

Oregon REALTORS® Plan Highlights



MORE Realty, Inc.

	Option Advantage Plus		Choice		HSA Embedded	
	\$25/30%/50%/\$5000/\$2500cd		\$35/30%/50%/\$6350/\$3500sd		0%/0%/\$4000/\$4000cd	
	Signature Network		Choice Network		Signature Network	
	Referrals not required		Referrals required		Referrals not required	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual calendar-year deductible (2x family)	\$2,500❖	Common❖	\$3,500❖	\$7,000❖	\$4,000❖	Common❖
Individual out-of-pocket maximum (2x family)	\$5,000	Common	\$6,350	\$12,700	\$4,000	Common
PHYSICIAN/PROFESSIONAL SERVICES						
Office visits to Primary Care Provider and mental health provider	\$25✓	50%✓	\$35✓	50%	Covered in full	Covered in full
Phone/video visits to Primary Care Provider (including Providence Express Care Virtual®)	Covered in full✓	Not Covered	Covered in full✓	Not Covered	Covered in full	Not Covered
Office visits to specialists	\$35✓	50%✓	\$70✓	50%	Covered in full	Covered in full
Office visits to alternative care providers (such as naturopaths)	\$25✓	50%✓	\$35✓	50%	Covered in full	Covered in full
Chiropractic Manipulation & Acupuncture Any Licensed Provider – CHA Plus \$1000/Calendar year	\$25✓	N/A	\$25✓	N/A	\$25	N/A
HOSPITAL SERVICES						
Inpatient care, including mental health/chemical dependency, observation care, outpatient surgery at a hospital-based facility	30%	50%	30%	50%	Covered in full	Covered in full
Outpatient surgery at an ambulatory surgery center	20%	50%	20%	50%	Covered in full	Covered in full
Inpatient rehabilitative care (30 days per calendar year)	30%	50%	30%	50%	Covered in full	Covered in full
OUTPATIENT DIAGNOSTIC SERVICES						
X-ray and lab services (includes ultrasound)	30%*	50%	30%✓	50%	Covered in full	Covered in full
High-tech imaging services (such as PET, CT, MRI)	30%	50%	30%	50%	Covered in full	Covered in full
MEDICAL EQUIPMENT, SUPPLIES and DEVICES						
Medical equipment and supplies	30%	50%	30%	50%	Covered in full	Covered in full
Diabetes supplies (lancets/test strips/needles/glucose monitors)	30%✓	50%	30%✓	50%	20%✓	Covered in full
EMERGENCY/URGENT CARE & AMBULANCE SERVICES						
Emergency services	\$250	\$250	\$250	\$250	Covered in full	Covered in full
Urgent care services	\$35✓	50%✓	\$70✓	50%	Covered in full	Covered in full
Emergency medical transportation	30%		30%		Covered in full	

PRESCRIPTION – FORMULARY P						
Tier 1 – Preventive & Generic	Covered in full✓	Not Covered	Covered in full✓	Not Covered	Covered in full	Not Covered
Tier 2 – Medium Cost Share Generic	\$10✓	Not Covered	\$10✓	Not Covered	Covered in full	Not Covered
Tier 3 – High Value, First Line Brand & Generic	\$30✓	Not Covered	\$30✓	Not Covered	Covered in full	Not Covered
Tier 4 – All other Brand & High Cost Generic	\$60✓	Not Covered	\$60✓	Not Covered	Covered in full	Not Covered
Tier 5&6 – Specialty Brand & Generic	50% up to \$200✓	Not Covered	50% up to \$200✓	Not Covered	Covered in full	Not Covered
VISION PLUS (VSP)						
Exam – Every 12 months	\$10✓	Covered up to \$45✓	\$10✓	Covered up to \$45✓	\$10✓	Covered up to \$45✓
Lenses (12 months) & Frames (24 months) <i>(Contacts in lieu of glasses/frames – 12 months)</i>	\$130 Frame Allowance	See Benefit Summary	\$130 Frame Allowance	See Benefit Summary	\$130 Frame Allowance	See Benefit Summary

- ✓ No deductible needs to be met prior to receiving this benefit.
- ◆ Deductible applies to the Out-of-Pocket Maximum.
- * Option Advantage Plus - Covered In Full, Deductible Waived for the first \$500 of in-network lab and x-ray services in a calendar year, then deductible and coinsurance.

This overview is for illustration purposes only. Any errors are unintentional. Please refer to your member handbook and benefit summary for complete details.

Click here for provider directory search: [Providence Provider Directory](#)



Providence Signature

- + Nationwide PPO network
- + Approx. 1 million providers
- + Includes Choice network
- + Preferred pricing for PSJH providers and facilities in OR and WA
- + First Choice and First Health networks



Providence Choice

- + High-performing mixed delivery network
- + Statewide network
- + PMG and contract providers
- + Includes over 400 medical homes in OR and SW WA
- + PCMH clinical model, continuity in quality and care management



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	\$35/30%/50%/\$8150/\$6000sd		0%/0%/\$6750/\$6750cd			
	Choice Network		Signature Network			
	Referrals required		Referrals not required			
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
Individual calendar-year deductible (2x family)	\$6,000❖	\$12,000❖	\$6,750❖	Common❖	❖	❖
Individual out-of-pocket maximum (2x family)	\$8,150	\$16,300	\$6,750	Common		
PHYSICIAN/PROFESSIONAL SERVICES						
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