# Multnomah County Employee Benefits

**The Moda PPO 400 Plan replaces the Moda Platinum Plan**

| MODA PPO 400 Plan | Current Platinum Plan | | 2019 Moda 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<br><br>20% up to $4 max copay value meds 20% coinsurance Tier 1 and 2<br>50% coinsurance Tier 3 | $2,000 ind/$6,000 OOP max<br><br>20% up to $4 max copay value meds 20% coinsurance Tier 1 and 2<br>50% coinsurance Tier 3 | $2,000 ind/$6,000 OOP Max<br>20% up to $4 max copay value meds<br>20% coinsurance Tier 1 and 2<br>50% coinsurance Tier 3<br>Add opioid and Specialty drug cost mgt. programs | $2,000 ind/$6,000 OOP Max<br>20% up to $4 max copay value meds<br>20% coinsurance Tier 1 and 2<br>50% coinsurance Tier 3<br>Add opioid and Specialty drug cost mgt. programs |
| **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) |

| MODA PPO 400 Plan | Current Platinum Plan | | 2019 Moda 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 | $20 Primary Care / $40 Specialty Care Deductible waived | 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 | $20 Primary Care / $40 Specialty Care Deductible waived | |
| 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 Benefits - 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.**