[6]	$100 + 15%	$100 + 15%	$100 + 20%	$100 + 20%
Durable medical equip.	15%	30%	20%	50%
Insulin, diabetic supplies	0% or $0, deductible waived			
Additional Cost Tier $100 copay[7]	$100 + 15%	$100 + 30%	$100 + 20%	$100 + 50%
Additional Cost Tier $500 copay[9]	$500 + 15%	$500 + 30%	$500 + 20%	$500 + 50%
Alternative care provider visits	15%	30%	20%	50%
Spinal manipulation, acupuncture services[13]	15%, up to 60 services/yr max combined. Not apply to out of pocket max.	30 %, up to 60 services/yr max combined. Not apply to out of pocket max.	20%, up to 60 services/yr max combined. Not apply to out of pocket max.	50%, up to 60 services/yr max combined. Not apply to out of pocket max.
Prescription drugs	• $50/individual, $150/family deductible[10] • $1000 out-of-pocket maximum[11] • $0 Value, not subject to deductible[12] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket maximum apply • Reimbursed as if filled in network; member pays difference between network rate & billed amount	• $50/individual, $150/family deductible[10] • $1000 out-of- pocket maximum[11] • $0 Value, not subject to deductible[12] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket maximum apply • Reimbursed as if filled in network; member pays difference between network rate & billed amount

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Medical Plans (continued)

Providence Choice

Providence.org/pebb

Regional Service Area: Baker, Benton, Clackamas, Clatsop, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Malheur, Marion, Multnomah, Polk, Umatilla, Union, Wallowa, Wasco, Washington, Yamhill; Clark and Walla Walla, WA; Payette, ID

	Full-time		Part-time	
Providers	**In Medical home[1]**	**Out of medical home[1]**	**In Medical home[1]**	**Out of medical home[1]**
Standard deductible[2]	$250/individual $750/ family, 4 visits not subject	$500/individual $1500/ family	$500/individual $1500/ family, 4 visits not subject	$1000/individual $3000/ family
Additional non-HEM participant deductible[3]	$100/individual, $300/family (applies to all services unless otherwise noted)			
Out-of-pocket max (some deductibles, copays, services don't apply)	$1500/individual, $4500/family	$2500/individual, $7500/family	$2500/individual, $7500/family	$4500/individual, $13500/family
Primary care visit	$5, first 4 visits deductible waived	30%	$30, first 4 visits deductible waived	50%
Chronic care visit[5]	$0, deductible waived	30%	$0, deductible waived	50%
Specialty visit	$5, with referral	30%	$30, with referral	50%
Mental health care	Cost same as medical services			
Substance abuse treatment	$0, deductible waived	Cost same as medical services	$0, deductible waived	Cost same as medical services
Maternity, & childbirth services provider	$0, deductible waived	30%	$0, deductible waived	50%
Delivery	Inpatient delivery subject to inpatient hospital charges			
Preventive	$0, deductible waived	30%	$0, deductible waived	50%
Lab & x-ray	$0, deductible waived	30%	20%, deductible applies	50%
Inpatient hospital per admission	$50/day to $250 max	30%	$500	50%
Emergency department[6]	$100	$100	$100	$100
Durable medical equip.	15%	30%	20%	50%
Insulin, diabetic supplies	$0, deductible waived			
Additional Cost Tier $100 copay[7]	$100	$100 + 30%	$100	$100 + 50%
Additional Cost Tier $500 copay[9]	$500	$500 + 30%	$500	$500 + 50%
Alternative care provider visits	$5	30%	$30	50%
Spinal manipulation, acupuncture services[13]	$5/visit, up to $1000/yr max combined. Not applied to out-of-pocket max.	30%, up to $1000/yr max combined. Not applied to out-of-pocket max.	$30/visit, up to $1000/yr max combined. Not applied to out-of-pocket max	50% up to $1000/yr max combined. Not applied to out-of-pocket max.
Prescription drugs	• $50/individual, $150/ family deductible[10] • $1000 out-of-pocket maximum[11] • $0 Value, not subject to deductible[12] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• In-network deductible, out-of-pocket maximum apply • $0 Value, not subject to deductible[12] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• $50/individual, $150/ family deductible[10] • $1000 out-of- pocket maximum[11] • $0 Value, not subject to deductible[12] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• In-network deductible, out-of-pocket maximum apply • $0 Value, not subject to deductible[12] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty • Member pays difference between in-network rate and billed amount

This is a summary only. See the plan's documents for details. In the case of a discrepancy between this summary and a plan document, the plan document will apply. See footnotes, pages 10-11.

