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 Costs⁵	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of- Network Services Member Pays	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of- Network Services Member Pays	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of- Network Services Member Pays	In-Network Coordinated Care⁵ 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 deductit
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		50% after deductible	\$50 ¹	N/A	50% after deductible	\$50 ¹	N/A	50% after deductib
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		\$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 deductik
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 deductib
Mental Health and Chemical Dependency Services					-							
Mental health office visits	\$20 ¹	\$20 ¹	50% after deductible	\$20 ¹		50% after deductible	\$25 ¹	\$25 ¹	50% after deductible	\$25 ¹	\$25 ¹	50% after deductib
Mental health inpatient and residential services									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 deductil
	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 deductil
Outpatient 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 deductil
a 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 deductil
Tests (outpatient)												
Labs, x-ray, and imaging					20% 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		\$20 ¹	20% after deductible		\$25 ¹		50% after deductible	\$25 ¹	25% 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 deductil
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 deducti
Physician or midwife services & bosnital stay, delivery &	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 deductil
Hospital 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 deducti

Plans 1–4 – continued

moda

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 Costs⁵	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of- Network Services Member Pays	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of- Network Services Member Pays	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of- Network Services Member Pays	In-Network Coordinated Care⁵ 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% \$	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 + 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 copa	bay + 20% after ded	luctible	\$100 c	opay + 20% after ded	luctible	\$100 copay + 25% after deductible			\$100 copay + 25% after deductible		
Ambulance	20	0% after deductible			20% after deductible			25% after deductible		25% after deductible		
Other Covered Services												
Harring side \$4,000 maying hangit avery 40 months for		0% 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
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible 10											
	20% after deductible 20							25% after deductible	50% after deductible	25% after deductible	25% after deductible	
adults, see handbook for State mandated benefit for children	20% after deductible 20	0% after deductible	50% after deductible				25% after deductible			25% after deductible	25% after deductible	
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum	20% after deductible 20		50% after deductible	20% after deductible		50% after deductible	25% after deductible	25% after deductible applies toward OOP N			25% after deductible applies toward OOP M	50% after deductible
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail	20% after deductible 20	0% after deductible	50% after deductible	20% after deductible Rx	20% after deductible applies toward OOP M	50% after deductible	25% after deductible	applies toward OOP N		R۶	capplies toward OOP N	50% after deductible
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value	20% after deductible 20	0% after deductible oplies toward OOP N	50% after deductible	20% after deductible Rx \$4 per 31-4	20% after deductible applies toward OOP M day supply	50% after deductible	25% after deductible Rx \$4 per 31	applies toward OOP N day supply		R) \$4 per 31	< applies toward OOP N -day supply	50% after deductible
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans)	20% after deductible 20 Rx ap \$4 per 31-day \$12 per 31-day	0% after deductible oplies toward OOP M ay supply ay supply	50% after deductible Nax See Plan	20% after deductible Rx \$4 per 31- \$12 per 31-	20% after deductible applies toward OOP M day supply day supply	50% after deductible Nax See Plan	25% after deductible Rx \$4 per 31 \$12 per 31	applies toward OOP M day supply -day supply	Nax See Plan	R) \$4 per 31 \$12 per 31	< applies toward OOP M -day supply I-day supply	50% after deductible Aax See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand	20% after deductible 20 Rx ap 84 per 31-day \$12 per 31-day 25% up to \$75 per 3	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply	50% after deductible Nax	20% after deductible Rx \$4 per 31-0 \$12 per 31- 25% up to \$75 p	20% after deductible applies toward OOP M day supply day supply er 31-day supply	50% after deductible Nax	25% after deductible Rx 25% after deductible Rx 84 per 31 \$12 per 31 25% up to \$75 p	applies toward OOP N day supply -day supply wer 31-day supply	ſax	R» \$4 per 31 \$12 per 31 25% up to \$75 p	c applies toward OOP M -day supply I-day supply per 31-day supply	50% after deductible Aax
