

## Choose your 2017 health plan (continued)

The tables below show the monthly premium rate by tier for each of the medical plans. Part-time employees who choose a part-time plan have a subsidy. The subsidy is not shown in the premium rate. It is included in the cost estimators at [www.oregon.gov/oha/pebb](http://www.oregon.gov/oha/pebb).

### 2017 Employee Medical Plan Monthly Premium Rates (available to both full-time and part-time employees)

|                                   | Employee | Employee & Spouse/<br>Partner | Employee & Children | Employee & Family |
|-----------------------------------|----------|-------------------------------|---------------------|-------------------|
| AllCare PEBB <sup>1</sup>         | \$748.06 | \$1,234.29                    | \$1,047.27          | \$1,496.11        |
| Kaiser <sup>2</sup>               | \$893.14 | \$1,473.66                    | \$1,250.38          | \$1,786.25        |
| Kaiser Deductible <sup>2</sup>    | \$816.24 | \$1,346.78                    | \$1,142.73          | \$1,632.46        |
| Moda Summit, Synergy <sup>1</sup> | \$790.74 | \$1,304.71                    | \$1,107.02          | \$1,581.47        |
| PEBB Statewide <sup>1</sup>       | \$910.51 | \$1,502.33                    | \$1,274.71          | \$1,821.01        |
| Providence Choice <sup>1</sup>    | \$763.18 | \$1,259.24                    | \$1,068.45          | \$1,526.35        |

<sup>1</sup> No in-plan vision coverage

<sup>2</sup> Kaiser routine vision care

### 2017 Part-time Employee Medical Plan Monthly Premium Rates (available only to part-time employees)

|                                   | Employee | Employee & Spouse/<br>Partner | Employee & Children | Employee & Family |
|-----------------------------------|----------|-------------------------------|---------------------|-------------------|
| AllCare PEBB <sup>1</sup>         | \$642.68 | \$1,060.42                    | \$899.75            | \$1,285.35        |
| Kaiser <sup>2</sup>               | \$756.08 | \$1,247.53                    | \$1,058.49          | \$1,512.15        |
| Kaiser Deductible <sup>2</sup>    | \$663.07 | \$1,094.08                    | \$928.30            | \$1,326.15        |
| Moda Summit, Synergy <sup>1</sup> | \$641.39 | \$1,058.28                    | \$897.93            | \$1,282.75        |
| PEBB Statewide <sup>1</sup>       | \$739.66 | \$1,220.43                    | \$1,035.51          | \$1,479.31        |
| Providence Choice <sup>1</sup>    | \$618.47 | \$1,020.47                    | \$865.85            | \$1,236.93        |

<sup>1</sup> No in-plan vision coverage

<sup>2</sup> Vision exam only

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply.

## Health Plans by Oregon County

This table shows the higher-cost and lower-cost plans available in each county. A part-time version of each of these plans with an employer subsidy is available to part-time employees. Full-time employees cannot enroll in part-time plans.

| County     | Lower-cost Plans, Lower Premium Share              | Higher-cost Plans, Higher Premium Share |
|------------|--|---|
| Baker      | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Benton     | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |
| Clackamas  | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |
| Clatsop    | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Columbia   | Kaiser Deductible, Moda Synergy                    | Kaiser HMO, PEBB Statewide              |
| Coos       | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Crook      | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Curry      | AllCare PEBB, Moda Synergy, Providence Choice      | PEBB Statewide                          |
| Deschutes  | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Douglas*   | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Gilliam    | Moda Summit  | PEBB Statewide                          |
| Grant      | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Harney     | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Hood River | Moda Synergy, Providence Choice                    | Kaiser HMO, PEBB Statewide              |
| Jackson    | AllCare PEBB, Moda Synergy, Providence Choice      | PEBB Statewide                          |
| Jefferson  | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Josephine  | AllCare PEBB, Moda Synergy, Providence Choice      | PEBB Statewide                          |
| Klamath    | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Lake       | Moda Summit  | PEBB Statewide                          |
| Lane       | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Lincoln    | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Linn       | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |
| Malheur    | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Marion     | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |
| Morrow     | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Multnomah  | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |
| Polk       | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |
| Sherman    | Moda Summit  | PEBB Statewide                          |
| Tillamook  | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Umatilla   | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Union      | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Wallowa    | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Wasco      | Moda Synergy, Providence Choice                    | PEBB Statewide                          |
| Washington | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |
| Wheeler    | Moda Summit, Providence Choice                     | PEBB Statewide                          |
| Yamhill    | Kaiser Deductible, Moda Synergy, Providence Choice | Kaiser HMO, PEBB Statewide              |

