OREGON PERS HEALTH INSURANCE PROGRAM
2018 NON-MEDICARE BENEFIT COMPARISON – CORE VALUE PLANS

	KAISER PERMANENTE	MODA HEALTH		PACIFICSOURCE HEALTH PLANS [1]		PROVIDENCE HEALTH PLANS	
		In-Network	Out-of-Network	In-Network	Out-of-Network	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
	MEMBER pays:	**MEMBER pays:**		**MEMBER pays:**		**MEMBER pays:**	
Calendar Year Deductible	None	$500 per individual		$500 per individual $1,500 per family	$1,000 per individual $3,000 per family	$500 per individual $1,500 per family (3 or more)	
Calendar Year Medical Out-of-Pocket Maximum	$2,000 per individual $4,000 per family (2 or more)	$2,000 + deductible per individual	$6,000 + deductible per individual	$2,000 + deductible per individual $6,000 + deductible per family (3 or more)	$6,000 + deductible per individual $18,000 + deductible per family (3 or more)	$2,000 + deductible per individual $6,000 + deductible per family (3 or more)	$6,000 + deductible per individual $18,000 + deductible per family (3 or more)
INPATIENT CARE							
▪ Inpatient Hospital Care	▪ $200 copay/day; $1,000 max per admit	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible
▪ Skilled Nursing	▪ Covered in full	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible
OUTPATIENT CARE							
▪ Physician Office Visits	▪ $30 copay	▪ $20 copay, no deductible	▪ 40% after deductible	▪ $20 copay, no deductible	▪ 40% after deductible	▪ $20 copay, no deductible	▪ 40%, no deductible
▪ Specialist Office Visits	▪ $40 copay	▪ $20 copay, no deductible	▪ 40% after deductible	▪ $20 copay, no deductible	▪ 40% after deductible	▪ $20 copay, no deductible	▪ 40%, no deductible
▪ Outpatient Surgery	▪ $200 copay	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible
▪ Ambulance	▪ $100 copay	▪ 20% after deductible	▪ 20% after deductible	▪ 20%, no deductible	▪ 20%, no deductible	▪ 20% after deductible	▪ 20% after deductible
▪ Emergency Services	▪ $200 copay	▪ $200 copay, then 20%	▪ $200 copay, then 20%	▪ $200 copay, then 20%	▪ $200 copay, then 20%	▪ $200 copay, then 20% [4]	▪ $200 copay, then 20% [4]
▪ Urgent Care	▪ $30 copay	▪ $20 copay, no deductible	▪ 40% after deductible	▪ $20 copay, no deductible	▪ 40%, no deductible	▪ $20 copay, no deductible [5]	▪ 40%, no deductible [5]
▪ DME	▪ 20%	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible
▪ Lab Test	▪ $30 copay per visit	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible
▪ X-Ray	▪ $30 copay per visit	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible
▪ Diagnostic Imaging (CT/MRI)	▪ 20%	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible	▪ 20% after deductible	▪ 40% after deductible
▪ OT/PT/ST Therapies [2]	▪ $40 copay [3]	▪ 20% after deductible [6]	▪ 40% after deductible [6]	▪ $20 copay, no deductible [6]	▪ 40% after deductible [6]	▪ 20% after deductible [6]	▪ 40% after deductible [6]
PREVENTIVE CARE Follows USPSTF/ACA Guidelines	▪ Covered in full	▪ Covered in full	▪ 40% after deductible	▪ Covered in full	▪ 40% after deductible	▪ Covered in full	▪ 40% after deductible
OTHER SERVICES							
▪ Alternative Care	▪ $25 copay [7]	▪ $25 copay, no deductible [7]	▪ 40% after deductible [7]	▪ $25 copay, no deductible [7]	▪ 40% after deductible [7]	▪ $25 copay [7]	▪ Not covered
▪ Vision Routine Eye Exam	▪ $30 copay	▪ Discounts available, contact Moda Health	▪ Discounts available, contact Moda Health	▪ Not covered	▪ Not covered	▪ Discounts available, contact Providence Health Plan	▪ Discounts available, contact Providence Health Plan
▪ Vision Hardware	▪ Not covered			▪ Not covered	▪ Not covered		
PRESCRIPTION DRUGS Brand and Generic	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	
RX 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 comparison and the plan document, the information in the plan document shall prevail.

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[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] Deductible does not apply.
[5] 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.
[6] Limited to 30 visits per calendar year; this 30 visit limitation encompasses all therapy modalities combined.
[7] Spinal manipulation and acupuncture are limited to 12 combined visits per calendar year. No massage therapy coverage.