Healthcare Comparison

Willamette University 2024-25

Plan Name & Provider Network	Option 1: Kaiser Medical HMO	Option 2: Added Choice PPO		
		Tier 1	Tier 2	Tier 3
	Kaiser Providers	Kaiser Providers	First Choice PPO Providers	Non-Participating Providers
Annual Deductible (January – December)	Individual $500 Family $1,500	Individual $1000 Family $3,000	Individual $2,000 Family $6,000	Individual $3,000 Family $9,000
Annual Out-of-Pocket Maximum *Tier 1 & 2 cross accumulate	Individual $3,000 Family $9,000	Individual $4,000* Family $8,000*	Individual $6,000* Family $12,000*	Individual $7,500 Family $15,000
Preventive Care	$0	$0	$0	40% coinsurance after deductible
Primary Care / Naturopathic Care	$15	$25	$35	40% coinsurance after deductible
Specialty Care	$25	$35	$45	40% coinsurance after deductible
Urgent Care	$35	$45	$55	40% coinsurance after deductible
Diagnostic Lab & X-Ray	$15 per department visit	$25 per department visit	$35 per department visit	40% coinsurance after deductible
CT, MRI, PET Scan	$100 per department visit	$100 per department visit	30% Coinsurance after deductible	40% coinsurance after deductible
Inpatient Stay/Surgery	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
Outpatient Surgery	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
Emergency Room	20% Coinsurance after deductible	$200 after deductible (waived if admitted)		
Ambulance Services	20% Coinsurance after deductible	20% Coinsurance after deductible		
Durable Medical Equipment	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
Alternative Care *(Acupuncture, Chiropractic, Massage Therapy)*	$25 per visit. Visit limitations: Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits	$25 per visit. Visit limitations: Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits	20% Coinsurance	40% coinsurance
Prescription Retail *(Up to 30 – day supply)*	$20 generic $40 preferred $60 non-preferred	$20 generic $40 preferred $60 non-preferred		
Mail Order Prescriptions (Up to 90 – day supply)	$40 generic $80 preferred $120 non-preferred	*Kaiser Mail Order* $40 generic $80 preferred $120 non-preferred	*Med Impact Mail Order* $60 generic $120 preferred $180 non-preferred	
Routine Eye Exam	$15 co-pay	$25 co-pay	$35 co-pay	40% coinsurance after deductible
Vision Hardware and optical services	$250 annual allowance	$250 annual allowance		