

Benefit Plan Design Survey, April 2010

	City of Portland CityCore Medical Plan	
	In-Network	Out-Network
Providers/Hospital	ODS or MHN	Any Licensed Provider
Annual Deductible	\$150 Individual \$450 Family	\$450 Individual \$1,350 Family
Annual OOP Max	\$1,800 Individual \$5,400 Family	\$5400 Individual \$16,200 Family
Co-insurance (Plan/Employee)	80%/20%	60%/40%
Lifetime Maximum	\$2,000,000	
	Insured pays after Deductible	Insured pays after Deductible
Doctor Visit	20%	40% of MPA
Xray/Lab	20%	40% of MPA
Inpatient Hospitalization	20%	40% of MPA
Outpatient Surgery	20%	40% of MPA
Urgent Care	20%	40% of MPA
Emergency Room	20% after \$50 copay	20% of MPA after \$50 copay
Rx Drugs - Retail 30 day supply	\$5 copay minimum - \$50 copay maximum	
Generic	10%	Pay Rx reimb'd 40% after ded
Formulary Brand Name	20%	Pay Rx reimb'd 40% after ded
Non-Formulary Brand Name	30%	Pay Rx reimb'd 40% after ded
RX Drugs - Mail Order 90 day supply	Same as benefit levels above	
Routine Physical	Pd in full -no deductible	40% of MPA after deductible
Annual GYN	Pd in full -no deductible	40% of MPA after deductible
Alternative Care (Chiropratic, Acupuncture and Naturopathic)	20% after deductible	40% of MPA after deductible
	35 visit max - uses network	
Hearing Aid/Exam	40% of MPA no ded to \$1200 x36 months	
Vision Care	VSP Network	Out-Network
Exam	\$15/childx1/adultsx2 0%of prescribed len.1x24 mo	Plan pays \$42
Lenses		\$45,\$65,\$85 1x24 mo
Frames	\$120 paid 1x24 mo	Plan pays \$45

RATES(medical/dental/vision)

	36 + hours/week		
	Employer	Employee	Total
All Others - City Core, VSP Vision and ODS Dental			
Single	\$485.25	\$25.56	\$510.81
Two-Party	\$933.65	\$49.16	\$982.81
Family	\$1,288.66	\$67.84	\$1,356.50

	City of Portland - Non Represented Economy Medical Plan	
	In-Network	Out-Network
Providers/Hospital	ODS or MHN	Any Licensed Provider
Annual Deductible	\$2,850 Individual \$5,700 Family	\$2,850 Individual \$5,700 Family
Annual OOP Max	\$5,250 Individual \$10,500 Family	\$5,250 Individual \$10,500 Family
Co-insurance (Plan/Employee)	80%/20%	60%/40%
Lifetime Maximum	\$2,000,000	
	Insured pays after Deductible	Insured pays after Deductible
Doctor Visit		
Xray/Lab		
Inpatient Hospitalization	20%	40%
Outpatient Surgery	20%	40%
Urgent Care	20% after deductible	40% of MPA after Deductible
Emergency Room	20% after deductible	40% of MPA after Deductible
Rx Drugs - Retail 30 day supply	\$5 copay minimum - \$50 copay maximum	
Generic	10% after network ded.	40% after network ded.
Formulary Brand Name	20% after network ded.	40% after network ded.
Non-Formulary Brand Name	30% aafter network ded.	40% after network ded.
RX Drugs - Mail Order 90 day supply	Same as benefit levels above	
Routine Physical	Pd in full -no deductible	40% of MPA after deductible
Annual GYN	Pd in full -no deductible	40% of MPA after deductible
Alternative Care (Chiropratic, Acupuncture and Naturopathic)	20% after deductible	40% of MPA after deductible
	35 visit max - uses network	
Hearing Aid/Exam	40% of MPA .ded to \$1200 x36 months	
Vision Care	VSP Network	Out-Network
Exam	\$15/childx1/adultsx2 0%of prescribed len.1x24 mo	Plan pays \$42
Lenses		\$45,\$65,\$85 1x24 mo
Frames	\$120 paid 1x24 mo	Plan pays \$45

