Medical Plan Comparison 2013 - 2014

Plan Name & Provider Network	PPO (Preferred Provider Organization)		Kaiser Permanente
	Pioneer Medical **Regence BlueCross/BlueShield Preferred Provider Network *(No PCP/Specialist referral required)***		**Kaiser Provider Network** ***(PCP/Specialist referral required)***
	In-Network	**Out-of-Network**	**In-Network Only**
Monthly Pre-tax Employee Premium	Employee Only: $93.53 Employee + 1: $362.47 Family: $522.17		Employee Only: $66.50 Employee + 1: $257.66 Family: $372.36
Annual Deductible	Individual -$250 Family -$750	Individual -$500 Family -$1,500	None
Annual Out-of-Pocket Maximum	Individual -$2,000 Family -$6,000	Individual -$6,000 Family -$18,000	Individual -$1,250 Family -$2,500
Annual Maximum Benefit	$2,000,000		None
Preventive Care	Plan pays 100% (deductible waived)	Participating 0% (deductible waived) Non-Participating Employee pays 40% after deductible	No Charge
Primary & Specialty Care	$25 copay (deductible waived)	Employee pays 40% after deductible	$15 copay
Diagnostic Lab & X-ray	Employee pays 20% (deductible waived)	Employee pays 40% after deductible	No charge
Inpatient Stay/Surgery	Employee pays 20% after deductible	Employee pays 40% after deductible	$250 per admission
Outpatient Surgery	Employee pays 20% (deductible waived)	Employee pays 40% after deductible	$15 copay
Urgent Care	Plan pays 100% after $25 co-pay (deductible waived)	Employee pays 40%	$35 copay
Emergency Room	$150 co-pay, then employee pays 20% (deductible waived if admitted)		$75 copay plus any other charges that normally apply
Ambulance Services	Employee pays 20% after deductible		$75 copay
Durable Medical Equipment	Employee pays 20% after deductible	Employee pays 40% after deductible	Employee pays 20%
Prescription Retail (Up to 30 – day supply)	$20 generic $40 preferred $60 non-preferred		$15 generic $30 brand-name *Kaiser Permanente pharmacies and mail-order only*
Mail Order Prescriptions (Up to 90 – day supply)	$30 generic $60 preferred $90 non-preferred		$30 generic $60 brand-name *Kaiser Permanente pharmacies and mail-order only*
Vision Benefits	Annual exam – Plan pays 100% (deductible waived). Hardware: $250 per calendar year maximum benefit. *No vision network required.*		Routine eye exam - $15 co-pay Prescription eyeglasses & contact lenses - balance after $150 credit every 24 months. *Kaiser Permanente vision providers only*

Please note: This summary provides a brief description of the Plan benefits. It is not meant to address all covered services, nor does it address all limitations, exclusions, or instances where prior authorization may be required. Please refer to the Summary Plan Document as it is the binding contract in the event of a discrepancy.