



# Healthcare Comparison

## Willamette University 2026-27

Plan Name & Provider Network	Option 1: Kaiser Medical HMO	Option 2: Added Choice POS		
	Kaiser Providers	Tier 1 Kaiser Providers	Tier 2 First Choice PPO Providers	Tier 3 Non-Participating Providers
<b>Calendar Year Deductible**</b>	Individual \$1,000 Family \$3,000	Individual \$1000 Family \$3,000	Individual \$2,000 Family \$6,000	Individual \$3,000 Family \$9,000
<b>Calendar Year Out-of-Pocket Maximum**</b> <i>*Tiers 1 &amp; 2 cross accumulate</i>	Individual \$4,000 Family \$8,000	Individual \$4,000* Family \$8,000*	Individual \$6,000* Family \$12,000*	Individual \$7,500 Family \$15,000
<b>Preventive Care</b>	\$0	\$0	\$0	40% coinsurance after deductible
<b>Primary Care / Naturopathic Care/ Outpatient Mental Health Care</b>	1 <sup>st</sup> 3 visits \$5, then \$25	1 <sup>st</sup> 3 visits \$5, then \$25	1 <sup>st</sup> 3 visits \$5, then \$35	40% coinsurance after deductible
<b>Specialty Care</b>	\$35	\$35	\$45	40% coinsurance after deductible
<b>Urgent Care</b>	\$45	\$45	\$55	40% coinsurance after deductible
<b>Diagnostic Lab &amp; X-Ray</b>	\$25 per department visit	\$25 per department visit	\$35 per department visit	40% coinsurance after deductible
<b>CT, MRI, PET Scan</b>	\$100 per department visit	\$100 per department visit	30% Coinsurance after deductible	40% coinsurance after deductible
<b>Inpatient Stay/Surgery</b>	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
<b>Outpatient Surgery</b>	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
<b>Emergency Room</b>	20% Coinsurance after deductible	\$200 after deductible (waived if admitted)		
<b>Ambulance Services</b>	20% Coinsurance after deductible	20% Coinsurance after deductible		
<b>Durable Medical Equipment</b>	20% Coinsurance after deductible	20% Coinsurance after deductible	30% Coinsurance after deductible	40% coinsurance after deductible
<b>Self-Referred Alternative Care</b> <i>(Acupuncture, Chiropractic, Massage Therapy)</i>	\$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 Visit limitations** Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits	40% coinsurance Visit limitations** Acupuncture – 12 visits Chiropractic – 20 visits Message Therapy – 12 visits
<b>Prescription Retail</b> <i>(Up to 30 – day supply)</i>	\$20 generic \$40 preferred \$60 non-preferred	\$20 generic \$40 preferred \$60 non-preferred		
<b>Mail Order Prescriptions</b> <i>(Up to 90 – day supply)</i>	\$40 generic \$80 preferred \$120 non-preferred	<i>Kaiser Mail Order</i> \$40 generic \$80 preferred \$120 non-preferred	<i>Med Impact Mail Order</i> \$60 generic \$120 preferred \$180 non-preferred	
<b>Routine Eye Exam</b>	\$25 co-pay	\$25 co-pay	\$35 co-pay	40% coinsurance after deductible
<b>Vision Hardware and optical services</b>	\$250 annual allowance	\$250 annual allowance		

\*\*Deductibles, out of pocket maximums, and alternative care visit limits accumulate on a calendar year basis.