36 + hours/week

	36 + hours/week		
	Employer	Employee	Total
Non- Rep Only - Economy, VSP Vision and ODS Dental			
Single	\$366.17	\$19.30	\$385.47
Two-Party	\$691.92	\$36.44	\$728.36
Family	\$961.20	\$50.60	\$1,011.80

	Clackamas County (General Employees) Providence Open Option	
	In-Network	Out-Network
Providers/Hospital	Providence	Any Licensed Provider
Annual Deductible	\$250 Individual \$750 Family	
Annual OOP Max	\$2000 Individual \$6000 Family	
Co-insurance (Plan/Employee)	90%/10% and HMO co-pays	70%/30%
Lifetime Maximum	\$2,000,000	
	Insured Pays	Insured Pays
Doctor Visit	\$15	30%
Xray/Lab	10%	30%
Inpatient Hospitalization	10%	30%
Outpatient Surgery	10% after ded.	30% after ded.
Urgent Care	\$25	\$25
Emergency Room	\$100	\$100
Rx Drugs - Retail 30 day supply		
Generic	\$15	No Coverage
Formulary Brand Name	\$30	No Coverage
Non-Formulary Brand Name		
RX Drugs - Mail Order 90 day supply		
Generic	\$15	No Coverage
Formulary Brand Name	\$30	No Coverage
Non-Formulary Brand Name		
Routine Physical	\$15	30%
Annual GYN	\$15	30%
Alternative Care (includes Chiro, Naturopath, MassTher)	\$15 to \$1500 annual max	Not Covered
Hearing Aid/Exam	Discount Available	
Vision Care	Every 24 months	
Exam	\$400	
Lenses	Adults per 2 cal year	
Frames	Child per cal year	

	Clackamas County (General Employees) Providence Personal Option In Plan Coverage Only	
	Providers/Hospital	Providence
Annual Deductible	\$250 individual \$750 family	
Annual OOP Max	\$1200 individual \$3600 family	
Co-insurance (Plan/Employee)	80%/20% and HMO co-pays	
Lifetime Maximum	\$2,000,000	
	Insured Pays	
Doctor Visit	\$20	
Xray/Lab	Covered in full	
Inpatient Hospitalization	20%	
Outpatient Surgery	20% after deductible	
Urgent Care	\$25	
Emergency Room	\$100	
Rx Drugs - Retail 30 day supply		
Generic	\$15	
Formulary Brand Name	\$30	
Non-Formulary Brand Name		
RX Drugs - Mail Order 90 day supply		
Generic	\$15	
Formulary Brand Name	\$30	
Non-Formulary Brand Name		
Routine Physical	\$20	
Annual GYN	\$20	
Alternative Care (includes Chiro, Naturopath, MassTher)	\$20 to \$1,500 annual	
Hearing Aid/Exam	Discount Available	
Vision Care		
Exam	\$400 adult x 2 yr, child ea yr	
Lenses		
Frames		

RATES(medical/dental/vision)

30 + hours/week

Nonrepresented - Open Option	Employer	Employee	Total
Single	\$474.74	\$24.99	\$499.73
Single w/chidren	\$854.55	\$44.97	\$899.52
Married	\$949.55	\$49.98	\$999.53
Family	\$1,424.24	\$74.96	\$1,499.20

30 + hours/week

Nonrepresented - Personal Option	Employer	Employee	Total
Single	\$485.95	\$25.58	\$511.53
Single w/chidren	\$874.72	\$46.04	\$920.76
Married	\$971.97	\$51.16	\$1,023.13
Family	\$1,457.87	\$76.73	\$1,534.60

