

Portland Community College Medical and Dental Plans

Effective October 1, 2008 through September 30, 2009

OEBB Medical Plans

Plan Option	ODS Medical Plan 3 PPO	ODS Medical Plan 6 PPO	ODS Medical Plan 8 PPO	Kaiser Medical Plan 1 HMO
Preventive Services				
In Network (no deductible)	100%	100%	100%	100%
Out of Network	70%	60%	60%	-
Deductible (Individual/Family)				
In Network / Out of Network	\$100/\$300	\$300/\$900	\$1,000/\$3,000	None
Annual Coinsurance Maximum (Individual/Family)				
In Network	\$500	\$1,500	\$2,000	\$1,000
Out of Network	\$1,500	\$3,000	\$4,000	-
Benefit Maximum				
In Network	\$2,000,000	\$2,000,000	\$2,000,000	unlimited
Out of Network	\$2,000,000	\$2,000,000	\$2,000,000	-
Coinsurance				
In Network	90%	80%	80%	100%
Out of Network	70%	60%	60%	-
Office Visit Copay				
In Network	\$10	\$20	20%	\$10
Out of Network	30%	40%	40%	-
Hospital Copay				
In Network	10%	20%	20%	\$100 per day
Out of Network	30%	40%	40%	-
Emergency Room Copay				
In Network / Out of Network (waived if admitted)	\$100 per visit then 10%	\$100 per visit then 20%	\$100 per visit then 20%	\$100

OEBB Pharmacy Plans (tied to medical plan)

Plan Option	ODS Pharmacy Option A	ODS Pharmacy Option A	ODS Pharmacy Option A	Kaiser Pharmacy Plan 1
Deductible	None	None	None	None
Retail				
Generic	\$5	\$5	\$5	\$5
Preferred	20%	20%	20%	\$15
Non Preferred	50%	50%	50%	N/A
Mail				
Generic	\$10	\$10	\$10	\$10
Preferred	20%	20%	20%	\$30
Non Preferred	50%	50%	50%	N/A

OEBB Vision Plans

Plan Option	ODS Vision Plan 5	Kaiser Vision Plan 5
Plan Maximum	See allowances	See allowances
Routine Eye Exam	100% up to \$64.50	100% up to \$64.50
Exam Frequency	12 months	12 months
Lenses	Either one pair of lenses or contacts	Either one pair of lenses or contacts
Single Vision	100% up to \$58.50 / year	100% up to \$58.50 / year
Bifocal	100% up to \$86.00 / year	100% up to \$86.00 / year
Lenticular	100% up to \$86.00 / year	100% up to \$86.00 / year
Trifocal	100% up to \$109.00 / year	100% up to \$109.00 / year
Contact Lenses	100% up to \$192.50 / year	100% up to \$192.50 / year
Lens Frequency	12 months	12 months
Frames	100% up to \$75.00 / year	100% up to \$75.00 / year
Frame Frequency	child: 12 months, adult: 24 months	child: 12 months, adult: 24 months

OEBB Dental Plans

	ODS Dental Plan 5	Willamette Dental Plan 8	Kaiser Dental Plan 7
Deductible	\$50	None	None
Annual Maximum	\$1,500	None	None
Preventive Care	100%	100% (\$10 per visit)	100% (\$5 per visit)
Restorative Services	80%	100% (\$10 per visit)	100% (\$5 per visit)
Major Services	50%	100%	\$45
Prosthodontics	50%	100%	\$95 partial - \$65 full denture, \$25 reline

OEBB Plan Rates

OEBB Plan	Tier-Rated Groups Employee Only	Employee + Spouse	Employee + Child(ren)	Family
MEDICAL-PHARMACY-VISION				
ODS Plan 3 with Pharmacy Plan A	\$418.89	\$921.58	\$795.90	\$1,298.57
ODS Plan 6 with Pharmacy Plan A	\$366.75	\$806.87	\$696.84	\$1,136.95
ODS Plan 8 with Pharmacy Plan A	\$307.47	\$676.45	\$584.20	\$953.16
Kaiser Plan 1 with Pharmacy Plan 1	\$353.56	\$777.86	\$671.78	\$1,096.07
VISION				
ODS Vision Plan 5	\$7.55	\$16.61	\$14.35	\$23.40
Kaiser Vision plan 5	\$7.56	\$16.64	\$14.38	\$23.45
DENTAL				
ODS Plan 5	\$38.48	\$76.18	\$77.34	\$118.12
Willamette Plan 8	\$42.62	\$84.40	\$85.68	\$130.86
Kaiser Plan 7	\$58.23	\$128.11	\$110.63	\$180.51

PCC CAP AMOUNTS	Employee Only	Employee + Spouse	Employee + Child(ren)	Family
PCC Contribution*	\$520	\$765	\$765	\$860

Benefited Part-Time Faculty PCC Contribution \$260

*Based on medical enrollment; prorated for part time employees