Medical Plans (continued)

AllCare PEBB

Regional Service Area: Curry, Jackson, Josephine, Glendale and Azalea in Douglas

Allcarepebb.com

	Full-time			Part-time		
Providers	**Preferred**	**Participating**	**Out-of-network**	**Preferred**	**Participating**	**Out-of-network**
Standard deductible	$250/individual, $750/family **Apply toward each other**	$500/individual, $1500/family	$500/individual, $1500/family	$500/individual, $1500/family **Apply toward each other**	$1000/ individual, $3000/family	$1000/ individual, $3000/family
Additional HEM non-participant deductible[3]	$100/individual, $300/family (applies to all services unless otherwise noted)					
Out-of-pocket max (some deductibles, copays, services don't apply)	$1500/ individual, $4500/family **Apply toward each other**	$2500/ individual, $7500/family	$2500/ individual, $7500/family	$2500/ individual, $7500/family **Apply toward each other**	$4500/ individual, $13500/family	$4500/ individual, $13500/family
Primary care visit	$5, deductible waived	$20, deductible waived	30%	$5, deductible waived	$30, deductible waived	50%
Chronic care visit[5]	$0, deductible waived	$10, deductible waived	30%	$0, deductible waived	$10, deductible waived	50%
Specialty visit	$20, w referral	$30	30%	$30, w referral	$60	50%
Mental health care	$5	$20	30%	$5	$20	50%
Substance abuse treatment	$0, deductible waived		Cost same as medical services	$0, deductible waived		Cost same as medical services
Maternity, child birth provider	$0, deductible waived		30%	$0, deductible waived		50%
Delivery	$0, deductible waived	$100/day up to $500 max	30%	$0, deductible waived	40%	50%
Preventive	$0, deductible waived		30%	$0, deductible waived		50%
Lab & X-ray	$0	30%	30%	20%	40%	50%
Inpatient hospital per admission	$50/day up to $250 max	$100/day up to $500 max	30%	$500	40%	50%
Emergency deptartment	$100					
Durable medical equip.	15%		30%	50%		
Insulin, diabetic supplies	$0 or 0%, deductible waived					
Additional Cost Tier $100 copay[7]	$100	$100 + 30%	$100 + 50%	$100	$100 +40%	$100 + 50%
Additional Cost Tier $500 copay[9]	$500	$500 + 30%	$500 + 50%	$500	$500 + 40%	$500 + 50%
Alternative care provider visits	$10	$20	30%	$30	40%	50%
Spinal manipulation, acupuncture services[13]	$10 up to $1000/yr max combined. Not applied to out-of-pocket max.	$20 up to $1000/yr max combined. Not applied to out-of-pocket max.	30% up to $1000/yr max combined. Not applied to out-of-pocket max.	$30 up to $1000/yr max combined. Not applied to out-of-pocket max.	40% up to $1000/yr max combined. Not applied to out-of-pocket max.	50% up to $1000/yr max combined. Not applied to out-of-pocket max.
Prescription drugs	(continued on following page)					

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Medical Plans (continued)

AllCare PEBB (continued)

Regional Service Area: Curry, Jackson, Josephine, Glendale and Azalea in Douglas

	Full-time			Part-time		
Providers	**Preferred**	**Participating**	**Out-of-network**	**Preferred**	**Participating**	**Out-of-network**
Prescription drugs	• $50/individual, $150/family deductible[10] • $1000 out-of-pocket maximum[11] • $0 preventive/EHB, not subject to deductible • $10 generic • $30 brand • $60 non-preferred • Copay x 2 for 90-day • $100 specialty	Out-of-Network. Member pays full cost and may be reimbursed for AllCare PEBB share of cost.		• $50/individual, $150/family deductible[10] • $1000 out-of-pocket maximum[11] • $0 preventive/EHB, not subject to deductible • $15 generic • $40 brand • $75 non-preferred • Copay x 2 for 90-day • $100 specialty	Out-of-Network. Member pays full cost and may be reimbursed for AllCare PEBB share of cost.	