	Marion County ODS Traditional PPO	
	In-Network	Out-Network
Providers/Hospital	ODS Network	Any Licensed Provider
Annual Deductible	\$500 Individual	
	\$1500 Family	
Annual OOP Max	\$5,000 Individual	\$10,000 Individual
	\$15,000 Family	\$30,000 Family
Co-insurance (Plan/Employee)	75%/25%	50%/50%
Lifetime Maximum	\$2,000,000	\$250,000
Insured pays, after deductible: Insured pays, after deductible:		
Doctor Visit	25%	50%
Xray/Lab	25% deductible waived	50%
Inpatient Hospitalization	25%	50%
Outpatient Surgery	25%	50%
Urgent Care	25%	50%
Emergency Room	\$50 co-pay per visit, plus 25% on any lab & x-ray;	
Rx Drugs - Retail 30 day supply		
Generic	\$10	
Formulary Brand Name	\$25	
Non-Formulary Brand Name	50%	
RX Drugs - Mail Order 90 day supply		
Generic	2 co-pays for 90-day supply	
Formulary Brand Name	2 co-pays for 90 day supply	
Non-Formulary Brand Name	n/a	
Routine Physical	25%, deductible waived	50%
Annual GYN	25%, deductible waived	50%
Alternative Care (includes Chiro, Naturopath, Acupuncture)	25%, deductible waived (\$1500 combined annual max)	
Hearing Aid/Exam	n/a	
Vision Care	Every 12 months	
Exam	\$10	
Lenses	add'l \$10 co-pay for single, bifocal or trifocal	
Frames	\$200 MPA	

RATES (medical/dental)

ODS Traditional PPO/ODS Dental	Employer*	Employee	Total
Employee Only	\$1,154.00	\$12.14	\$1,166.14
Employee & Child(ren)	\$1,154.00	\$12.14	\$1,166.14
Employee & Spouse	\$1,154.00	\$12.14	\$1,166.14
Employee & Family	\$1,154.00	\$12.14	\$1,166.14

*cafeteria plan, premium caps listed under ER

	City of Vancouver Regence PPO	
	In-Network	Out-Network
Providers/Hospital	Providence	Any Licensed Provider
Annual Deductible	\$100 Individual \$200 Family	\$200 Individual \$600 Family
Annual OOP Max (Coinsurance only)	\$1,000	\$3,200
Co-insurance (Plan/Employee)	90%/10% and co-pays	70%/30%
Lifetime Maximum	\$2,000,000	
	Insured Pays, after deductible	Insured Pays, after deductible
Doctor Visit	\$15, deductible waived	30%
Xray/Lab	10%	30%
Inpatient Hospitalization	10%	30%
Outpatient Surgery	10%	30%
Urgent Care	\$25	\$25
Emergency Room	\$100 co-pay + 10%	\$100 co-pay + 30%
Rx Drugs - Retail 30 day supply		
Generic	\$10	No Coverage
Formulary Brand Name	\$20	No Coverage
Non-Formulary Brand Name	\$40	No Coverage
RX Drugs - Mail Order 90 day supply		
Generic	\$20	No Coverage
Formulary Brand Name	\$40	No Coverage
Non-Formulary Brand Name	\$80	No Coverage
Routine Physical	\$15	30%
Annual GYN	\$10	30%
Alternative Care (includes Chiro, Naturopath, MassTher)	\$15	
Hearing Aid/Exam		
Vision Care	Exam Every 12 months/Benefit Every 24 months after co-pay	
Exam	\$15 co-pay; up to contracted UCR	
Lenses	\$25 co-pay; up to contracted UCR	
Frames	\$25 co-pay; up to contracted UCR	

RATES (medical only)

Non-Union

Regence BCBSO PPO	Employee	Employer	Total
Employee Only	\$0.00	\$1,180.50	\$1,180.50
Employee & Spouse	\$83.64	\$1,096.86	\$1,180.50
Full Family	\$144.45	\$1,036.05	\$1,180.50
Employee & Child(ren)	\$60.81	\$1,119.69	\$1,180.50

