



# Multnomah County Medical Plans Comparison Chart



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

2020 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
<b>Moda Performance PPO</b>	\$200 per individual; \$600 per family	\$1,250 per individual; \$3,750 per family	<b>In-Network</b>	10% after deductible	10% after deductible	No charge	No charge
	Out-of-Pocket Max includes deductibles, coinsurance & copays, but Rx, Vision, and Hearing not included.		<b>Out-of-Network</b>	30% after deductible	30% after deductible	30% after deductible	30% after deductible
<b>Moda Preferred PPO</b>	\$400 per individual; \$800 per family	\$2,500 per individual; \$7,500 per family	<b>In-Network</b>	20% after deductible	20% after deductible	No charge	No charge
	Out-of-Pocket Max includes deductibles, coinsurance & copays, but Rx, Vision, and Hearing not included.		<b>Out-of-Network</b>	40% after deductible	40% after deductible	40% after deductible	40% after deductible
<b>Moda Major Medical PPO</b>	\$1,000 per individual; \$2,500 per family	\$6,150 per individual; \$12,300 per family	<b>In-Network</b>	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.		<b>Out-of-Network</b>	50% after deductible	50% after deductible	50% after deductible	50% after deductible
<b>Kaiser Permanente</b>	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	No charge	No charge	No charge
<b>Kaiser Maintenance</b> (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

Comparisons not intended to provide comprehensive plan information. All benefits and coverage subject to plan limitations and definitions. This summary should not be considered a guarantee of coverage. Consult the Summary Plan Description, Evidence of Coverage, Summary of Benefits and Coverage for applicable health plan for coverage information.

## Moda Plan Providers

Moda plan uses the Connexus Network for your in-network providers. For a complete list of in-network providers, go to [modahealth.com](http://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, except for qualifying urgent or emergency care as described in the plan materials.



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2020 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 Performance PPO	In-Network	10% after deductible	10% after deductible	10% after deductible	10% after deductible (\$50 copay)	10% after deductible	10% after deductible	10% after deductible	10% after deductible	50% up to \$300 max(deductible waived)	10% after deductible, 20 visits per year
	Out-of-Network	30% after deductible	30% after deductible	30% after deductible		30% after deductible	30% after deductible	30% after deductible	30% after deductible		30% after deductible
Moda Preferred PPO	In-Network	20% after deductible	20% after deductible	20% after deductible	20% after deductible (\$75 copay)	20% after deductible	20% after deductible	20% after deductible	20% after deductible non-preventive	50% up to \$300 max (deductible waived)	20% after deductible, 20 visits per year
	Out-of-Network	40% after deductible	40% after deductible	40% after deductible		40% after deductible	40% after deductible	40% after deductible	40% after deductible		40% after deductible
Moda Major Medical PPO	In-Network	30% after deductible	30% after deductible	30% after deductible	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	50% after deductible		50% after deductible	50% after deductible	50% after deductible	50% after deductible		50% after deductible
Kaiser Permanente	Services must be provided, prescribed, referred, or authorized by Kaiser Providers	\$10 copay	No charge	\$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)		

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[You pay copay and coinsurance as indicated after applicable deductible.](#)

You pay the listed copay or coinsurance and applicable deductible up to Out-of-Pocket max.

2020 Vision Coverage	Network	Routine Vision Exam		Vision Hardware		2020 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 Performance - 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 Performance - WellDyneRx	None	\$2,000 per individual \$6,000 per family	30-day supply (retail/ specialty)	N/A	20% to \$50 max per Rx		50%
	Out-of-Network	\$70 allowance	\$70 allowance						90-day supply (mail order)	N/A	20% to \$25 max	20% to \$100 max	50%
Moda Preferred - 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 Preferred - WellDyneRx	None	\$2,000 per individual \$6,000 per family	30-day supply (retail/ specialty)	N/A	20% to \$50 max per Rx		50%
	Out-of-Network	\$70 allowance	\$70 allowance						90-day supply (mail order)	N/A	20% to \$35 max	20% to \$150 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)	N/A	30% after deductible		
	Out-of-Network	Not covered	Not covered	Not covered	Not covered				90-day supply (mail order)	N/A	30% after deductible		
Kaiser Permanente	Services must be provided, prescribed, referred, or authorized by Kaiser Providers	\$10 copay	No charge	\$150 allowance once in a 2 calendar year period (lenses and frames or contacts)	No charge	Kaiser Permanente	None	Accrues toward Medical Max Out-of-Pocket	30-day supply (retail)	≤ \$10	\$10 copay		Same as Tier 2; requires physician approval
									90-day supply (mail order)	≤ \$20	\$20 copay		
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	
									90-day supply (mail order)	≤ \$30	\$30 copay for generic; \$60 copay for brand		