Medical Plan Comparison 2017-2018			
	Pioneer Educators Health Trust (PEHT) Regence BlueCross/BlueShield PPO		**Kaiser HMO**
	In-Network	Out-of-Network	In-Network Only
Monthly Employee Premium	Employee Only: $114.15 Employee + 1: $442.41 Family: $637.32		Employee Only: $82.90 Employee + 1: $321.18 Family: $464.17
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*	40%	$15 Copay
Specialty Care	$50 Copay*	40%	$15 Copay
Diagnostic Lab & X-ray	20%*	40%	No Charge
Inpatient Stay/Surgery	20%	40%	$250 per admission
Outpatient Surgery	20%	40%	$15 Copay
Urgent Care	$25 Copay*	40%	$35 Copay
Emergency Room	$250 Copay*, then 20%		$75 Copay + normal applicable charges
Ambulance Services	20%		$75 Copay
Alternative Care	24 Visit Max per Calendar Year 20% of allowed amount Chiropractic, Acupuncture & Massage (Naturopathic services are covered under Primary Care if provider is practicing within the scope of their license)		$1,500 Max / Calendar Year $15 Copay Chiropractic, Acupuncture & Naturopath $25 Copay Massage (massage max is 12 per year)
Prescription Retail (up to 30-day supply)	$20 Generic* $40 Preferred* $60 Non-Preferred*		$15 Generic $30 Preferred $50 Non-Preferred
Mail Order Rx (up to 90-day supply)	1.5 x Retail		2 x Retail
Vision Benefits	$0 Exam* $250 Hardware allowance per calendar year maximum benefit. No vision network required.		$15 Exam Copay Up to $150 Hardware allowance every 24 months.

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.

* Deductible Waived