Multnomah County Employee Benefits

The Kaiser HMO 10/20 plan replaces the current Kaiser Standard HMO

Kaiser HMO Plan Design	Current HMO Standard Plan You Pay	HMO 10/20 Plan You Pay
Deductible		
For one Member	None	None
For an entire Family	None	None
Annual Out-of-Pocket Maximum (Copayment and Coinsurance amounts count toward the maximum, unless otherwise noted.)		
For one Member	$600	$600
For an entire Family	$1,200	$1,200
Office visits		
Routine preventive physical exam	$0	$0
Primary Care	$10	$10
Specialty Care	$10	$20
Urgent Care	$10	$30
Tests (outpatient)		
Preventive tests	$0	$0
Laboratory	$0	$0
X-ray, imaging, and special diagnostic procedures	$0	$0
CT, MRI, PET scans	$0	$0
Medications		
Prescription drugs (outpatient)	$10 generic or brand $0 formulary contraception	$10 generic/$20 brand $0 formulary contraception
Administered medications, including injections (all outpatient settings)	$0	$0
Nurse treatment room visits to receive injections	$0	$0
Maternity Care		
Scheduled prenatal care and first postpartum visit	$0	$0
Laboratory	$0	$0
X-ray, imaging, and special diagnostic procedures	$0	$0
Inpatient Hospital Services	$0	$50/day up to $250 per admission
Hospital Services		
Ambulance Services (per transport)	$50	$50
Emergency department visit (Waived if admitted)	$50	$50
Inpatient Hospital Services	$0	$50/day up to $250 per admission
Outpatient Services (other)		
Outpatient surgery visit	$10	$25
Chemotherapy/radiation therapy visit	$10	$10
Durable medical equipment, external prosthetic devices, and Orthotic devices	$0	$0
Physical, speech, and occupational therapies (up to 20 visits per therapy per Calendar Year)	$10	$10

Kaiser HMO Plan Design	Current HMO Standard Plan	2019 HMO 10/20 Plan
	You Pay	You Pay
Alternative Care		
Alternative care (physician-referred) (Acupuncture is limited to 12 visits per calendar year.)	$10	$10
Alternative care (self-referred)* (Massage is limited to 12 visits per calendar year.)	$15/$25/$500	$15/$25/$500
Vision Services		
Routine eye exam (ages 18 years and younger)	$0	$0
Routine eye exam (ages 19 years and older)	$10	$10
Vision hardware and optical Services (ages 18 years and younger)	No charge for one pair standard frames and lenses or contact lenses every calendar year.	No charge for one pair standard frames and lenses or contact lenses every calendar year.
Vision hardware and optical Services (ages 19 years and older)*	$150/2 years	$150/2 years
Skilled Nursing Facility Services		
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	$0	$50/day up to $250 per admission
Chemical Dependency Services		
Outpatient Services	$10	$10
Inpatient hospital & residential Services	$0	$50/day up to $250 per admission
Mental Health Services		
Outpatient Services	$10	$10
Inpatient hospital & residential Services	$0	$50/day up to $250 per admission
Hearing Aids		
Hearing Aids for Children (limited to one hearing aid per ear every four years per Member age 18 years and younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution)	$0	$0
Hearing aids (ages 19 years and older) **	1 per ear every 4 yrs/$4,000 max	1 per ear every 4 yrs/$4,000 max
Student Out-of-Area Coverage		
Routine, continuing, and follow-up Services	20% of actual fee	20% of actual fee

***Amounts do not count towards annual Out-of-Pocket Maximum.**

Note - This is a high level plan summary. Refer to plan documents for complete descriptions of coverage.