

OREGON GROUP PLAN COMPARISON

	CoDeduct 70% Plan	CoDeduct Value 70% Plan
Maximum Lifetime Benefit	\$2,000,000	\$2,000,000
Deductible Options	\$2,000, \$3,000	\$300, \$500, \$750, \$1,000, \$1,500, \$2,000, \$2,500, \$3,000, \$5,000, \$7,500
Coinsurance Options	Office visits: 100%/70% Major medical: 70%/60% (most services)	Office visits: 100%/70% Major medical: 70%/50% (most services)
Copay Options	\$35	\$35, \$50
Out-Of-Pocket Limit Par (x2 for family)	Varies based on plan chosen	Individual OOP limit will be \$1,000 higher
Out-Of-Pocket Limit Nonpar	\$5,000 per person	Varies based on plan chosen

	BENEFIT			
SERVICE	Par Provider	Nonpar Provider	Par Provider	Nonpar Provider

PREVENTIVE CARE

Well Baby Care	\$35 per visit, 100%*	\$35 per visit, 70%*	\$35 per visit, 100%*	\$35 per visit, 70%*
Routine Physicals	\$35 per visit, 100%*	\$35 per visit, 70%*	\$35 per visit, 100%*	\$35 per visit, 70%*
Routine Gynecological Exams	\$35 per visit, 100%*	\$35 per visit, 70%*	\$35 per visit, 100%*	\$35 per visit, 70%*
Immunizations	100%*	70%*	100%*	70%*
Routine Colonoscopy	70%	60%	70%	50%

PROFESSIONAL

Office Visits—Bundled

Office and Urgent Care Visits—Unbundled

Office and Home Visits	\$35 per visit, 100%*	\$35 per visit, 70%*	\$35 per visit, 100%*	\$35 per visit, 70%*
Urgent Care Visits	\$35 per visit, 100%*	\$35 per visit, 70%*	\$35 per visit, 100%*	\$35 per visit, 70%*
Surgery	70%	60%	70%	50%
Physical Therapy	70%	70%	70%	60%

HOSPITAL

Inpatient Room and Board	70%	60%	70%	50%
Inpatient Rehabilitative Care	70%	60%	70%	50%
Skilled Nursing Facility Care	70%	60%	70%	50%

OUTPATIENT

ER Visits—Bundled

ER Visits—Unbundled

Outpatient Surgery	70%	60%	70%	50%
Diagnostic/Therapeutic Radiology and Lab	70%*	60%*	100% of first \$400*, then 70%	50%
CT/PET Scans, CATH Labs and MRIs	70%	60%	\$100 per test, 70%	\$100 per test, 50%
Emergency Room Visits	\$100 per visit, 70%*	\$100 per visit, 60%*	\$250 per visit, 70%*	\$250 per visit, 50%*

MENTAL HEALTH/CHEMICAL DEPENDENCY

Office Visits	\$35 per visit, 100%*	\$35 per visit, 70%*	\$35 per visit, 100%*	\$35 per visit, 70%*
Residential Programs	70%	60%	70%	50%
Inpatient Care	70%	60%	70%	50%

OTHER COVERED SERVICES

Allergy Injections	\$5 per visit, 100%*	\$5 per visit, 70%*	\$5 per visit, 100%*	\$5 per visit, 70%*
Ambulance, Ground	70%	70%	70%	70%
Ambulance, Air	50%	50%	50%	50%
Durable Medical Equip.	70%	50%	70%	50%
Home Healthcare	70%	50%	70%	50%

*Not subject to deductible. Note: CoDeduct Value items in **bold red** indicate differences from our current CoDeduct 70% plan.