	City of Beaverton ODS Preferred 200 Plan	
	In-Network	Out-Network
Providers/Hospital		
Annual Deductible	\$200 Individual \$600 Family	
Annual OOP Max	\$1000 Individual \$2000 Family	\$2000 Individual \$4000 Family
Co-insurance (Plan/Employee)	90%/10% and HMO co-pays	70%/30%
Lifetime Maximum		
	Insured Pays	Insured Pays
Doctor Visit	10%	30%
Xray/Lab	10%	30%
Inpatient Hospitalization	10%	30%
Outpatient Surgery	10%	30%
Urgent Care	10%	\$25
Emergency Room	\$100, then 10% (co-pay waived if admitted)	\$100, then 30% (co-pay waived if admitted)
Rx Drugs - Retail 30 day supply Generic	10% after reimbursement	No Coverage
Formulary Brand Name Non-Formulary Brand Name	10% after reimbursement	No Coverage
RX Drugs - Mail Order 90 day supply Generic	\$30 \$50 + difference between generic and Brand	No Coverage
Formulary Brand Name Non-Formulary Brand Name		No Coverage
Routine Physical	10%	30%
Annual GYN	\$15	30%
Alternative Care (includes Chiro)	\$15, referral required	30%
Hearing Aid/Exam		
Vision Care	\$200 Benefit maximum	
Exam	included in \$200 benefit maximum	
Lenses	included in \$200 benefit maximum	
Frames	included in \$200 benefit maximum	

RATES (medical/vision only)

SEIU (ODS Preferred 200)	Employer	Employee	Total
Employee Only	\$717.27	\$0.00	\$717.27
Employee & Spouse	\$1,273.32	\$39.38	\$1,312.70
Employee & Family	\$1,920.36	59.39	1979.75

	City of Beaverton ODS Point of Service Plan (PCP Required)	
	In-Network	Out-Network
Providers/Hospital	PCP required	
Annual Deductible	None None	\$300 Individual \$900 Family
Annual OOP Max	\$1250 Individual \$2500 Individual	\$4000 Individual \$8000 Individual
Co-insurance (Plan/Employee)	0%/10% and HMO co-pays	70%/30%
Lifetime Maximum	\$2,000,000	
	Insured Pays	Insured Pays
Doctor Visit	\$15	30%
Xray/Lab	0%	30%
Inpatient Hospitalization	0%	30%
Outpatient Surgery	0%	30%
Urgent Care	\$15	30%
Emergency Room	\$100, copay waived if admitted	\$100
Rx Drugs - Retail 30 day supply Generic	\$15	\$15
Formulary Brand Name Non-Formulary Brand Name	\$25 + cost difference between generic and brand	\$25 + cost difference between generic and brand
RX Drugs - Mail Order 90 day supply Generic	\$30	No Coverage
Formulary Brand Name Non-Formulary Brand Name	\$50 + cost over generic	\$50 + cost over generic
Routine Physical	\$15	30%
Annual GYN	\$15	30%
Alternative Care (includes Chiro, Naturopath, MassTher)	see out of plan	Not Covered
Hearing Aid/Exam		
Vision Care		
Exam		
Lenses		
Frames		

SEIU (ODS -POS)	Employer	Employee	Total
Employee Only	\$722.69	\$0.00	\$722.69
Employee & Spouse	\$1,247.66	\$75.00	\$1,322.66
Employee & Family	\$1,879.77	\$115.00	\$1,994.77