\*AllCare PEBB in Azalea and Glendale

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# Medical Plans

## Kaiser Permanente NW Deductible

[my.kp.org/pebb](http://my.kp.org/pebb)

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

|   | Full-time   | Part-time  |
|---|---|--|
| <b>Standard deductible<sup>2</sup></b>                        | \$250/individual, \$750/family<br>Some services not subject to deductible   | \$250/individual, \$750/family<br>Some services not subject to deductible  |
| <b>Additional non-HEM participant deductible<sup>3</sup></b>  | Additional deductible: \$100/individual, \$300/family applies to all services unless otherwise noted  |  |
| <b>Out-of-pocket max</b>                                      | \$1500/individual \$4500/family   | \$1500/individual, \$4500/family   |
| <b>Providers</b>  | Kaiser Permanente network of providers  |  |
| <b>Referrals</b>  | Referrals to non-Kaiser Permanente providers only from Kaiser provider  |  |
| <b>Primary care visit</b>                                     | \$5, deductible waived  | \$30, deductible waived  |
| <b>Chronic care visit<sup>5</sup></b>                         | \$5, deductible waived  | \$30, deductible waived  |
| <b>Specialty visit</b>  | \$5 w/referral, deductible waived   | \$30 w/referral, deductible waived   |
| <b>Outpatient mental health care</b>                          | \$5, deductible waived  | \$30, deductible waived  |
| <b>Substance abuse treatment</b>                              | \$0, deductible waived  | \$0, deductible waived   |
| <b>Prenatal, first postnatal visit</b>                        | \$0, deductible waived  | \$0, deductible waived   |
| <b>Delivery</b>   | Inpatient delivery subject to inpatient hospital charges  |  |
| <b>Preventive</b>   | \$0, deductible waived  | \$0, deductible waived   |
| <b>Lab &amp; X-ray</b>  | \$15, deductible waived   | \$20, deductible waived  |
| <b>Inpatient hospital per admission</b>                       | \$50/day up to \$250 max  | \$500  |
| <b>Emergency department<sup>6</sup></b>                       | \$75  | \$100  |
| <b>Durable medical equipment</b>                              | 15%, deductible waived  | 50%, deductible waived   |
| <b>Insulin &amp; diabetic supplies</b>                        | \$0 or 0%, deductible waived  |  |
| <b>Additional Cost Tier \$100 copay<sup>8</sup></b>           | \$100 copay, deductible waived  | \$100 copay, deductible waived   |
| <b>Additional Cost Tier \$500 copay</b>                       | Standard copay only, applies to out of pocket maximum   | Standard copay only, applies to out of pocket maximum  |
| <b>Alternative care provider visits<sup>13</sup></b>          | \$10, deductible waived   | \$30, with physician's authorization referral, deductible waived   |
| <b>Spinal manipulation, acupuncture services<sup>13</sup></b> | \$10, deductible waived   | \$30 with physician's authorization referral, deductible waived  |
| <b>Prescription drugs</b>                                     | <ul style="list-style-type: none"> <li>No deductible</li> <li>Copays accumulate to out-of-pocket maximum</li> <li>\$5 generic</li> <li>\$25 brand</li> <li>50% up to \$100 max non-formulary brand</li> <li>\$50 Specialty</li> <li>Mail order (31-90 day), \$5 generic, \$25 formulary brand, 50% up to \$100 max non-formulary brand</li> </ul> | <ul style="list-style-type: none"> <li>No deductible</li> <li>Copays accumulate to out-of-pocket maximum</li> <li>\$10 generic</li> <li>\$25 brand</li> <li>\$50 Specialty</li> <li>Mail order 2 copays for up to 90-day supply</li> </ul> |

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## Medical Plans (continued)

### Kaiser Permanente NW HMO

[my.kp.org/pebb](http://my.kp.org/pebb)

