2012 Full-time Medical Plan

This information gives a high-level summary only. See plan documents for details.

Benefits apply without regard to HEM participation[1]	PEBB Statewide Plan		Providence Choice		Kaiser HMO	Kaiser Deductible Plan
Service Area	Statewide and Nationwide		Clackamas, Clark, Curry, Deschutes, Lane, Linn-Benton, Marion-Polk, Multnomah, Washington and Yamhill counties		Zip codes in Benton, Clackamas, Clark, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties	
Provider Status	In Network	Out of Network	In Network	Out of Network	Kaiser Permanente	Kaiser Permanente
Deductible[2]	$250/individual $750/family 4 primary care visits not subject	$500/individual $1500/family 4 primary care visits not subject	$250/individual $750/family 4 primary care visits not subject	$500/individual $1500/family 4 primary care visits not subject	$0	$250/individual $750/family office visits and some services not subject
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum[3]	$1500/individual $4500/family	$2500/individual $7500/family	$1500/individual $4500/family	$2500/individual $7500/family	$600/individual $1200/family	$1500/individual $4500/family
Spouse/Domestic Partner Surcharge[4]	$50/month	$50/month	$50/month	$50/month	$50/month	$50/month
Tobacco Surcharge[5]	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner
Primary Care	15%	30%	$5	30%	$5	$5
Chronic Care Office Visit	0%	30% subject to deductible	$0	30% subject to deductible	$5	$5
Specialty Care	15%	30%	$5	30%	$5	$5
Mental Health	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services
Maternity/Childbirth Provider Services	15%	30%	$0	30%	$0/prenatal, $50/day; up to $250 maximum/admission	$0/prenatal; $50/day; up to $250 maximum per admission. Prenatal not subject to deductible; deductible does apply to maternity/childbirth
Preventive	$0	30%	$0	30%	$0	$0
Lab & X-ray	15%	30%	$0	30%	$0	$15
MRI, CT, PET, SPECT	15% + $100	30% + $100	$100	30% + $100	$100	$100
Sleep Study	15% + $100	30% + $100	$100	30% + $100	$100	$100
Inpatient Hospital	15%	30%	$50/day; up to $250 maximum per admission	30%	$50/day; up to $250 maximum per admission	$50/day; up to $250 maximum after deductible
Emergency Department	15% + $100	15% + $100	$100	$100	$75	$75, after deductible has been met
Durable Med Equipment	15%	30%	15%	30%	$0	15%
Insulin/Diabetic Supplies	$0	$0	$0	$0	$0	$0
Prescription Drugs[6]	$50 deductible (not applied to Value) $0 Value $10 generic $30 preferred brand $100 specialty 2.5X for 90-day No tier exceptions	Paid as if filled in network; Member pays difference between network & billed amt + coinsurance 2.5X for 90-day	$50 deductible (not applied to Value) $0 Value $10 generic $30 preferred brand $100 specialty 2.5X for 90-day No tier exceptions	Paid as if filled in network; Member pays difference between network & billed amt + coinsurance 2.5X for 90-day	$1 generic/$15 brand $1 generic 31-90 day maintenance mail order $15 brand 31-90 day maintenance mail order	$5 generic / $25 brand $50/50% whichever is greater for exception-approved non-formulary drugs $5 generic 31-90 day maintenance mail order $25 brand 31-90 day maintenance mail order
Vision	$10 exam copay	VSP reimburses exam to $50 office	$10 exam copay	VSP reimburses exam to $50	$5 exam copay	$5 exam copay