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Medical Plans Footnotes

[1] To receive In-Medical Home benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or from providers referred by their medical home. Otherwise, benefits typically have higher costs or may not be covered. See the list of medical homes on the plan's website.

[2] All medical plans have a standard plan deductible (except Kaiser HMO). This is the amount a member must pay for covered services before the plan begins to pay its share for medically necessary covered services. Deductibles apply per individual, or the family deductible will apply when there are three or more individuals within a family, based on the employee's choice of coverage tier. Payments toward the deductible accumulate separately for services in-network and out-of-network, and In- Medical Home and Out-of-Medical Home (see [1] above). Certain in-network services are not subject to the deductible. Examples: first four visits per individual to a primary care provider; insulin and diabetic supplies; visits for care of asthma, diabetes, cardiovascular disease or congestive heart failure; and preventive services. On the Kaiser deductible plans, the deductible is waived on additional services; please see the benefit summary for additional details.

[3] The goal of the Health Engagement Model (HEM) program is to engage as many people as possible in improving their health, which can help to contain health care costs over time. A $100-per individual HEM Non-Participant deductible will be added to their plan's standard deductible for members who 1) choose not to enroll in the HEM program 2) sign up but don't complete their health assessment within the scheduled time frame or 3) don't actively enroll in 2015 benefits. This HEM deductible is in addition to the plan's standard deductible (both in-network and out-of-network). This deductible works the same as the standard plan deductible as described in [2] above. Kaiser HMO non-HEM participant plan will have a $100 deductible.

[4] PEBB Statewide plan members whose in-network provider has been recognized by the Oregon Health Authority as a Patient-Centered Primary Care Home will have the lower coinsurance.

[5] These are visits for care of asthma, diabetes, cardiovascular disease and congestive heart failure. Not subject to deductible in-network.

[6] Copay amounts for use of a hospital emergency department are waived if the member is admitted directly to the hospital for inpatient treatment. This does not include admittance for observation. Copay does not apply to out-of-pocket maximum except in Kaiser plans. In-plan deductible applies.

[7] These procedures are MRI, CT, PET and SPECT scans; sleep studies; spinal injections; upper endoscopy; bunionectomy; surgery for hammertoe and Morton's neuroma; and knee viscosupplementation. Copay does not apply to out-of-pocket maximum. Not applied to cancer-related procedures. These procedures may be overused compared with their risks and benefits.

[8] Applies only to MRI, CT, PET and SPECT scans, and sleep studies in Kaiser plans. Additional copay applies to out of pocket maximum.

[9] These are surgical procedures for hip or knee replacement or resurfacing; knee or shoulder arthroscopy; bariatric surgery; spine procedures; and sinus surgery. Copay does not apply to out-of- pocket maximum. Not applied to cancer-related procedures. These procedures may have alternatives that provide equal or better outcomes with lower risks and costs.

Medical Plans Footnotes (continued)

[10] *The prescription drug deductible is $50 per person or $150 for families with three or more members. It applies separately from the medical deductible.*

[11] *The prescription drug out-of-pocket maximum is $1,000 per person, with a family (three-person) maximum of $3,000. It accrues separately from the medical out-of-pocket maximum.*

[12] *All plans have formularies that list covered drugs. Value drugs typically are generic drugs that are used in treating most common chronic conditions. (EHB stands for Essential Health Benefits.)*

[13] *Limited to $1,000/year (combined in Kaiser plans). Limited to 60 visits/year in PEBB Statewide plan max. Copays and coinsurance do not apply to out-of-pocket maximum.*