Summary of Medical and Pharmacy Benefits 2024–2025 Plan Year

✓ Plan Offered X Plan Not Offered

Contents:

KAISER PERMANENTE® Plans

Please see Plan Handbook for details.

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network ✓		Medical Plan 2A Kaiser Permanente Network ✓		Medical Plan 2B Kaiser Permanente Network X		Medical Plan 3 Kaiser Permanente Network *HSA Optional* ✓	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Deductible per person	None	N/A	$800	N/A	$1,200	N/A	$1,600[2]	N/A
Maximum deductible per family	None	N/A	$2,400	N/A	$3,600	N/A	$3,200[2]	N/A
Out-of-pocket (OOP) maximum per person	$1,500	N/A	$4,000	N/A	$4,500	N/A	$6,550[2]	N/A
Out-of-pocket (OOP) maximum per family	$3,000	N/A	$12,000	N/A	$13,500	N/A	$13,100[2]	N/A
Preventive Care Services								
Routine adult, well-child and women's exams; annual obesity screening & immunizations	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered
Office Visits and Virtual Care								
Primary care office visits	$20	Not Covered	$25[1]	Not Covered	$30[1]	Not Covered	20% after deductible	Not Covered
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Incentive care office visits (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0 after deductible	Not Covered
Specialist office visits	$30	Not Covered	$35[1]	Not Covered	$40[1]	Not Covered	20% after deductible	Not Covered
Urgent care	$35	See Plan Handbook	$40[1]	See Plan Handbook	$45[1]	See Plan Handbook	20% after deductible	See Plan Handbook
Mental Health and Chemical Dependency Services								
Mental health office visits	$20	Not Covered	$25[1]	Not Covered	$30[1]	Not Covered	20% after deductible	Not Covered
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Chemical dependency services (outpatient or residential)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	20% after deductible	Not Covered
Chemical dependency services (inpatient)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	20% after deductible	Not Covered
Outpatient Services								
Outpatient surgery/facility care	$75	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Outpatient rehabilitation (physical, occupational & speech therapy)	$30 per visit	Not Covered	$35[1] per visit	Not Covered	$40[1] per visit	Not Covered	20% after deductible	Not Covered
Diagnostic Testing								
Labs, x-ray, and imaging	$20 per visit	Not Covered	$25[1] per visit	Not Covered	$30[1] per visit	Not Covered	20% after deductible	Not Covered
CT, MRI, PET scans	$70 per visit	Not Covered	$75[1] per visit	Not Covered	$80[1] per visit	Not Covered	20% after deductible	Not Covered
Alternative Care Services								
Acupuncture and Chiropractic[7]	$20 per service	Not Covered	$25[1] per service	Not Covered	$30[1] per service	Not Covered	20% after deductible	Not Covered
Naturopathic Office Visits	$20 per service	Not Covered	$25[1] per service	Not Covered	$30[1] per service	Not Covered	20% after deductible	Not Covered
Maternity Care								
Routine maternity care	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission max	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Hospital Services								
Inpatient care/surgery	$100 per day, up to $500 per admission max	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook
Skilled nursing facility care	$0	N/A	20% after deductible	N/A	20% after deductible	N/A	20% after deductible	N/A

