MEDICAL AND PHARMACY BENEFIT COMPARISON

	REGENCE BLUECROSS BLUESHIELD OF OREGON			KAISER PERMANENTE
PROVIDERS / HOSPITALS	**PREFERRED PROVIDERS (PPO)**	**PARTICIPATING PROVIDERS**	**NON-PARTICIPATING NON-PPO PROVIDER [1]**	**KAISER PERMANENTE PROVIDERS & CONTRACTED FACILITIES**
Calendar Year (CY) Maximum	None			None
Calendar Year (CY) Deductible	$300 per individual - $600 per family			None
Medical Calendar Year (CY) Out-of-Pocket Maximum (OOPM)	$3,000 per individual $6,000 per family		$6,000 per individual $12,000 per family	$3,500 per individual $7,000 per family
Provider Office / Clinic Visit	**MEMBER PAYS after deductible (unless otherwise noted with * = deductible waived):**			**MEMBER PAYS:**
• Primary care (injury or illness) • Virtual Care / Telehealth • Specialist • Other practitioner (Acupuncture, Chiro)	• $20 copay / visit[2*] • $10 copay / visit[*] • $20 copay / visit[*] • 20%[*5]	• $20 copay / visit[*] • $20 copay / visit[*] • $20 copay / visit[*] • 20%[*5]	• 40% • 40% • 40% • 20%[*5]	• $15 copay / visit[3,4] • No cost share • $15 copay / visit • $10 copay / visit[6]
Preventive Care	• No cost share*	• No cost share*	• 40%[7]	• No cost share
Outpatient Testing • Diagnostic tests (x-ray, blood work) • Imaging (CT/PET scans, MRIs)	 • 20%* • 20%*	 • 40% • 40%	 • 40% • 40%	 • $20 copay / visit • $20 copay / visit
Prescription Drugs RX Calendar Year Out-of-Pocket Maximum • Value medications • Generic medications • Preferred brand medications • Non-preferred brand medications • Specialty medications	• $4,300 per individual • Retail and Mail Order: $0 copay (Optimum Value medications) • Retail: $10 or 20% (whichever is greater) Mail Order: $20 or 20% (whichever is greater) • Retail: $20 or 20% (whichever is greater) Mail Order: $40 or 20% (whichever is greater) • Retail & Mail Order: 50% • Paid according to their formulary designation			• None (accumulates under medical OOPM) • Specific list of medications apply • Retail: $15 copay Mail Order: $30 copay • Retail: $30 copay Mail Order: $60 copay • Retail: $50 copay Mail Order: $100 copay • Paid according to their formulary designation
Outpatient surgery • Facility fee • Physician / surgeon fees	 • 20%[8] • 20%	 • 40% • 40%	 • 40% • 40%	 • No cost share • $15 copay / procedure
Emergency Care • Emergency Room • Emergency medical transportation • Urgent care	 • $75 copay/visit, then 20% • 20% • $20 copay / visit[9]	 • $75 copay/visit, then 20% • 20% • $20 copay / visit[9]	 • $75 copay / visit, then 20% • 20% • 40%	 • $75 copay / visit • $75 copay / transport • $15 copay / visit
Hospital • Facility fee • Physician / surgeon fees	 • 20% • 20%	 • 40% • 40%	 • 40% • 40%	 • $100 copay / day ($500 max/CY) • No cost share
Mental Health / Substance Abuse • Inpatient services • Outpatient services	 • 20% • $20 copay / visit[2*]	 • 20% • $20 copay / visit[*]	 • 40% • 40%	 • $100 copay / day ($500 max/CY) • $15 copay / visit
Maternity • Prenatal and postnatal care • Delivery and all inpatient services	 • 20% • 20%	 • 40% • 40%	 • 40% • 40%	 • $15 copay / office visit[10] • $100 copay / day ($500 max/CY)
Recovery or special health needs • Home health care[11] • Rehabilitation services (OT, PT, ST) • Skilled nursing care • Durable medical equipment	 • 20% • 20%[12] • 20% • 20%	 • 40% • 40%[12] • 40% • 40%	 • 40% • 40%[12] • 40% • 40%	 • No cost share • $15 copay / visit (20 visits/CY) • No cost share • 20%

Please note: This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this comparison and the plan document, the information in the plan document shall prevail.

1. Members may be balanced billed for balances beyond any deductible and coinsurance amounts.
2. The first three mandated primary care/behavioral health (Preferred providers only) office visit or psychotherapy visits are covered after a $5 copay. Regular plan cost shares apply for subsequent visits.
3. First preventive care visits each year, either virtually or in-person covered at no member cost share.
4. First three visits each year for primary care or primary care related services are covered after a $5 copay per visit.
5. Chiropractic spinal manipulations are limited to 30 visits, and are combined with osteopathic spinal manipulation visits for a combined 30 visits per calendar year. Acupuncture visits are limited to 30 visits per calendar year.
6. Chiropractic care is limited to 20 visits per calendar year. Self-referred acupuncture is limited to 12 visits per calendar year. Copays do not apply to the out-of-pocket maximum (OOPM).
7. Immunizations for children up to age 18 are covered in full.
8. Coinsurance is reduced to 10% when in-network Preferred Provider Ambulatory Surgery Centers are used.
9. Members are responsible for their portion of any ancillary charges, e.g. x-rays, lab work, and outpatient surgery.
10. Prenatal care is considered preventive, therefore there is no cost share and the copay does not apply.
11. Up to 130 visits per year
12. Inpatient: 60 day limit/CY; Outpatient: 45 visit limit/CY (combined limit includes occupational therapy (OT), physical therapy (PT), and speech therapy (ST)).