	Multnomah County ODS Performance PPO Plan	
	In-Network	Out-Network
	Providers/Hospital	ODS or MHN
Annual Deductible	\$200 Individual	\$200 Individual
	\$600 Family	\$600 Family
Annual OOP Max	\$1000 Individual	\$1000 Individual
	\$3000 Family	\$3000 Family
Co-insurance (Plan/Employee)	90%/10%	70%/30%
Lifetime Maximum	\$2,000,000	\$2,000,000
	Insured pays	Insured pays
	after Deductible	after Deductible
Doctor Visit	10%	30%
Xray/Lab	10%	30%
Inpatient Hospitalization	10%	30%
Outpatient Surgery	10%	30%
Urgent Care	10%	30%
Emergency Room	\$50 copay-10%	\$50 copay-30%
Rx Drugs - Retail 30 day supply	Caremark Card Program	
Generic	20% to \$50 max ea rx	No Coverage
Formulary Brand Name	20% to \$50 max ea rx	No Coverage
Non-Formulary Brand Name	50%	No Coverage
RX Drugs - Mail Order 90 day supply	Caremark Card Program	
Generic	20% to \$25 max ea rx	No Coverage
Formulary Brand Name	20% to \$100 max ea rx	No Coverage
Non-Formulary Brand Name	50%	No Coverage
Routine Physical	\$400 yr-ded waived	\$400 yr-ded waived
Annual GYN	\$15 Copay	30%
Alternative Care (includes Chiro, Naturopath, MassTher)	50% to \$300/year (Deductible waived)	
Hearing Aid/Exam	50% to \$500 1x36 mo	Not Covered
Vision Care		
Exam	Pd in full 1x12 mo	
Lenses	\$52.50 ea lens	
Frames	\$90 paid 1x12 mo	

RATES (medical only)

32 + hours/week or 30 if on 4/10 sch.

All Others - Performance PPO	Employer	Employee	Total
Single	\$591.10	\$65.68	\$656.78
Two-Party	\$1,182.22	\$131.36	\$1,313.58
Family	\$1,685.88	\$187.32	\$1,873.20

	Multnomah County ODS PREFERRED PPO Plan	
	In-Network	Out-Network
	Providers/Hospital	ODS - MHN
Annual Deductible	\$400 Individual	\$400 Individual
	\$800 Family	\$800 Family
Annual OOP Max	\$2000 Individual	\$2000 Individual
	\$6000 Family	\$6000 Family
Co-insurance (Plan/Employee)	80%/20%	60%/40%
Lifetime Maximum	\$2,000,000	\$2,000,000
	Insured pays	Insured pays
	after Deductible	after Deductible
Doctor Visit	20%	40%
Xray/Lab	20%	40%
Inpatient Hospitalization	20%	40%
Outpatient Surgery	20%	40%
Urgent Care	20%	40%
Emergency Room	\$75 copay 20% after	\$75 copay 40% after
Rx Drugs - Retail 30 day supply	Caremark Card Program	
Generic	20% to \$50 max ea rx	No Coverage
Formulary Brand Name	20% to \$50 max ea rx	No Coverage
Non-Formulary Brand Name	50%	No Coverage
RX Drugs - Mail Order 90 day supply	Caremark Card Program	
Generic	20% to \$25 max	No Coverage
Formulary Brand Name	20% to \$100 max	No Coverage
Non-Formulary Brand Name	50%	No Coverage
Routine Physical	\$400 yr-ded waived	\$400 yr-ded waived
Annual GYN	\$15 Copay	40%
Alternative Care (includes Chiro, Naturopath, MassTher)	50% to \$300/year (Deductible waived)	
Hearing Aid/Exam	Not Covered	Not Covered
Vision Care	Any Licensed OD/MD	
Exam	Pd in full 1x12 mo	
Lenses	\$52.50 ea lens	
Frames	\$90 paid 1x24 mo	

32 + hours/week or 30 if on 4/10 sch.

All Others - Preferred PPO	Employer	Employee	Total
Single	\$549.50	\$28.92	\$578.42
Two-Party	\$1,098.98	\$57.84	\$1,156.82
Family	\$1,567.22	\$82.48	\$1,649.70