KAISER PERMANENTE®

Plans – *continued*

✓ Plan Offered X Plan Not Offered

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network ✓		Medical Plan 2A Kaiser Permanente Network ✓		Medical Plan 2B Kaiser Permanente Network X		Medical Plan 3 Kaiser Permanente Network ✓ *HSA Optional*	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Additional Cost Tier								
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[3], knee & shoulder arthroscopy, uncomplicated hernia repair	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Services								
Emergency room (copay waived if admitted)	$150 per visit (waived if admitted)		20% after deductible		20% after deductible		20% after deductible	
Ambulance	$75		$100[1]		$100[1]		20% after deductible	
Other Covered Services								
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for state-mandated benefit for children	10%	Not Covered	10%[1]	Not Covered	10%[1]	Not Covered	20% after deductible	Not Covered
Durable medical equipment (DME)	20%	Not Covered	20%[1]	Not Covered	20%[1]	Not Covered	20% after deductible	Not Covered
Pharmacy Services								
Out-of-pocket (OOP) maximum	Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max	
Retail								
Value	N/A	N/A	N/A	N/A	N/A	N/A	$0[7]	N/A
Generic (Kaiser Plans) / Select generic (Moda Plans)	$10 per 30-day supply	See Plan Handbook	$10 per 30-day supply	See Plan Handbook	$10 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred brand	$30 per 30-day supply	See Plan Handbook	$30 per 30-day supply	See Plan Handbook	$30 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$50 per 30-day supply if criteria met	See Plan Handbook	$50 per 30-day supply if criteria met	See Plan Handbook	$50 per 30-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Mail								
Value	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Generic (Kaiser plans) / Select generic (Moda Plans)	$20 per 90-day supply	See Plan Handbook	$20 per 90-day supply	See Plan Handbook	$20 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred Brand	$60 per 90-day supply	See Plan Handbook	$60 per 90-day supply	See Plan Handbook	$60 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$100 per 90-day supply if criteria met	See Plan Handbook	$100 per 90-day supply if criteria met	See Plan Handbook	$100 per 90-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Specialty								
Generic (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook

N/A – Not applicable

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

4 A formulary exception must be approved for non-preferred brand prescription medication.

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.

moda HEALTH

Plans 1–4

Please see Plan Handbook for details.

✓ Plan Offered X Plan Not Offered

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network ✓			Medical Plan 2 Connexus Network ✓			Medical Plan 3 Connexus Network ✓			Medical Plan 4 Connexus Network ✗		
Plan Year Costs[5]	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	$400	$500	$800	$800	$900	$1,600	$1,200	$1,300	$2,400	$1,600	$1,700	$3,200
Maximum deductible per family	$1,500	$1,500	$2,400	$2,700	$2,700	$4,800	$3,900	$3,900	$7,200	$5,100	$5,100	$9,600
Out-of-pocket (OOP) maximum per person[3]	$2,850	$3,250	$6,000	$3,850	$4,250	$8,000	$4,850	$5,250	$10,000	$6,700	$7,100	$13,700
Out-of-pocket (OOP) maximum per family[3]	$9,750	$9,750	$18,000	$12,750	$12,750	$24,000	$15,750	$15,750	$27,400	$15,800	$15,800	$27,400
Preventive Care Services												
Routine adult, well-child and women's exams; annual obesity screening & immunizations	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office Visits and Virtual Care												
Primary care office visits	$20[1,5]	20% after deductible	50% after deductible	$20[1,5]	20% after deductible	50% after deductible	$25[1,5]	25% after deductible	50% after deductible	$25[1,5]	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$40[1]	N/A	50% after deductible	$40[1]	N/A	50% after deductible	$50[1]	N/A	50% after deductible	$50[1]	N/A	50% after deductible
Incentive care office visits (Moda plans only)	$15[1]	20% after deductible	N/A	$15[1]	20% after deductible	N/A	$20[1]	25% after deductible	N/A	$20[1]	25% after deductible	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered
Specialist office visits	$40[1]	20% after deductible	50% after deductible	$40[1]	20% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible
Urgent care	$40[1]	20% after deductible	20% after deductible	$40[1]	20% after deductible	20% after deductible	$50[1]	25% after deductible	25% after deductible	$50[1]	25% after deductible	25% after deductible
Mental Health and Chemical Dependency Services												
Mental health office visits	$20[1]	$20[1]	50% after deductible	$20[1]	$20[1]	50% after deductible	$25[1]	$25[1]	50% after deductible	$25[1]	$25[1]	50% after deductible
Mental health inpatient and residential services	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	$20[1]	$20[1]	50% after deductible	$20[1]	$20[1]	50% after deductible	$25[1]	$25[1]	50% after deductible	$25[1]	$25[1]	50% after deductible
Chemical dependency services (inpatient)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient Services												
Outpatient surgery/facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational & speech therapy)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Tests (outpatient)												
Labs, x-ray, and imaging	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible
Alternative Care Services[7]												
Acupuncture and Chiropractic[7]	$20[1]	20% after deductible	50% after deductible	$20[1]	20% after deductible	50% after deductible	$25[1]	25% after deductible	50% after deductible	$25[1]	25% after deductible	50% after deductible
Naturopathic office visits	$40[1]	20% after deductible	50% after deductible	$40[1]	20% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible
Maternity Care												
Routine maternity care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Hospital Services												
Inpatient care/surgery	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible

No lifetime maximum on any medical plans.	**Medical Plan 1 Connexus Network ✓**			**Medical Plan 2 Connexus Network ✓**			**Medical Plan 3 Connexus Network ✓**			**Medical Plan 4 Connexus Network X**		
Plan Year Costs[5]	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Additional Cost Tier												
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible
Emergency Services												
Emergency room (copay waived if admitted)	$100 copay + 20% after deductible			$100 copay + 20% after deductible			$100 copay + 25% after deductible			$100 copay + 25% after deductible		
Ambulance	20% after deductible			20% after deductible			25% after deductible			25% after deductible		
Other Covered Services												
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible
Durable medical equipment (DME)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Pharmacy Services												
Out-of-pocket (OOP) maximum	Rx applies toward OOP Max			Rx applies toward OOP Max			Rx applies toward OOP Max			Rx applies toward OOP Max		
Retail												
Value	$4 per 31-day supply	See Plan Handbook		$4 per 31-day supply	See Plan Handbook		$4 per 31-day supply	See Plan Handbook		$4 per 31-day supply	See Plan Handbook	
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply		
Preferred brand	25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply		
Non-preferred brand[4]	50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply		
Mail												
Value	$8 per 90-day supply	See Plan Handbook		$8 per 90-day supply	See Plan Handbook		$8 per 90-day supply	See Plan Handbook		$8 per 90-day supply	See Plan Handbook	
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply		
Preferred brand	25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply		
Non-preferred brand[4]	50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply		
Specialty												
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed	See Plan Handbook		$12 per 31-day supply or $36 per 90-day supply when allowed	See Plan Handbook		$12 per 31-day supply or $36 per 90-day supply when allowed	See Plan Handbook		$12 per 31-day supply or $36 per 90-day supply when allowed	See Plan Handbook	
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		
Non-preferred brand[4]	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed		

N/A – Not applicable

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

4 A formulary exception must be approved for non-preferred brand prescription medication.

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

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moda HEALTH

Plans 5–7

✓ Plan Offered X Plan Not Offered

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network ✗			Medical Plan 6 Connexus Network *HDHP HSA Compliant* ✓			Medical Plan 7 Connexus Network *HDHP HSA Compliant* ✓		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	$2,000	$2,100	$4,000	$1,600[2]	$1,700[2]	$3,200[2]	$2,000[2]	$2,100[2]	$4,000[2]
Maximum deductible per family	$6,300	$6,300	$12,600	$3,400[2]	$3,400[2]	$6,400[2]	$4,200[2]	$4,200[2]	$8,000[2]
Out-of-pocket (OOP) maximum per person[3]	$6,800	$7,200	$13,700	$6,400[2]	$6,750[2]	$13,100[2]	$6,500[2]	$6,750[2]	$13,300[2]
Out-of-pocket (OOP) maximum per family[3]	$15,800	$15,800	$27,400	$13,500[2]	$13,500[2]	$26,200[2]	$13,500[2]	$13,500[2]	$26,600[2]
Preventive Care Services									
Routine adult, well-child and women's exams; annual obesity screening & immunizations	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office Visits and Virtual Care									
Primary care office visits	$30[1,5]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$50[1]	N/A	50% after deductible	15% after deductible	N/A	50% after deductible	20% after deductible	N/A	50% after deductible
Incentive care office visits (Moda plans only)	$25[1]	25% after deductible	N/A	15% after deductible	20% after deductible	N/A	20% after deductible	25% after deductible	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0 after deductible	$0 after deductible	Not covered	$0 after deductible	$0 after deductible	Not covered
Specialist office visits	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Urgent care	$50[1]	25% after deductible	25% after deductible	15% after deductible	20% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Mental Health Services									
Mental health office visits	$30[1]	$30[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Mental health inpatient and residential services	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	$30[1]	$30[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (inpatient)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient Services									
Outpatient surgery/facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational & speech therapy)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Diagnostic Testing									
Labs, x-ray, and imaging	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative Care Services									
Acupuncture and Chiropractic[7]	$30[1]	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Naturopathic Services	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Maternity Care									
Outpatient maternity care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Hospital Services									
Inpatient care/surgery	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Additional Cost Tier									
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