**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 <sup>3</sup>  | 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  |
| Outpatient 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 <sup>6</sup>                       | \$75  | \$100  |
| Durable medical equipment                               | \$0   | 50%  |
| Insulin & diabetic supplies                             | \$0   |  |
| Additional Cost Tier \$100 copay <sup>8</sup>           | \$100 copay   | \$100 copay  |
| Additional Cost Tier \$500 copay                        | Does not apply in this plan   |  |
| Alternative care provider visits <sup>13</sup>          | \$10  | \$30, with physician's authorization approval  |
| Spinal manipulation, acupuncture services <sup>13</sup> | \$10  | \$30, with physician's authorization approval  |
| Prescription drugs                                      | <ul style="list-style-type: none"> <li>No deductible</li> <li>Copays accumulate to out-of-pocket maximum</li> <li>\$1 generic</li> <li>\$15 brand</li> <li>\$50 Specialty</li> <li>Mail order (31-90 day), \$1 generic, \$15 brand</li> </ul> | <ul style="list-style-type: none"> <li>No deductible</li> <li>Copays accumulate to out-of-pocket maximum</li> <li>\$10 generic</li> <li>\$25 brand</li> <li>\$50 Specialty</li> <li>Mail order 2 copays for up to 90-day supply</li> </ul> |

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## Medical Plans (continued)

### Moda Synergy, Summit

[Modahealth.com/pebb](http://Modahealth.com/pebb)

**Synergy Service Area:** Benton, Clackamas, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Jefferson, Josephine, Klamath, 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

| Providers  | Full-time  |  | Part-time  |   |
|--|--|--|--|---|
|  | In Medical home <sup>1</sup>   | Out of network <sup>1</sup>  | In Medical home <sup>1</sup>   | Out of network <sup>1</sup>   |
| <b>Standard deductible<sup>2</sup></b>                                       | \$250/individual,<br>\$750/family  | \$500/individual,<br>\$1500/family   | \$500/individual,<br>\$1500/family   | \$1000/individual,<br>\$3000/family   |
| <b>Additional non-HEM participant deductible<sup>3</sup></b>                 | \$100/individual, \$300/family applies to all services unless otherwise noted  |  |  |   |
| <b>Out-of-pocket max</b><br>(some deductibles, copays, services don't apply) | \$1500/individual,<br>\$4500/family  | \$2500/individual<br>\$7500/family   | \$2500/individual<br>\$7500/family   | \$4500/individual,<br>\$13500/family  |
| <b>Primary care visit</b>  | \$5, first 4 visits deductible waived  | 30%  | \$30, first 4 visits deductible waived   | 50%   |
| <b>Chronic care visit<sup>5</sup></b>  | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%   |
| <b>Specialty visit</b>   | \$5, with referral   | 30%  | \$30, with referral  | 50%   |
| <b>Outpatient mental health care</b>   | \$5, deductible waived   | 30%  | \$30, deductible waived  | 50%   |
| <b>Substance abuse treatment</b>   | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%   |
| <b>Physician, midwife maternity services</b>                                 | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%   |
| <b>Delivery</b>  | Inpatient delivery subject to inpatient hospital charges   |  |  |   |
| <b>Preventive</b>  | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%   |
| <b>Lab &amp; x-ray</b>   | \$0, deductible waived   | 30%  | \$0, Quest provider, deductible waived, or 20%   | 50%   |
| <b>Inpatient hospital per admission</b>                                      | \$50/day to \$250 max  | 30%  | \$500  | 50%   |
| <b>Urgent care</b>   | \$5 in network   | 30%  | \$30 in network  | 50%   |
| <b>Emergency department<sup>6</sup></b>                                      | \$100  | \$100  | \$100  | \$100   |
| <b>Durable medical equip.</b>  | 15%  | 30%  | 20%  | 50%   |
| <b>Insulin, diabetic supplies</b>  | \$0, deductible waived   |  |  |   |
| <b>Additional Cost Tier \$100 copay<sup>7</sup></b>                          | \$100  | \$100 + \$30   | \$100  | \$100 + 50%   |
| <b>Additional Cost Tier \$500 copay<sup>9</sup></b>                          | \$500  | \$500 + 30%  | \$500  | \$500 + 50%   |
| <b>Alternative care provider visits</b>                                      | \$5  | 30%  | \$30   | 50%   |
| <b>Spinal manipulation, acupuncture services<sup>13</sup></b>                | \$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.   |
| <b>Prescription drugs</b>  | <ul style="list-style-type: none"> <li>\$50/individual, \$150/family deductible<sup>10</sup></li> <li>\$1000 out-of-pocket maximum<sup>11</sup></li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$10 generic</li> <li>\$30 brand</li> <li>Copay x 2.5 for 90-day</li> <li>\$100 specialty</li> </ul> | <ul style="list-style-type: none"> <li>In-network deductible, out-of-pocket max apply</li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$20 generic</li> <li>\$50 preferred brand</li> <li>\$100 specialty</li> <li>Copay x 2.5 for 90-day</li> <li>Member pays difference between in-network rate and billed amount</li> </ul> | <ul style="list-style-type: none"> <li>\$50/individual, \$150/family deductible<sup>10</sup></li> <li>\$1000 out-of-pocket maximum<sup>11</sup></li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$20 generic</li> <li>\$50 preferred brand</li> <li>Copay x 2.5 for 90-day</li> <li>\$100 specialty</li> </ul> | <ul style="list-style-type: none"> <li>In-network deductible, out-of-pocket max apply</li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$20 generic</li> <li>\$50 preferred brand</li> <li>\$100 specialty.</li> <li>Copay x 2.5 for 90-day</li> <li>Member pays difference between in-network rate and billed amount</li> </ul> |

