# Healthcare Comparison

*Willamette University 2023-24*

| 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<br>Family $1,500 | Individual $1000<br>Family $3,000 | Individual $2,000<br>Family $6,000 | Individual $3,000<br>Family $9,000 |
| **Annual Out-of-Pocket Maximum** ***Tier 1 & 2 cross accumulate** | Individual $3,000<br>Family $9,000 | Individual $4,000*<br>Family $8,000* | Individual $6,000*<br>Family $12,000* | Individual $7,500<br>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 | | |
| **Ambulance Services** | 20% Coinsurance after deductible | 20% Coinsurance after deductible | N/A | 40% 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:<br>Acupuncture – 12 visits<br>Chiropractic – 20 visits<br>Message Therapy – 12 visits | $25 per visit.<br>Visit limitations:<br>Acupuncture – 12 visits<br>Chiropractic – 20 visits<br>Message Therapy – 12 visits | 20% Coinsurance.<br>Visit limitations:<br>Acupuncture – 12 visits<br>Chiropractic – 20 visits<br>Message Therapy – 12 visits | 40% Coinsurance.<br>Visit limitations:<br>Acupuncture – 12 visits<br>Chiropractic – 20 visits<br>Message Therapy – 12 visits |
| **Prescription Retail** *(Up to 30 – day supply)* | $20 generic<br>$40 preferred<br>$60 non-preferred | $20 generic<br>$40 preferred<br>$60 non-preferred | | |
| **Mail Order Prescriptions** (Up to 90 – day supply) | $40 generic<br>$80 preferred<br>$120 non-preferred | *Kaiser Mail Order*<br>$40 generic<br>$80 preferred<br>$120 non-preferred | | *Med Impact Mail Order*<br>$60 generic<br>$120 preferred<br>$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 | | |