Multnomah County Medical Plans Comparison Chart

You pay copay and coinsurance as indicated after applicable deductible up to out-of-pocket max.

YOUR HEALTH MATTERS!

2021 Medical Plans	Annual Deductible	Annual Out-of-Pocket Maximum	Network	Office Visits: Primary, Specialty, and Urgent Care	Diagnostic Lab & X-ray (outside routine physical)	Preventive Care Services	
						Office Visits; Routine Physicals including exam, lab work, x-rays; Well Baby Care	Mammogram; Annual GYN exam; Prostate Screening; Preventative Immunizations
Moda PPO 400	$400 per individual; $1,200 per family	$2,000 per individual; $6,000 per family	**In-Network**	Primary: $20 copay, Specialty/Urgent: $40 copay; deductible waived; No copays for chronic condition benefit	15% after deductible	No charge	No charge
	Out-of-Pocket Max includes deductibles, coinsurance & copays, but doesn't include Rx, Vision, and Hearing.		**Out-of-Network***	35% after deductible	35% after deductible	35% after deductible	35% after deductible
Moda Major Medical PPO	$1,000 per individual; $2,500 per family	$6,150 per individual; $12,300 per family	**In-Network**	30% after deductible	30% after deductible	No charge	No charge
	Out-of-Pocket Max includes deductibles, coinsurance, copays & Rx, but doesn't include Vision, or Hearing.		**Out-of-Network***	50% after deductible	50% after deductible	50% after deductible	50% after deductible
Kaiser 10/20	No deductible	$600 per individual; $1,200 per family Out-of-Pocket Max includes deductibles & copays; excludes alterative care, hearing & vision	Services must be provided, prescribed, referred, or authorized by Kaiser Providers	$10 copay for Primary Care, $20 copay for Specialty Care, $30 copay for Urgent Care	No charge	No charge	No charge
Kaiser Maintenance (Part-time employees only)	$500 per individual OR $1,500 per family	$2,000 per individual; $6,000 per family Out-of-Pocket Max includes deductibles and copays; excludes alterative care, hearing & vision		$20 copay; 20% after deductible for specialty care	$10 copay	No charge	No charge

*You may be billed more than the Moda coinsurance cost based on the out-of-network provider charges exceeding standard costs.

Moda Plan Providers
Moda uses the Connexus Network for your in-network providers. For a complete list of in-network providers, go to modahealth.com, Find Care, Search by Connexus Network. You receive the highest level of coverage when you use physicians and facilities who are in-network.

Kaiser Permanente Providers
Kaiser Permanente is a geographically specific HMO plan. Medical services and supplies must be provided, prescribed, and authorized by a Kaiser provider. You must receive the services and supplies at a Kaiser,

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2021 Medical Plans	Network	Outpatient Surgery	Hospital Inpatient	Ambulance	Emergency Room (copay waived if admitted)	Chemical Dependency: Detox or Inpatient Treatment	Mental Health: Residential Treatment	Chemical Dependency or Mental Health: Outpatient Treatment	Chiropractic, Naturopathic, and Acupuncture Office Visits	Spinal Manipulation, Massage Therapy and Naturopathic Supplies	Acupuncture
Moda PPO 400	**In-Network**	15% after deductible	15% after deductible	No in-network, see out of network	$100 copay; deductible applies -then an additional 15%	15% after deductible	15% after deductible	15% after deductible	$40 copay	50% up to $350 max (deductible waived)	15% after deductible; 20 visits per year
	Out-of-Network*	35% after deductible	35% after deductible	15% after deductible		35% after deductible	35% after deductible	35% after deductible	35% after deductible		35% after deductible, 20 visits per year
Moda Major Medical PPO	**In-Network**	30% after deductible	30% after deductible	No in-network, see out of network	30% after deductible ($100 copay)	30% after deductible	30% after deductible	30% after deductible	30% after deductible	50% up to $300 max (deductible waived)	30% after deductible, 20 visits per year
	Out-of-Network*	50% after deductible	50% after deductible	30% after deductible		50% after deductible	50% after deductible	50% after deductible	50% after deductible		50% after deductible, 20 visits per year
Kaiser 10/20	Services must be provided, prescribed, referred, or authorized by Kaiser Providers	$25 copay	$50 per day copay up to $250 max per admission	$50 copay	$50 copay	No charge	No charge	$10 copay	$500 allowance per calendar year combined; after $15 copay for Acupuncture, Chiropractic care and Naturopathy; $25 copay for Massage Therapy (limit 12 visits for Massage)		
Kaiser Maintenance (Part-time employees only)		20% after deductible	20% after deductible	20%; deductible waived	20% after deductible	20% after deductible	20% after deductible; $20 copay for day treatment	$20 copay	$500 allowance per calendar year combined; after $15 copay for Acupuncture, Chiropractic care and Naturopathy; $25 copay for Massage Therapy (limit 12 visits for Massage)		

*You may be billed more than the Moda coinsurance cost based on the out-of-network provider charges exceeding standard costs.

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YOUR HEALTH MATTERS!

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2021 Vision Coverage	Network	Routine Vision Exam		Vision Hardware		2021 Prescription Coverage	Annual Deductible	Annual Out-of-Pocket Maximum	Supply Quantity	Value / Low Cost Tier	Tier 1 Select	Tier 2 Preferred	Tier 3 Non-Formulary
		Adult	Children	Adult	Children								
Moda PPO 400 - VSP	**In-Network**	$0 copay	$0 copay	Plan pays up to $200 for frames every 2 yrs; 100% for standard lenses every year	Plan pays up to $200 for frames and 100% for lenses every year	**Moda PPO 400 - WellDyneRx**	None	$2,000 per individual $6,000 per family	**30-day supply (retail/ specialty)**	≤ $4	20% up to $50 max per Rx		50%
	Out-of-Network	$70 allowance	$70 allowance					Rx Deductibles & Out-of-Pocket costs not included in Medical Deductibles or Max Out-of-Pocket	**90-day supply (mail order)**	≤ $8	20% up to $30 max	20% up to $125 max	50%
Moda Major Medical	**In-Network**	Not covered	Not covered	Not covered	Not covered	**Moda Major Medical - WellDyneRx**	$300 per individual	Accrues toward Medical Max Out-of-Pocket	**30-day supply (retail/ specialty)**	≤ $4	30% after deductible		
	Out-of-Network	Not covered	Not covered	Not covered	Not covered				**90-day supply (mail order)**	≤ $8	30% after deductible		
Kaiser 10/20	Services must be provided, prescribed, referred, or authorized by Kaiser Providers	$10 copay	No charge	$150 allowance once in 2 calendar year period (lenses and frames or contacts)	No charge	**Kaiser 10/20**	None	Accrues toward Medical Max Out-of-Pocket	**30-day supply (retail)**	≤ $10	$10 copay for generic; $20 copay for brand		Same as Tier 2; requires physician approval
									90-day supply (mail order)	≤ $20	$20 copay for generic; $40 copay for brand		
Kaiser Maintenance (Part-time employees only)		$20 copay	No charge	Not covered	Not covered	**Kaiser Maintenance** (part-time employees only)	None	Accrues toward Medical Max Out-of-Pocket	**30-day supply (retail)**	≤ $15	$15 copay for generic; $30 copay for brand		Same as Tier 2; requires physician approval
									90-day supply (mail order)	≤ $30	$30 copay for generic; $60 copay for brand		

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