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# Medical Plans (continued)

## PEBB Statewide

Service Area: Statewide and Nationwide

[Providencehealthplan.com/PEBB](http://Providencehealthplan.com/PEBB)

|  | Full-time  |  | Part-time  |  |
|--|--|--|--|--|
| Providers  | In Network   | Out of Network   | In Network   | Out of Network   |
| <b>Standard deductible<sup>2</sup></b>                                       | \$250/individual, \$750/family<br>Four primary care visits not subject   | \$500/individual, \$1500/family  | \$500/individual, \$1500/family<br>Four primary care visits not subject  | \$1000/individual, \$3000/family   |
| <b>Additional non-HEM participant deductible<sup>3</sup></b>                 | \$100/individual, \$300/family applies to all services unless otherwise noted  |  |  |  |
| <b>Out-of-pocket max</b><br>(some deductibles, copays, services don't apply) | \$1500/individual \$4500/family  | \$2500/individual \$7500/family  | \$2500/individual \$7500/family  | \$4500/individual \$13500/family   |
| <b>Primary care visit</b>  | 15% or 10% <sup>4</sup> , deductible waived  | 30%  | 20% or 15% <sup>4</sup> , deductible waived  | 50%  |
| <b>Chronic care visit<sup>5</sup></b>  | 0%, deductible waived  | 30%  | 0%, deductible waived  | 50%  |
| <b>Specialty visit</b>   | 15%  | 30%  | 20%  | 50%  |
| <b>Outpatient mental health care</b>   | 15%, deductible waived   | 30%  | 20%, deductible waived   | 50%  |
| <b>Substance abuse treatment</b>   | 0%, deductible waived  | 30%  | 0%, deductible waived  | 50%  |
| <b>Pre-natal</b>   | 0%, deductible waived  | 30%  | 0%, deductible waived  | 50%  |
| <b>Delivery and postnatal</b>  | 15%  | 30%  | 20%  | 50%  |
| <b>Preventive</b>  | 0%, deductible waived  | 30%  | 0%, deductible waived  | 50%  |
| <b>Lab &amp; x-ray</b>   | 15%  | 30%  | 20%  | 50%  |
| <b>Inpatient hospital per admission</b>                                      | 15%  | 30%  | 20%  | 50%  |
| <b>Urgent care</b>   | 15%  | 15%  | 20%  | 20%  |
| <b>Emergency department<sup>6</sup></b>                                      | \$100 + 15%  | \$100 + 15%  | \$100 + 20%  | \$100 + 20%  |
| <b>Durable medical equip.</b>  | 15%  | 30%  | 20%  | 50%  |
| <b>Insulin, diabetic supplies</b>  | 0% deductible waived   |  |  |  |
| <b>Additional Cost Tier \$100 copay<sup>7</sup></b>                          | \$100 + 15%  | \$100 + 30%  | \$100 + 20%  | \$100 + 50%  |
| <b>Additional Cost Tier \$500 copay<sup>9</sup></b>                          | \$500 + 15%  | \$500 + 30%  | \$500 + 20%  | \$500 + 50%  |
| <b>Alternative care provider visits</b>                                      | 15%  | 30%  | 20%  | 50%  |
| <b>Spinal manipulation, acupuncture services<sup>13</sup></b>                | 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.  |
| <b>Prescription drugs</b>  | <ul style="list-style-type: none"> <li>\$50/individual, \$150/family deductible<sup>10</sup></li> <li>\$1000 out-of-pocket maximum<sup>11</sup></li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$10 generic</li> <li>\$30 brand</li> <li>Copay x 2.5 for 90-day</li> <li>\$100 specialty</li> </ul> | <ul style="list-style-type: none"> <li>Urgent, emergent and out-of-country</li> <li>In-network deductible, out-of-pocket maximum apply</li> <li>Reimbursed as if filled in network; member pays difference between network rate &amp; billed amount</li> </ul> | <ul style="list-style-type: none"> <li>\$50/individual, \$150/family deductible<sup>10</sup></li> <li>\$1000 out-of-pocket maximum<sup>11</sup></li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$20 generic</li> <li>\$50 preferred brand</li> <li>Copay x 2.5 for 90-day</li> <li>\$100 specialty</li> </ul> | <ul style="list-style-type: none"> <li>Urgent, emergent and out-of-country</li> <li>In-network deductible, out-of-pocket maximum apply</li> <li>Reimbursed as if filled in network; member pays difference between network rate &amp; billed amount</li> </ul> |

