Faculty Benefit Plan Comparison
October 1, 2011 - September 30, 2012

Medical Plans - effective October 1, 2011	Medical Plan 2 Providence (POS)	Medical Plan 3 ODS (PPO)	Medical Plan 5 ODS (PPO)	Medical Plan 8 ODS (PPO)
	$ and % shown is the Member Cost		$ Amounts = Copayments	
Deductible				
Individual / Family	$100 / $300	$200 / $600	$300 / $900	$1,000 / $3,000
Coinsurance				
In-Network / Out-of-Network	20% / 50%	20% / 50%	20% / 50%	20% /50%
Maximum Out-of-Pocket Cost per Plan Year (then Plan pays 100% - Additional Cost Tier & Copayments still apply)				
In-Network (Individual / Family)	$1,200 / $3,600**	$1,500 / $4,500**	$2,000 / $6,000**	$2,200 / $6,600**
Out-of-Network (Individual / Family)	$2,400 / $7,200**	$3,000 / $9,000**	$4,000 / $12,000**	$4,400 / $13,200**
Preventive Care Services (In-Network / Out-of-Network)				
Adult, Well-child & Well-baby exams	$0* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Immunizations	$0* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Preventive Care Services, see Plan Handbooks	$0* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Provider Services (In-Network / Out-of-Network)				
Incentive Office Visits for asthma, heart conditions (CHF, cholesterol & high BP), and diabetes management	$10* / 50%	$10* / 50%	$10* / 50%	20% / 50%
Primary Care Services, see Plan Handbook	$15* / 50%	$25* / 50%	$25* / 50%	20% / 50%
Urgent Care Visit	$50*	$50*	$50*	20%
Specialist Office Visits	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Additional Cost Tier**	$500 + 20% / $500 + 50%	$500 + 20% / $500 + 50%	$500 + 20% / $500 + 50%	$500 + 20% / $500 + 50%
Other Services (In-Network / Out-of-Network)				
Laboratory / X-Ray	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Imaging (CT, PET & MRI)**; Upper Endoscopies**; and Sleep Studies**	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%
Durable Medical Equipment	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Hearing Aids ($4000 maximum every 48 months)	10% / 50%	10% / 50%	10% / 50%	10% / 50%
Tobacco Cessation Program (available to age 18 and over)	Unlimited calls to Free & Clear, maximum 5 calls from Free & Clear per Plan Year. Patches, gum, and prescribed medications are subject to Rx copays. See plan handbook for details.			
Maternity (In-Network / Out-of-Network)				
Outpatient Maternity Care	20% / 50%	$25* / 50%	$25* / 50%	20% / 50%
Delivery & Routine Newborn Nursery Care	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Mental Health & Chemical Dependency Services (In-Network / Out-of-Network)				
Outpatient Services	$15* / 50%	$25* / 50%	$25* / 50%	20% / 50%
Inpatient Services	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Residential Services	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Weight Loss Management (subscriber and covered dependents)				
Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply)	No Charge	No Charge	No Charge	No Charge
12 Health Coaching Sessions per Plan Year & Online Educational Resources	No Charge	No Charge	No Charge	No Charge
Hospital & Outpatient Services (In-Network / Out-of-Network)				
Inpatient Care	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Outpatient Surgery	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Outpatient Rehabilitation (max 30 visits / Plan Year) (physical, occupational, and speech therapy)	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Ambulance	20%	20%	20%	20%
Emergency Room Copay (waived if admitted unless noted otherwise)	$100 + 20%	$100 + 20%	$100 + 20%	$100 + 20%
Alternative Care Services (In-Network / Out-of-Network)		**ODS Copayments do not apply to Out-of-Pocket Maximums**		
Acupuncture, Chiropractic & Naturopathic Cost of lab, x-rays, supplies, and procedures performed in Alternative Care Provider's office applies to Benefit Maximum	$15* / NA $2000 maximum benefit per Plan Year	$25* / 50% $2000 maximum benefit per Plan Year	$25* / 50% $2000 maximum benefit per Plan Year	20% / 50% $2000 maximum benefit per plan year

* Deductible Waived

** Additional Cost Tier copayments and $100 Imaging/Sleep Studies/Upper Endoscopies copayments do not count toward Deductible or Out-of-Pocket Maximum

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Pharmacy Services effective October 1, 2011	**Medical Plan 2 Providence (POS) with Providence Rx**	**Medical Plan 3 ODS (PPO) with ODS Rx Plan B**	**Medical Plan 5 ODS (PPO) with ODS Rx Plan B**	**Medical Plan 8 ODS (PPO) with ODS Rx Option B**
Out-of-Pocket Maximum (per person)	$1,100	$1,100	$1,100	$1,100
Retail	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)
Value	$4	$4	$4	$4
Generic	$8	$8	$8	$8
Preferred	$25	$25	$25	$25
Non-preferred	50%	50%	50%	50%
Mail	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)
Value	$8	$8	$8	$8
Generic	$16	$16	$16	$16
Preferred	$50	$50	$50	$50
Non-preferred	50%	50%	50%	50%
Specialty	(Up to a 30-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)
Generic	$8	$16	$16	$16
Preferred	$25	$50	$50	$50
Non-preferred	50%	50%	50%	50%

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Dental Plans - effective October 1, 2011	ODS Dental Plan 1 ♦	ODS Dental Plan 4	Willamette Dental Plan 8*
Dental Office Visit Copayment	NA	NA	$20*
Benefit Maximum	$2,200	$1,500	NA
Deductible	$50	$50	NA
Maximum Benefit per Plan Year	$2,200	$1,500	NA
Preventive and Diagnostic Services	**Deductible Waived for Preventive & Diagnostic Services on ODS Plans**		
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	100%	100%
Restorative Services			
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	80% [1]	100% [2]
Simple Extraction			
Simple tooth extractions	70% + 10% each Plan Year	80%	100%
Oral Surgery			
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	80%	100%
Periodontics			
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	80%	100%
Endodontics			
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	80%	100%
Major Restorative Services			
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	80%	100%
Implants	70% + 10% each Plan Year	50%	See Certificate of Coverage for copays
Fixed and Removable Prosthetic Services			
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	100%
Bridge retainers and pontics	70% + 10% each Plan Year	50%	100%
Orthodontics	80% to $1,800 lifetime max	80% to $1,800 lifetime max	$1,500 copay + $20 / visit**

♦ Benefits start at 70% the first plan year then increase by 10% each play year (up to a maximum of 100% provided the individual has visited the dentist at least once during the previous plan year.

* Office visit copayment applies to each visit, in addition to any plan copayments for services.

** Pre-Orthodontic Service fee of $150 is credited toward the orthodontic benefit if patient accepts treatment plan.

[1] Posterior fillings paid to amalgam fee.

[2] Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and one-surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Willamette Dental directly for actual fees.

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Vision Plans - effective October 1, 2011	**ODS Vision Plan 4**
Maximum Benefit per Plan Year	$600*
Exam Frequency	Once per Plan Year
Routine Eye Exam	100%
Lens Frequency	Once per Plan Year
Lenses	Either one pair of lenses or contacts
Single Vision	100%
Bifocal	100%
Lenticular	100%
Trifocal	100%
Contact Lenses	100%
Frame Frequency	Child: once per Plan Year
	Adult: once every two Plan Years
Frames	100%

* Exam and hardware charges all apply to the Plan Year maximum benefit.

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