Benefits apply without regard to HEM participation[1]	PEBB Statewide Plan		Providence Choice		Kaiser HMO	Kaiser Deductible Plan
	$25 frame copay $150 retail frame allowance Single and lined bifocal and trifocal lenses covered in full Progressive lenses available at a 35-40% discount. Or $200 allowance for contacts and contacts fitting/evaluation	copay $70 frame allowance $50-$125 single and lined bi or trifocal lenses allowance Progressive lenses available at a 35-40% discount Contact lenses covered in full to $105 if elective, $210 if necessary	$25 frame copay $150 retail frame allowance Single and lined bifocal and trifocal lenses covered in full Progressive lenses available at a 35-40% discount. Or $200 allowance for contacts and contacts fitting/evaluation	$70 frame allowance $50-$125 single and lined bi or trifocal lenses allowance Progressive lenses available at a 35-40% discount Contact lenses covered in full to $105 if elective, $210 if necessary	$200 hardware allowance max/24 months	$200 hardware allowance max/24 months
Chiropractic, Acupuncture, Naturopathic Services	30% coinsurance, applies to in-network deductible 60 visits/yr max		$10 copay, applies to in-network deductible, limited to the lesser of $1000 or 60 visits/yr		$10 up to $1000/yr	$10 up to $1000/yr
Additional-cost Tier (does not apply to cancer related services)						
Hip replacement Knee replacement Knee arthroscopy Shoulder arthroscopy Bariatric Surgery Spine pain procedures Sinus surgery Knee/Hip resurfacing Hip arthroplasty	15% + $500	30% + $500	$500	30% + $500	Copay same as other conditions	Copay same as other conditions
Upper endoscopy	15% + $100	30% + $100	$100	30% + $100 copay	Copay same as other conditions	Copay same as other conditions
Excluded Services[7]						

[1] **Benefits and HEM:** The benefits shown here apply in or out of the Health Engagement Model (HEM) program. Employees (and spouses or domestic partners) who participate in HEM will have $20 (or $35) per month less deducted from their pay. NOTE: A PEBB-eligible employee must participate in the HEM program to allow a spouse or domestic partner to participate. A spouse or domestic partner of a PEBB-eligible employee may not participate in the HEM program as an individual if the employee does not.

[2] **Deductibles:** In the Statewide and Providence Choice plans, the deductible does not apply to the first 4 visits to a primary care provider, preventive services, or the out-of-pocket maximum; however, the coinsurance applies even if the deductible does not. The deductible applies to all specialty visits and all lab and x-ray services. Once 3 members of family have met their individual deductible, all in-network services for all members of the family will be paid as if their individual in-network deductible has been met. Deductible amounts accumulate separately in these plans when using in-network and out-of-network providers. The Kaiser Health Maintenance Organization (HMO) plan has no deductible. In the Kaiser Deductible plan, office visits and some other services do not apply to the deductible. See the plan's evidence of coverage or call Kaiser Member Services. In this plan, once 3 members of family have met their individual deductible, all in-network services for all members of the family will be paid as if their individual in-network deductible has been met.

[3] **Annual Out-of-Pocket (OOP) Maximums:** In the Statewide and Providence choice plans, once 3 members of a family have met their individual $1500 in-network OOP, all in-network services for all members of the family will be paid as if their individual in-network OOP has been met; once 3 members of a family have met their individual $2500 out-of-network OOP, all out-of-network services for all members of the family will be paid as if their individual out-of-network OOP has been met. In the Kaiser HMO, once 2 members of a family have met their individual $600 OOP, all in-plan services for all members of the family will be paid as if their individual in-network OOP has been met. In the Kaiser Deductible Plan, once 3 members of a family have met their individual $1500 in-network OOP, all in-plan services for all members of the family will be paid as if their individual in-network OOP has been met.

[4] **Spouse or Domestic Partner Coverage Surcharge:** A $50 monthly surcharge is applied if an employee's spouse or domestic partner has access to other non-Oregon-state-agency employer-based group health insurance and chooses not to enroll.

[5] **Tobacco Surcharge:** A $25 monthly surcharge is applied to employees and covered spouses or domestic partners who use tobacco as stated when they enroll.

[6] **Prescription Drugs:** See the plans' formularies, which list drugs covered in the plan and how they are covered.

[7] **Excluded Services:** PEBB Statewide and Providence Choice (full- and part-time) plan members will pay 100% of the cost for excluded services. Beginning 2012, these include surgery for warts, varicose vein surgery (including radio frequency ablation), varicose vein stripping, TMJ surgery, surgery for ganglions of the wrist, surgery for Morton's neuroma, hammertoe surgery, bunionectomy surgery and breast reduction surgery. Surgery for certain varicose vein conditions may be considered for prior authorization. Kaiser HMO and Kaiser Deductible (full- and part-time) plan members will pay a copay, as for treatment of other conditions.

2012 Part-time Medical Plan. ***See footnotes on page 32.***

This information gives a high-level summary only. See plan documents for details. See footnotes on page 32.

