Medical Plan Comparison 2016-2017

Plan Name & Provider Network	PPO (Preferred Provider Organization)		Kaiser Permanente
	Pioneer Educators Health Trust (PEHT) 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 Employee Premium	Employee Only: $109.09 Employee + 1: $422.79 Family: $609.06		Employee Only: $74.02 Employee + 1: $286.77 Family: $414.44
Annual Deductible	Individual $1,500 Family $4,500	Individual $3,000 Family $9,000	None
Annual Out-of-Pocket Maximum	Individual $4,000 Family $12,000	Individual $8,000 Family $24,000	Individual $1,250 Family $2,500
Primary Care	$25 copay (deductible waived)	Employee pays 40% after deductible	No Charge
Specialty Care	$50 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% after deductible	Employee pays 40% after deductible	$15 copay
Urgent Care	$25 co-pay	Employee pays 40%	$35 copay
Emergency Room	$250 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
Prescription Retail (Up to 30 – day supply)	$20 generic $40 preferred $60 non-preferred		$15 generic $30 preferred / $50 non-preferred *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 / $100 non-preferred 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.