OREGON PERS HEALTH INSURANCE PROGRAM
2017 NON-MEDICARE BENEFIT COMPARISON – SELECT VALUE PLANS

	Kaiser Permanente	Moda Health		PacificSource Health Plans [1]		Providence Health Plans	
		In – Network	Out – of - Network	Participating Providers	Non-Participating Providers	In – Network	Out – of - Network
Eligible Providers	Kaiser Permanente and The Portland Clinic Physicians and hospitals	Preferred physicians and providers	Any licensed physician or facility	Plan physicians and hospitals	Any licensed physician or facility	Plan physicians and hospitals	Any licensed physician or facility
Calendar Year Deductible	$1,000 per individual $3,000 per family (3 or more)	$1,000 per individual		$1,000 per individual $3,000 per family (3 or more)		$1,000 per Individual $3,000 per family (3 or more)	
Calendar Year Medical Out-of-Pocket Maximum	$3,000 + deductible per individual $9,000 + deductible per family	$3,000 + deductible/individual	$9,000 + deductible/individual	$3,000 + deductible per individual $9,000 + deductible per family	$9,000 + deductible per individual No family maximum	$3,000 + deductible per individual $9,000 + deductible per family	$9,000 + deductible per individual No family maximum
	MEMBER PAYS:	**MEMBER PAYS:**		**MEMBER PAYS:**		**MEMBER PAYS:**	
INPATIENT CARE							
▪ Inpatient Hospital Care	▪ 30% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible
▪ Skilled Nursing	▪ 30% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible
OUTPATIENT CARE							
▪ Physician Office Visits	▪ $25 copay, no deductible	▪ $25 copay, no deductible	▪ 50% after deductible	▪ $25 copay, no deductible	▪ 50% after deductible	▪ $25 copay, no deductible	▪ 50%, no deductible
▪ Specialist Office Visits	▪ $35 copay, no deductible	▪ $35 copay, no deductible	▪ 50% after deductible	▪ $35 copay, no deductible	▪ 50% after deductible	▪ $35 copay, no deductible	▪ 50%, no deductible
▪ Outpatient Surgery	▪ 30% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible
▪ Ambulance	▪ 30% after deductible	▪ 30% after deductible	▪ 30% after deductible	▪ 30%, no deductible	▪ 30%, no deductible	▪ 30% after deductible	▪ 30% after deductible
▪ Emergency Services	▪ 30% after deductible	▪ $200 copay, then 20%	▪ $200 copay, then 20%	▪ $200 copay, then 20%	▪ $200 copay, then 20%	▪ $200 copay, then 20%	▪ $200 copay, then 20%
▪ Urgent Care	▪ $25 copay, no deductible	▪ $25 copay, no deductible	▪ 50% after deductible	▪ $25 copay, no deductible	▪ 50%, no deductible	▪ $25 copay, no deductible [4]	▪ 50%, no deductible [4]
▪ DME	▪ 30% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible
▪ Lab Test	▪ 30% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible
▪ X-Ray	▪ 30% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible
▪ Diagnostic Imaging (CT/MRI)	▪ 30% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible	▪ 30% after deductible	▪ 50% after deductible
▪ OT/PT/ST Therapies [2]	▪ $35 copay after deductible [3]	▪ $25 copay, no deductible [5]	▪ 50% after deductible [5]	▪ $25 copay, no deductible [5]	▪ 50% after deductible [5]	▪ $25 copay, no deductible [5]	▪ 50% after deductible [5]
PREVENTIVE CARE							
▪ Preventive Physical Exam [6]	▪ Covered in full	▪ Covered in full	▪ 50% after deductible	▪ Covered in full	▪ 50%, no deductible	▪ Covered in full	▪ 50% after deductible
▪ Women's Preventive	▪ Covered in full	▪ Covered in full	▪ 50% after deductible	▪ Covered in full	▪ 50% after deductible	▪ Covered in full	▪ 50% after deductible
▪ Prostate Cancer Screening	▪ Covered in full	▪ $25 copay, no deductible	▪ 50% after deductible	▪ Covered in full	▪ 50% after deductible	▪ $25 copay, no deductible [7]	▪ 50% after deductible
▪ Immunizations	▪ Covered in full	▪ Covered in full	▪ 50% after deductible	▪ Covered in full	▪ 50%, no deductible	▪ Covered in full	▪ 50%, no deductible
OTHER SERVICES							
▪ Alternative Care	▪ $25 copay, no deductible [8]	▪ $25 copay, no deductible [8]	▪ 50% after deductible [8]	▪ $25 copay, no deductible [8]	▪ 50% after deductible [8]	▪ $25 copay, no deductible [8]	▪ Not covered
▪ Vision Routine Eye Exam	▪ $25 copay, no deductible	▪ Discounts available, contact Moda Health	▪ Discounts available, contact Moda Health	▪ Not covered	▪ Not covered	▪ Discounts available, contact Providence Health Plans	▪ Discounts available, contact Providence Health Plans
▪ Vision Hardware	▪ Not covered			▪ Not covered	▪ Not covered		
PRESCRIPTION DRUGS ▪ Generic & Brand	40% of charge up to a $250 maximum per prescription for a 30-day supply	40% of charge up to a $250 maximum per prescription for a 31-day supply		40% of charge up to a $250 maximum per prescription for a 31-day supply		40% of charge up to a $250 maximum per prescription for a 31-day supply	
Calendar Year Prescription Drug Out-of-Pocket Maximum	$5,000 out-of-pocket maximum per member per calendar year	$5,000 out-of-pocket maximum per member per calendar year		$5,000 out-of-pocket maximum per member per calendar year		$5,000 out-of-pocket maximum per member per calendar year	

This is a summary of benefits only, for general comparison. Any errors or omissions are unintentional. Should any discrepancies be found between this handbook and the plan document, the information in the plan document shall prevail.

[1] Member must select a Primary Care Physician (PCP).
[2] Outpatient Rehab: OT= Occupational Therapy, PT= Physical Therapy, ST= Speech Therapy
[3] Benefit is limited to 20 visits per calendar year.
[4] Urgent/Immediate Care – ancillary charges billed separately will be subject to the applicable cost share. The deductible will apply to diagnostic imaging, lab, x-rays, etc. received during the visit.
[5] Limited to 30 visits per calendar year; this 30 visit limitation encompasses all therapy modalities combined.
[6] Preventive services will be covered in accordance with ACA guidelines. This applies to Kaiser and in-network services under Moda Health, PacificSource, and Providence.
[7] Prostate cancer screening lab work is subject to the lab benefit.
[8] Spinal manipulation and acupuncture limited to 12 combined visits per calendar year. No massage therapy coverage.