Benefits apply without regard to HEM participation[1]	**Part-Time PEBB Statewide Plan**		**Part-Time Providence Choice**		**Part-Time Kaiser HMO**	**Part-Time Kaiser Deductible Plan**
Service Area	Statewide and Nationwide		Clackamas, Clark, Curry, Deschutes, Lane, Linn-Benton, Marion-Polk, Multnomah, Washington and Yamhill counties		Zip codes in Benton, Clackamas, Clark, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties	
Provider Status	In Network (Medical home)	Out of Network	In Network	Out of Network	Kaiser Permanente	Kaiser Permanente
Deductible[2]	$500/individual, $1500/ family' 4 primary care visits not subject	$1000/individual, $3000/family; 4 primary care visits not subject	$500/individual, $1500/ family; 4 primary care visits not subject	$1000/individual, $3000/family; 4 primary care visits not subject	$0	$250/individual, $750/Family; office visits & some services not subject
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Out-of-Pocket Maximum[3]	$2500/individual, $7500/family	$4500/individual, $13500/family	$2500 individual, $7500/family	$4500/individual, $13500/family	$1500/individual, $3000/family	$1500/individual, $4500/family
Spouse/Partner Surcharge[4]	$50/month	$50/month	$50/month	$50/month	$50/month	$50/month
Tobacco Surcharge[5]	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner	$25/month/employee $25/spouse/domestic partner
Primary Care	20%	50%	$30	50%	$30	$30
Chronic Care Office Visit	$0	50% subject to deductible	$0	50% subject to deductible	$30	$30
Specialty Care	20%	50%	$30	50%	$30	$30
Mental Health	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services
Maternity/Childbirth Provider Services	20%	50%	$0	50%	$0/prenatal; up to $500 maximum per admission	$0/prenatal (not subject); $500/ admit. deductible doesn't apply
Preventive	0%	50%	$0	50%	$0	$0
Lab & X-ray	20%	50%	20%	50%	$10	$20
MRI, CT, PET, SPECT	20% + $100	50% + $100	20% + $100	50% + $100	$100	$100
Sleep Study	20% + $100	50% + $100	20% + $100	50% + $100	$100	$100
Inpatient Hospital	20%	50%	$500/admission	50%	$500 per admission	$500/admit after deductible
Emergency Department	20% + $100	20% + $100	$100	$100	$100	$100, after deductible
Durable Med Equipment	20%	50%	20%	50%	50%	50%
Insulin/Diabetic Supplies	$0	$0	$0	$0	Both Plans: 20% (insulin covered as prescription drug)	
Prescription Drugs[6]	$50 deductible (not applied to Value drugs); $0 Value; $20 generic/$40 preferred brand; $100 specialty 2.5X for 90-day; No tier exceptions	PD as if filled in network; Member pays difference between network & billed amt + coinsurance; 2.5X for 90-day	$50 deductible (not applied to Value drugs); $0 Value; $20 generic/$40 preferred brand; $100 specialty 2.5X for 90-day; No tier exceptions	PD as if filled in network; Member pays difference between network & billed amt + coinsurance; 2.5X for 90-day	$10 generic; $25 brand; $20 generic and $50 brand 31-90 day maintenance mail order	$10 generic; $25 brand $20 generic and $50 brand 31-90 day maintenance mail order
Vision	The VSP full time vision plan is available to retirees enrolled in these plans as a separate policy. Vision not covered for all other enrollees				These plans have a $30 exam copay; hardware not covered	
Chiropractic, Acupuncture, Naturopathic	50% coinsurance, applies to in-network deductible 60 visits/yr max		50% copayment, applies to in-network deductible, limited to the lesser of $1000 or 60 visits/yr		not covered	not covered
Additional-cost Tier (does not apply to cancer related services) Applies to Hip and Knee replacement, Knee and shoulder arthroscopy. Bariatric Surgery. Spine pain procedures Sinus surgery, Knee/Hip resurfacing, Hip arthroplasty						
	20% + $500	50% + $500	$500	50% + $500	Copay same as other conditions	Copay same as other conditions
Upper endoscopy	20% + $100	50% + $100	$100 copay	50% + $100 copay	Copay same as other conditions	Copay same as other conditions
Excluded Services[7]						