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴	20% after deductible 20 Rx ap \$4 per 31-day \$12 per 31-day	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply	50% after deductible Nax See Plan	20% after deductible Rx \$4 per 31- \$12 per 31-	20% after deductible applies toward OOP M day supply day supply er 31-day supply	50% after deductible Nax See Plan	25% after deductible Rx 25% after deductible Rx 84 per 31 \$12 per 31 25% up to \$75 p	applies toward OOP M day supply -day supply	Nax See Plan	R» \$4 per 31 \$12 per 31 25% up to \$75 p	< applies toward OOP M -day supply I-day supply	50% after deductible Aax See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Mail	20% after deductible 20 Rx ap Rx ap \$4 per 31-day \$12 per 31-da 25% up to \$75 per 50% up to \$175 per	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply	50% after deductible Nax See Plan	20% after deductible Rx \$4 per 31- \$12 per 31- 25% up to \$75 p 50% up to \$175 p	20% after deductible applies toward OOP M day supply day supply er 31-day supply per 31-day supply	50% after deductible Nax See Plan	25% after deductible Rx 4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175	applies toward OOP M day supply -day supply per 31-day supply per 31-day supply	Nax See Plan	Rx \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175	c applies toward OOP M -day supply I-day supply per 31-day supply per 31-day supply	50% after deductible Aax See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Mail Value	20% after deductible 20 Rx ap 84 per 31-day \$12 per 31-day 50% up to \$75 per 3 50% up to \$175 per 4	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply ay supply	50% after deductible Nax See Plan	20% after deductible Rx \$4 per 31 \$12 per 31- 25% up to \$75 p 50% up to \$175 p \$8 per 90-	20% after deductible applies toward OOP M day supply day supply er 31-day supply per 31-day supply day supply	50% after deductible Nax See Plan	25% after deductible Rx 25% after deductible Rx 25% up to \$12 50% up to \$75 p 50% up to \$175	applies toward OOP M day supply -day supply per 31-day supply per 31-day supply	Nax See Plan	R) \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175 \$8 per 90	 c applies toward OOP M -day supply l-day supply oer 31-day supply per 31-day supply -day supply 	50% after deductible Aax See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand ⁴ Mail Value Generic (Kaiser Plans) / Select generic (Moda Plans)	20% after deductible 20 Rx ap Rx ap 10 25% up to \$75 per 25% up to \$75 per 50% up to \$175 per 50% up to \$175 per \$8 per 90-day \$24 per 90-day	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply ay supply ay supply ay supply	50% after deductible Max See Plan Handbook See Plan	20% after deductible Rx 8 8 8 4 per 31- \$12 per 31- \$12 per 31- \$25% up to \$75 per 50% up to \$175 per 50% up to \$175 per \$8 per 90- \$24 per 90-	20% after deductible applies toward OOP M day supply day supply er 31-day supply ber 31-day supply day supply day supply	50% after deductible flax See Plan Handbook See Plan	25% after deductible RM 25% after deductible RM 25% up to \$12 per 31 25% up to \$75 p 50% up to \$175 \$50% up to \$175 \$50% up to \$175 p	applies toward OOP M day supply -day supply er 31-day supply per 31-day supply day supply -day supply	Aax See Plan Handbook See Plan	Rx \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175 \$8 per 90 \$24 per 90	 A applies toward OOP M -day supply I-day supply per 31-day supply per 31-day supply -day supply -day supply 	50% after deductible Max See Plan Handbook See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Mail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand	20% after deductible 20 Rx ap 8 4 per 31-day 9 12 per 31-day 9 25% up to \$75 per 3 50% up to \$175 per 4 50% up to \$175 per 4 8 per 90-day 9 25% up to \$150 per 4	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply ay supply ay supply ay supply r 90-day supply	50% after deductible Max See Plan Handbook	20% after deductible Rx 84 per 31 \$12 per 31- \$12 per 31- \$25% up to \$75 p 50% up to \$175 p \$50% up to \$175 p \$24 per 90- \$24 per 90- \$24 per 90-	20% after deductible applies toward OOP M day supply day supply er 31-day supply oer 31-day supply day supply day supply day supply oer 90-day supply	50% after deductible Max See Plan Handbook	25% after deductible Ry 4 per 31 \$12 per 31 \$12 per 31 \$12 per 31 \$50% up to \$75 p 50% up to \$175 \$50% up to \$175	applies toward OOP M day supply -day supply per 31-day supply per 31-day supply -day supply -day supply oper 90-day supply	/lax See Plan Handbook	Rx \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175 \$8 per 90 \$24 per 90 25% up to \$150	 c applies toward OOP M -day supply l-day supply per 31-day supply per 31-day supply -day supply -day supply per 90-day supply 	50% after deductible Max See Plan Handbook