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## Medical Plans (continued)

### Providence Choice

[Providencehealthplan.com/PEBB](http://Providencehealthplan.com/PEBB)

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

|   | Full-time  |  | Part-time  |  |
|---|--|--|--|--|
| Providers   | In Medical home <sup>1</sup>   | Out of medical home <sup>1</sup>   | In Medical home <sup>1</sup>   | Out of medical home <sup>1</sup>   |
| <b>Standard deductible<sup>2</sup></b>  | \$250/individual \$750/family, 4 visits not subject  | \$500/individual \$1500/family   | \$500/individual \$1500/family, 4 visits not subject   | \$1000/individual \$3000/family  |
| <b>Additional non-HEM participant deductible<sup>3</sup></b>                                | \$100/individual, \$300/family applies to all services unless otherwise noted  |  |  |  |
| <b>Out-of-pocket max</b><br><small>(some deductibles, copays, services don't apply)</small> | \$1500/individual, \$4500/family   | \$2500/individual, \$7500/family   | \$2500/individual, \$7500/family   | \$4500/individual, \$13500/family  |
| <b>Primary care visit</b>   | \$5, first 4 visits deductible waived  | 30%  | \$30, first 4 visits deductible waived   | 50%  |
| <b>Chronic care visit<sup>5</sup></b>   | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%  |
| <b>Specialty visit</b>  | \$5, with referral   | 30%  | \$30, with referral  | 50%  |
| <b>Outpatient mental health care</b>  | \$5, deductible waived   | 30%  | \$30, deductible waived  | 50%  |
| <b>Substance abuse treatment</b>  | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%  |
| <b>Maternity, &amp; childbirth services provider</b>  | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%  |
| <b>Delivery</b>   | Inpatient delivery subject to inpatient hospital charges   |  |  |  |
| <b>Preventive</b>   | \$0, deductible waived   | 30%  | \$0, deductible waived   | 50%  |
| <b>Lab &amp; x-ray</b>  | \$0, deductible waived   | 30%  | 20%, deductible applies  | 50%  |
| <b>Inpatient hospital per admission</b>   | \$50/day to \$250 max  | 30%  | \$500  | 50%  |
| <b>Urgent care</b>  | \$25   | \$25   | \$30   | \$30   |
| <b>Emergency department<sup>6</sup></b>   | \$100  | \$100  | \$100  | \$100  |
| <b>Durable medical equip.</b>   | 15%  | 30%  | 20%  | 50%  |
| <b>Insulin, diabetic supplies</b>   | \$0, deductible waived   |  |  |  |
| <b>Additional Cost Tier \$100 copay<sup>7</sup></b>   | \$100  | \$100 + 30%  | \$100  | \$100 + 50%  |
| <b>Additional Cost Tier \$500 copay<sup>9</sup></b>   | \$500  | \$500 + 30%  | \$500  | \$500 + 50%  |
| <b>Alternative care provider visits</b>   | \$5  | 30%  | \$30   | 50%  |
| <b>Spinal manipulation, acupuncture services<sup>13</sup></b>                               | \$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.  |
| <b>Prescription drugs</b>   | <ul style="list-style-type: none"> <li>\$50/individual, \$150/family deductible<sup>10</sup></li> <li>\$1000 out-of-pocket maximum<sup>11</sup></li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$10 generic</li> <li>\$30 brand</li> <li>Copay x 2.5 for 90-day</li> <li>\$100 specialty</li> </ul> | <ul style="list-style-type: none"> <li>Urgent, emergent and out-of-country.</li> <li>In-network deductible, out-of-pocket maximum apply.</li> <li>Reimbursed as if filled in-network; member pays difference between in-network rate and billed amount.</li> </ul> | <ul style="list-style-type: none"> <li>\$50/individual, \$150/family deductible<sup>10</sup></li> <li>\$1000 out-of-pocket maximum<sup>11</sup></li> <li>\$0 Value, not subject to deductible<sup>12</sup></li> <li>\$20 generic</li> <li>\$50 preferred brand</li> <li>Copay x 2.5 for 90-day</li> <li>\$100 specialty</li> </ul> | <ul style="list-style-type: none"> <li>Urgent, emergent and out-of-country.</li> <li>In-network deductible, out-of-pocket maximum apply.</li> <li>Reimbursed as if filled in-network; member pays difference between in-network rate and billed amount.</li> </ul> |