Plans 5–7 – *continued*

✓ Plan Offered X Plan Not Offered

No lifetime maximum on any medical plans.	**Medical Plan 5 Connexus Network** ✗			**Medical Plan 6 Connexus Network *HDHP HSA Compliant*** ✓			**Medical Plan 7 Connexus Network *HDHP HSA Compliant*** ✓		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum	**In-Network Coordinated Care[5] Member Pays**	**In-Network Non-Coordinated Care[6] Member Pays**	**Any Out-of-Network Services Member Pays**	**In-Network Coordinated Care[5] Member Pays**	**In-Network Non-Coordinated Care[6] Member Pays**	**Any Out-of-Network Services Member Pays**	**In-Network Coordinated Care[5] Member Pays**	**In-Network Non-Coordinated Care[6] Member Pays**	**Any Out-of-Network Services Member Pays**
Emergency Services									
Emergency room (copay waived if admitted)	$100 copay + 25% after deductible			20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Ambulance	25% after deductible			20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Other Covered Services									
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Pharmacy Services									
Out-of-pocket (OOP) maximum	Rx applies toward OOP max			Rx applies toward plan OOP max			Rx applies toward plan OOP max		
Retail									
Value	$4 per 31-day supply		See Plan Handbook	$4[1] per 31-day supply		See Plan Handbook	$4[1] per 31-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to $75 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[5]	50% up to $175 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Mail									
Value	$8 per 90-day supply		See Plan Handbook	$8[1] per 90-day supply		See Plan Handbook	$8[1] per 90-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to $150 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $450 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Specialty									
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

N/A – Not applicable

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

4 A formulary exception must be approved for non-preferred brand prescription medication.

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.

Summary of Dental Benefits 2024–2025 Plan Year

✓ Plan Offered X Plan Not Offered

Please see Plan Handbook for details.

Dental	Premier Plan 1[1]	Premier Plan 5[1]	Premier Plan 6	Exclusive PPO – Incentive Plan[1]	Exclusive PPO Plan	Kaiser Dental Plan	Willamette Dental Plan
	Delta Dental of Oregon & Alaska ✓	Delta Dental of Oregon & Alaska ✓	Delta Dental of Oregon & Alaska ✓	Delta Dental of Oregon & Alaska ✓	Delta Dental of Oregon & Alaska ✓	Kaiser Permanente ✓	Willamette Dental Group ✓
Network	Delta Dental Premier	Delta Dental Premier	Delta Dental Premier	Limited Network Plan – Delta Dental PPO[2]	Limited Network Plan – Delta Dental PPO[2]	Limited Network Plan – Kaiser Permanente Facilities[2]	Limited Network Plan – Willamette Dental Group Facilities[2]
Dental Office Visit Copay	N/A	N/A	N/A	N/A	N/A	$20[3]	$20[3]
Benefit Maximum	$2,200[4]	$1,700[4]	$1,200	$2,300[4]	$1,500[4]	$4,000[4]	N/A
Deductible	$50	$50	$50	$50	$50	N/A	N/A
Preventive & Diagnostic Services – Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans[6]							
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year[6]	70% + 10% each Plan Year[6]	100%[6]	100%[6]	100%[6]	100%[6]	100%
Restorative Services							
Routine fillings, inlays and stainless steel crowns	70% + 10%[1] each Plan Year	70% + 10%[1] each Plan Year	80%[1]	70% + 10%[1] each Plan Year	90%[1]	100%[3]	100%[3]
Simple Extraction							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100%[3]	100%[3]
Oral Surgery							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$50 Copay[3]	$50 Copay[3]
Periodontics							
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100%[3]	100%[3]
Endodontics							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$50 Copay[3]	$50 Copay[3]
Major Restorative Services							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	70% + 10% each Plan Year	80%	$250 Copay[3]	$250 Copay[3, 5]
Implants	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	50%[3]	Implant surgery up to $1,500 calendar year maximum[5]
Other covered services							
Occlusal guards (night guards)	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	65%, once every 5 years	100% once every 2 years
Athletic mouth guards	50%	50%	50%	50%	50%	65%, once every 12 months	$100 Copay[3]
Nitrous Oxide	50%	50%	50%	50%	50%	$0 copay (Age 12 & Under) $25 copay (Age 13 & Up)	$15 Copay[3]
Fixed and Removable Prosthetic Services							
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	$100 Copay[3]	$100 Copay[3, 5]
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	$250 Copay[3]	$250 Copay[3, 5]
Orthodontics							
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NO ORTHO COVERAGE on this plan	80% to $1,800 lifetime max	80% to $1,800 lifetime max	$2,500 Copay + $20 per visit	$2,500 Copay + $20 per visit

