Medical Benefit Comparison: April 1, 2016 - March 31, 2017
George Fox University

	Pioneer PPO (Preferred Provider Organization)		Kaiser Permanente HMO (Health Maintenance Organization)
Benefit Provisions	**In Network***	**Out of Network***	**Kaiser Network**
	When you receive services from any Preferred Provider in Network, you receive benefits in this column	**When you receive services from any Out of Network Participating Provider, you receive benefits in this column**	**When you receive servies from any Kaiser provider or facility you receive benefits at this rate**
Deductible *(Individual/Family)*	$1,500 / $4,500	$3,000 / $9,000	None
Annual Out-of-Pocket Max. Includes Deductible *(Individual/Family)*	$4,000 / $12,000	$8,000 / $24,000	$1500 / $3000
***Annual* Maximum Benefit**	None	None	None
	YOU PAY	**YOU PAY**	**YOU PAY**
Office Visits	Copays: $25 Primary, $50 Specialty	40% after deductible	Copays: $25 Primary, $35 Specialty
Immunizations for adults & children	covered in full	covered in full	covered in full
Preventive Care / Well Baby & Child	covered in full	40% after deductible	covered in full
Outpatient Lab and X-Ray	20%, deductible waived	40% after deductible	$25 copay per dept visit
Scans: CT, MRI, PET	20% after deductible	40% after deductible	$50 copay per dept visit
Hospital Services			
Inpatient	20% after deductible	40% after deductible	$500 per admission
Outpatient	20% after deductible	40% after deductible	$75 copay
Emergency Room (copay waived if admitted)	$250 copay, then 20%	$250 copay, then 20%	$200 copay
Urgent Care Center	$25 copay	40% after deductible	$45 copay
Ambulance	20% after deductible	20% after deductible	$75 copay
Prescription - Retail (At participating pharmacies) *(30 day supply)*	$20/$40/$60 generic / preferred brand / non-preferred brand		$15/$30/$50 generic / brand name/ non-preffered brand or specialty
Prescription - Mail Order *(up to 90 day supply)*	$30/$60/$90 generic / preferred brand / non-preferred brand		$30/$60/$100 generic / brand name/non-preffered brand or specialty
Rehabilitation Therapies	20% after deductible	40% after deductible	$35 copay
Vision	No vision coverage	No vision coverage	$25 exam copay, balance after $150 every 24 months
Alternative Care	No coverage	No coverage	$35 copay, No coverage unless referred

*** There are three levels of providers under the Pioneer PPO: In-Network Preferred, Out-of Network Participating & Out-of-Network Nonparticipating (not shown).**

Note: The above is intended to be a brief summary for comparison purposes. Actual benefits will be paid per contracts. See additional details at www.georgefox.edu/offices/hr/benefits.