



**PPO Plan  
Chemeketa Community College**

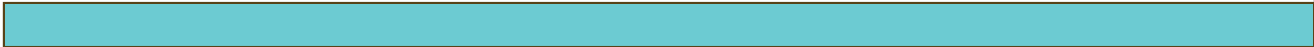
Standard PPO Plan	In-Network Provider	Out-of-Network Provider <sup>2</sup>
Annual In-network and Out-of-network Deductible (Individual / Family)	\$650 Individual / \$1,950 Family	
Annual Out-of-Pocket Maximum Including Deductible (Individual / Family)	\$3,000 Individual / \$9,000 Family	
<b>Preventive Care (As specified by the Affordable Care Act)</b>		
Periodic Health Exams	No cost sharing	No cost sharing
Routine Women's Exams (including pap test, pelvic exam & breast exam)	No cost sharing	No cost sharing
Immunizations	No cost sharing	No cost sharing
<b>Professional Services</b>		
Primary Care Office and Home Visits	\$30 Copay	40%
Specialist Office Visits	\$40 Copay	40%
Urgent Care Office Visits	\$40 Copay	40%
Surgery	20%	40%
Acupuncture Care, Chiropractic Adjustments, Naturopathic Supplies (\$1,500 Annual Maximum)	20%	40%
<b>Maternity Care</b>		
Practitioner Services	20%	40%
Hospital Stay	20%	40%
<b>Hospital Inpatient/ Outpatient Services</b>		
Inpatient Care	20%	40%
Skilled Nursing Facility Care	20%	40%
Outpatient Hospital / Facility	20%	40%
Outpatient Diagnostic X-Ray and Lab		40%
Specified Imaging (MRI, CT, CAT, PET scans)	20%	40%
<b>Emergency Care</b>		
Emergency Room Visits	\$200 Copay then 20% <sup>3</sup>	
<b>Other Covered Services</b>		
Physical Therapy	20%	40%
Allergy Injections	20%	40%
Durable Medical Equipment / Prosthetics	20%	40%
Ambulance Service	20%	
Home Health, Hospice, and Respite Care	20%	40%

\*Deductible waived.

<sup>1</sup> Copayments and deductibles apply to annual out-of-pocket maximums.

<sup>2</sup> Out-of-network coverage coinsurance is based on the maximum plan allowance for these services.

<sup>3</sup> Copay waived if admitted



***This document is provided for informational purposes only. It is not considered a Summary of Benefits and Coverage (SBC).***