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply. See footnotes, page 11.

## Medical Plans (continued)

### AllCare PEBB

Service Area: Curry, Jackson, Josephine Counties; Glendale and Azalea in Douglas County.

[Allcarehealth.com/  
public-employees](http://Allcarehealth.com/public-employees)

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

(continued on following page)

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply. See footnotes, page 11.



# Medical Plans (continued)

## AllCare PEBB (continued)

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

| Providers          | Full-time  |               |   | Part-time  |               |   |
|--------------------|--|---------------|---|--|---------------|---|
|                    | Preferred  | Participating | Out-of-network  | Preferred  | Participating | Out-of-network  |
| Prescription drugs | <ul style="list-style-type: none"> <li>• \$50/individual, \$150/family deductible<sup>10</sup></li> <li>• \$1000 out-of-pocket maximum<sup>11</sup></li> <li>• \$0 preventive/EHB, not subject to deductible</li> <li>• \$10 generic</li> <li>• \$30 brand</li> <li>• \$60 non-preferred</li> <li>• Copay x 2 for 90-day</li> <li>• \$100 specialty</li> </ul> |               | Out-of-Network. Member pays full cost and may be reimbursed for AllCare PEBB share of cost. | <ul style="list-style-type: none"> <li>• \$50/individual, \$150/family deductible<sup>10</sup></li> <li>• \$1000 out-of-pocket maximum<sup>11</sup></li> <li>• \$0 preventive/EHB, not subject to deductible</li> <li>• \$15 generic</li> <li>• \$40 brand</li> <li>• \$75 non-preferred</li> <li>• Copay x 2 for 90-day</li> <li>• \$100 specialty</li> </ul> |               | Out-of-Network. Member pays full cost and may be reimbursed for AllCare PEBB share of cost. |

This is a summary only. See the plan's documents for details. In the case of a discrepancy, the plan document will apply.

## Medical Plans Footnotes

<sup>1</sup> 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.

<sup>2</sup> 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.

<sup>3</sup> See Health Engagement Model (HEM), page 15.

<sup>4</sup> 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.

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

<sup>6</sup> 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.

<sup>7</sup> 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.

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

<sup>9</sup> 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.

<sup>10</sup> The prescription drug deductible is \$50 per person or \$150 for families with three or more members. It applies separately from the medical deductible.

<sup>11</sup> The prescription drug out-of-pocket maximum is \$1,000 per person, with a family maximum of \$3,000. It accrues separately from the medical out-of-pocket maximum.

<sup>12</sup> 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.)

<sup>13</sup> 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.