VISION, DENTAL AND HEARING BENEFIT COMPARISON

VISION BENEFITS			
	VISION SERVICE PLAN (VSP) REGENCE ENROLLEES ONLY		KAISER PERMANENTE[13]
PROVIDERS	**VSP SIGNATURE NETWORK**	**NON-VSP PROVIDERS[14]**	**KAISER PERMANENTE PROVIDERS**
	MEMBER PAYS:	**MEMBER PORTION & REIMBURSEMENT:**	**MEMBER PAYS:**
Exams	$20 copay Diabetic eyecare: $20 copay	$20 copay, then reimbursed up to $50	$15 copay
Lenses • Single • Bifocal – Lined • Trifocal - Lined	$25 copay[15]	$25 copay, then reimbursed: • Up to $50 • Up to $75 • Up to $100	Allowance of $175 for lenses, frames or contacts; if full allowance is not used, the balance is forfeited.
Frames	Allowance of $150	Reimbursed up to $70	
Contact Lenses • Fitting exam	Allowance of $150 for contacts; Up to a $60 copay for contact lens exam	Reimbursed up to $105	
Frequency (based on last date of service) • Exam • Lenses • Frames	• 12 months • 12 months • 24 months	• 12 months • 12 months • 24 months	• No limit • Two (2) calendar years • Two (2) calendar years

DENTAL BENEFITS			
	TRUST PLANS	WILLAMETTE DENTAL[16]	KAISER PERMANENTE[17]
PROVIDERS	**ANY LICENSED DENTIST**	**WILLAMETTE DENTAL INSURANCE, INC. PROVIDERS**	**KAISER PERMANENTE DENTIST'S**
Dental Calendar Year (CY) Deductible	$10 per individual	None	None
Dental Calendar Year (CY) Maximum	$1,500 – ***PLAN PAYS***	None[18]	None
	MEMBER PAYS after deductible:	**MEMBER PAYS:**	**MEMBER PAYS:**
Services • Preventive Care (exam/cleaning) • Basic (fillings, simple extractions) • Prosthetic (crowns, bridges) • Implant Surgery	• 20% of UCR • 20% of UCR • 20% of UCR[19] • Not covered	• $10 copay • $10 copay + applicable copays[20] • $10 copay + applicable copays[20] • $1,500 annual benefit maximum; per calendar year	• $5 copay • $5 copay + 20% • $5 copay + 50% • Not covered
Orthodontia • Services	• 50% of UCR	• $2,400 initial fee, then $10 copay each visit	• $5 copay + 50%
Orthodontia Lifetime Maximum	$1,000 – ***PLAN PAYS***	None	50% up to $1,000 – ***PLAN PAYS***

HEARING AID BENEFITS	
Eligibility	• All enrolled, Active employees and dependents regardless which medical plan.
Exam / Evaluation / Hardware	• The Plan will pay 80% of the usual and customary charges up to a maximum of $400 per ear in a period of three (3) consecutive calendar years. • Examination must be made by a physician prior to obtaining a hearing aid. Physician must provide a written certificate stating that hearing may be improved with the use of a hearing aid. Benefits will not be provided without this certificate.

Please note: This is a summary of benefits only, for general comparison. Any errors or omissions are purely unintentional. Should any discrepancies be found between this comparison and the plan document, the information in the plan document shall prevail.

13. Coverage shown is for members age 19 and older. Pediatric vision coverage for children 18 and younger is different; refer to the Kaiser medical summary for more information.
14. Services and eyewear obtained through out-of-network providers are subject to the same limitations as services obtained through VSP doctors.
15. Standard progressive lenses are covered in full.
16. Willamette Dental Insurance, Inc. is available to Oregon, Washington and Idaho residents only.
17. Kaiser dental is available to all members – one does not need to be enrolled on Kaiser medical.
18. Benefits for implant surgery have a benefit maximum.
19. Actual benefit varies; refer to your labor contract.
20. Applicable copays vary based on services received.

HEALTH PLAN CONTACT INFORMATION

	CARRIERS	CUSTOMER SERVICE INFORMATION	WEB INFORMATION
Medical and Prescription Drug	**Regence BCBSO** Group # 10010748	1.888.370.6157	www.regence.com
	Regence BCBSO Group # 10010748 ***Mail order Prescription Drugs - Express Scripts Pharmacy***	1.844.765.2894 1.833.599.0451	www.regence.com/pharmacy www.expressscripts.com
	Kaiser Permanente Group # 1616	1.800.813.2000	www.kp.org
	Kaiser Permanente Group # 1616 ***Mail order Prescription Drugs***	1.800.548.9809	www.kp.org/refill
Dental	**Trust Plans 10 – 11 – 12**	1.800.547.4457	www.westernstatesbenefits.org
	Willamette Dental Insurance, Inc. Group # OR67	1.855.433.6825	memberservices@willamettedental.com
	Kaiser Permanente Group # 1616	1.800.813.2000	www.kp.org
Vision	**Vision Service Plan (VSP)** Group # 12217447	1.800.877.7195	www.vsp.com
Life and Disability Benefits	**Standard Insurance** Group # 309780	1.888.937.4783	www.standard.com

If you have specific questions about treatment or how benefits apply to your situation, call the health plan directly.

24 HOUR PHONE NUMBERS FOR URGENT HELP

- **Regence BCBSO nurse advice line: 1.800.267.6729, Press 1**
- **Kaiser Permanente nurse advice line: 1.800.813.2000**