Multnomah County Employee Benefits

The PPO 400 Plan replaces the Platinum Plan

PPO 400 Plan	Current Platinum Plan		PPO 400 Plan	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Deductible (applies to coinsurance benefits unless noted)			Deductible waived for in-network office visits, urgent care	
For one Member	$300	$300	$400	$400
For an entire Family	$900	$900	$1,200	$1,200
Out-of-Pocket Maximum (Copayment & Coinsurance count toward the max unless otherwise noted.)				
For one Member	$1,900	$1,900	$2,000	$2,000
For an entire Family	$5,700	$5,700	$6,000	$6,000
Office visits			*Chronic Condition Benefit: Deductible and office visit copays / specified lab costs waived for covered routine, Chronic Condition management.	N/A
Routine preventive physical exam	No charge for most preventive services. 15% coinsurance for remaining services	35% coinsurance	No charge for most preventive services. 15% coinsurance for remaining services	35% coinsurance
Primary Care	15% coinsurance	35% coinsurance	$20 copay, deductible waived	35% coinsurance
Specialty Care - Includes Naturopath, Chiropractor, Acupuncturist	15% coinsurance	35% coinsurance	$40 copay, deductible waived	35% coinsurance
Urgent Care	15% coinsurance	35% coinsurance	$40 copay, deductible waived	35% coinsurance
Tests (outpatient)				
Preventive tests	No charge for routine preventive services. 15% coinsurance for remaining services	35% coinsurance	No charge for routine preventive services. 15% coinsurance for remaining services	35% coinsurance
Laboratory	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
X-ray, imaging, and special diagnostic procedures	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
CT, MRI, PET scans	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Prescription drugs (outpatient)				
Prescription drugs (outpatient)	$2,000 ind/$6,000 OOP Max 20% up to $4 max copay value meds 20% coinsurance Tier 1 and 2 50% coinsurance Tier 3	$2,000 ind/$6,000 OOP max 20% up to $4 max copay value meds 20% coinsurance Tier 1 and 2 50% coinsurance Tier 3	$2,000 ind/$6,000 OOP Max 20% up to $4 max copay value meds 20% coinsurance Tier 1 and 2 50% coinsurance Tier 3	$2,000 ind/$6,000 OOP Max 20% up to $4 max copay value meds 20% coinsurance Tier 1 and 2 50% coinsurance Tier 3
Maternity Care				
Scheduled prenatal care and first postpartum visit	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Laboratory	15% coinsurance	35% coinsurance	15% coinsurance *	35% coinsurance
X-ray, imaging, and special diagnostic procedures	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Inpatient Hospital Services	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Hospital Services				
Ambulance Services (per transport)	15% coinsurance	15% coinsurance	15% coinsurance	15% coinsurance
Emergency department visit (Waived if admitted)	$100 copay/visit, then 15% coinsurance	$100 copay/visit, then 15% coinsurance	$100 copay/visit, then 15% coinsurance	$100 copay/visit, then 15% coinsurance
Inpatient Hospital Services	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Outpatient Services (other)				
Outpatient surgery visit	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Chemotherapy/radiation therapy visit	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Durable medical equipment, external prosthetic devices, and Orthotic devices	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Physical, speech, and occupational therapies (up to 60 visits combined per Calendar Year)	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Alternative Care				
Alternative care	15% coinsurance for office visits, acupuncture insertion of needles max. 20 visits/yr / 50%, no deductible for spinal manipulation, naturopathic supplies and massage therapy ($350 max)	35% coinsurance for office visits, acupuncture insertion of needles max. 20 visits/yr /50%, no deductible for spinal manipulation, naturopathic supplies and massage therapy ($350 max)	Office visits: see Specialty Care Benefit, copays apply/ 15% coinsurance for acupuncture insertion of needles max. 20 visits/year/ 50%, no deductible for spinal manipulation, naturopathic supplies and massage therapy ($350 max)	35% coinsurance for office visits, acupuncture insertion of needles max. 20 visits/yr/ 50%, no deductible for spinal manipulation, naturopathic supplies and massage therapy ($350 max)

PPO 400 Plan	Current Platinum Plan		PPO 400 Plan	
	In-Network	Out-of-N etwork	In-Network	Out-of-Network
Vision Services (VSP Benefit)				
Routine eye exam (ages 18 years and younger)	VSP	VSP	VSP	VSP
Routine eye exam (ages 19 years and older)	VSP	VSP	VSP	VSP
Vision hardware and optical Services (ages 18 years and younger)	VSP	VSP	VSP	VSP
Vision hardware and optical Services (ages 19 years and older)**	VSP	VSP	VSP	VSP
Skilled Nursing Facility Services				
Skilled Nursing Facility Services (up to 100 days per Calendar Year)	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Chemical Dependency Services				
Office visits	15% coinsurance	35% coinsurance	Deductible and copay waived under Chronic Condition Benefit*	35% coinsurance
Outpatient Services	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Inpatient hospital & residential Services	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Mental Health Services				
Office visits	15% coinsurance	35% coinsurance	Deductible and copay waived under Chronic Condition Benefit*	
Outpatient Services	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Inpatient hospital & residential Services	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Hearing Aids				
Hearing Aids for member up to age 26 (limited to one hearing aid per ear every 36 months)	15% coinsurance	35% coinsurance	15% coinsurance	35% coinsurance
Hearing Aids for Adults over the age of 26 (limited to $4,000 maximum every 48 months)**	50% coinsurance	50% coinsurance	50% coinsurance	50% coinsurance

***Chronic Condition Benefit - Deductible and PCP/Specialist Office visit copays, routine lab (cholesterol and A1C) cost share waived when seeing an in-network provider for routine Chronic Condition management (Includes Asthma, Heart Disease, Diabetes, Cholesterol, High Blood Pressure and Behavioral Health visits). Frequency of covered chronic condition management subject to review for medical necessity.**

****Vision and hearing costs for adults 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.