1 Under Delta Dental Plans 1 and 5, and Exclusive PPO - Incentive Plan benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

2 Services performed by providers outside the limited network are not covered unless for a dental emergency. Emergency services include limited exam and palliative treatment only.

3 Office visit copayment applies at each visit, in addition to any plan copayments for services.

4 Preventive care and orthodontia do not accrue to this maximum.

5 Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit under the Willamette Dental Group plan.

6 Preventive services will not accrue towards the plan benefit maximum.

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Summary of Vision Benefits 2024–2025 Plan Year

✓ Plan Offered X Plan Not Offered

Vision	Kaiser Vision Plan[1] ✓ Kaiser Permanente Facilities	Moda Opal Plan ✓ May use any licensed provider	Moda Pearl Plan ✓ May use any licensed provider	Moda Quartz Plan ✓ May use any licensed provider	VSP Choice Plus Plan ✓ VSP Choice Network	VSP Choice Plan ✓ VSP Choice Network
Plan Year Maximum	$250	$600	$400	$250	N/A	N/A
Routine Eye Exam:						
Benefit:	Covered under the Kaiser Permanente medical plan (does not apply to the vision plan year maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	Plan pays 100% after $10 copay
Frequency:	As needed	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year
Lenses:						
Basic lens benefit:	**Under age 19:** No charge for one pair of standard frames and lenses or contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Polycarbonate lenses, scratch resistant and UV coatings covered in full	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Scratch resistant and UV coatings covered in full. Polycarbonate lenses covered in full for dependent children
Lens enhancements:					$0 copay for standard progressive lenses $15 copay for anti-reflective coating or premium/custom progressive lenses	$0 copay for standard progressive lenses Discounts for polycarbonate for adults, anti-reflective coating or premium/custom progressive lenses
Frequency:	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year
Frames						
Benefit:	**Under age 19:** No charge for one pair of standard frames and lenses **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Covered in full up to retail allowance of **$300;** 20% off amount over retail allowance for frames	Covered in full up to retail allowance of **$150;** 20% off amount over retail allowance for frames
Frequency:	Once per plan year	**Age 0–16:** Once per plan year **Age 17+:** Once every two plan years	**Age 0–16:** Once per plan year **Age 17+:** Once every two plan years	**Age 0–16:** Once per plan year **Age 17+:** Once every two plan years	Once per plan year	Once per plan year
Contacts (in lieu of frames and lenses)						
Benefit:	**Under age 19:** No charge for contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Covered in full up to retail allowance of **$300**	Covered in full up to retail allowance of **$150**
Frequency:	Once per plan year	Up to the plan maximum	Up to the plan maximum	Up to the plan maximum	Once per plan year	Once per plan year
Non-Prescription Benefit						
Benefit:	$100 of your annual $250 allowance may be used toward non-prescription sunglasses and/or digital eye strain glasses	Not Covered	Not Covered	Not Covered	OEBB members can use their frame allowance to pay for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts	OEBB members can use their frame allowance to pay for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts

1 Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan.

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