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand4 Mail Value Generic (Kaiser Plans) / Select generic (Moda Plans)	20% after deductible 20 Rx ap Rx ap 10 25% up to \$75 per 25% up to \$75 per 50% up to \$175 per 50% up to \$175 per \$8 per 90-day \$24 per 90-day	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply ay supply ay supply ay supply r 90-day supply	50% after deductible Max See Plan Handbook See Plan	20% after deductible Rx 8 8 8 4 per 31- \$12 per 31- \$12 per 31- \$25% up to \$75 per 50% up to \$175 per 50% up to \$175 per \$8 per 90- \$24 per 90-	20% after deductible applies toward OOP M day supply day supply er 31-day supply oer 31-day supply day supply day supply day supply oer 90-day supply	50% after deductible flax See Plan Handbook See Plan	25% after deductible Ry 4 per 31 \$12 per 31 \$12 per 31 \$12 per 31 \$50% up to \$75 p 50% up to \$175 \$50% up to \$175	applies toward OOP M day supply -day supply er 31-day supply per 31-day supply day supply -day supply	Aax See Plan Handbook See Plan	Rx \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175 \$8 per 90 \$24 per 90 25% up to \$150	 A applies toward OOP M -day supply I-day supply per 31-day supply per 31-day supply -day supply -day supply 	50% after deductible Max See Plan Handbook See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Mail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand	20% after deductible 20 Rx ap 8 4 per 31-day 9 12 per 31-day 9 25% up to \$75 per 50% up to \$175 per 8 8 per 90-day \$24 per 90-day \$25% up to \$150 per 50% up to \$450 per	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply ay supply ay supply ay supply r 90-day supply	50% after deductible Max See Plan Handbook See Plan	20% after deductible Rx Rx 4 per 31- \$12 per 31- \$25% up to \$75 p 50% up to \$175 p 50% up to \$175 p \$24 per 90- \$24 per 90- \$25% up to \$150 p 50% up to \$450 p	20% after deductible applies toward OOP M day supply day supply er 31-day supply ber 31-day supply day supply day supply day supply er 90-day supply ber 90-day supply	50% after deductible flax See Plan Handbook See Plan	25% after deductible Ry 25% after deductible 84 per 31 312 per 31 25% up to \$75 p 50% up to \$175 88 per 90 \$24 per 90 \$25% up to \$150 50% up to \$450	applies toward OOP M day supply -day supply er 31-day supply per 31-day supply -day supply -day supply our 90-day supply per 90-day supply	Aax See Plan Handbook See Plan	Rx \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175 \$8 per 90 \$24 per 90 \$24 per 90 \$25% up to \$150 50% up to \$450	c applies toward OOP M -day supply I-day supply per 31-day supply per 31-day supply -day supply D-day supply per 90-day supply per 90-day supply	50% after deductible Max See Plan Handbook See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Mail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Specialty Generic (Moda Plans only)	20% after deductible 20 Rx ap Rx ap 84 per 31-day 12 per 31-day 25% up to \$75 per 50% up to \$175 per \$24 per 90-day \$25% up to \$150 per 50% up to \$150 per 50% up to \$450 per	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply r 31-day supply r 90-day supply r 90-day supply r 90-day supply or \$36 per 90-day allowed	50% after deductible Max See Plan Handbook See Plan	20% after deductible Rx Rx S4 per 31-0 \$12 per 31- 25% up to \$75 per 50% up to \$175 per 50% up to \$175 per 50% up to \$150 per 5	20% after deductible applies toward OOP M day supply day supply er 31-day supply day supply day supply day supply er 90-day supply per 90-day supply ber 90-day supply day supply	50% after deductible flax See Plan Handbook See Plan	25% after deductible 8 8 8 8 8 9 1 25% up to \$75 p 50% up to \$175 8 9 1 25% up to \$175 1 25% up to \$150 50% up to \$450 1 25% up to \$450 1 25% up to \$450 1 2 2 2 2 2 2 2 2 2 2 2 2 2	applies toward OOP M day supply -day supply per 31-day supply per 31-day supply -day supply -day supply oper 90-day supply	Aax See Plan Handbook See Plan	Rx \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175 \$8 per 90 \$24 per 90 \$25% up to \$150 50% up to \$150 50% up to \$450	 c applies toward OOP M -day supply I-day supply per 31-day supply per 31-day supply -day supply -day supply per 90-day supply per 90-day supply per 90-day supply poly or \$36 per 90-day pen allowed 	50% after deductible Max See Plan Handbook See Plan
adults, see handbook for State mandated benefit for children Durable medical equipment (DME) Pharmacy Services Out-of-pocket (OOP) maximum Retail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Mail Value Generic (Kaiser Plans) / Select generic (Moda Plans) Preferred brand Non-preferred brand ⁴ Specialty	20% after deductible 20 Rx ap 8 4 per 31-day 9 12 per 31-day 9 25% up to \$75 per 3 50% up to \$175 per 4 50% up to \$175 per 4 25% up to \$150 per 4 50% up to \$150 per 4 50% up to \$450 per 4 50% up to \$450 per 4	0% after deductible oplies toward OOP M ay supply ay supply 31-day supply r 31-day supply r 31-day supply r 90-day supply r 90-day supply r 90-day supply or \$36 per 90-day allowed 31-day supply or	50% after deductible Max See Plan Handbook See Plan	20% after deductible Rx 84 per 31 \$12 per 31- 25% up to \$75 p 50% up to \$175 p 50% up to \$175 p 25% up to \$150 p 50% up to \$150 p 50% up to \$450 p	20% after deductible applies toward OOP M day supply day supply er 31-day supply er 31-day supply day supply day supply day supply er 90-day supply per 90-day supply er 90-day supply er 90-day supply er 90-day supply er 90-day supply er 31-day supply or	50% after deductible flax See Plan Handbook See Plan	25% after deductible RM 25% after deductible RM 25% up to \$12 per 31 25% up to \$75 p 50% up to \$175 25% up to \$175 25% up to \$150 50% up to \$450 25% up to \$450 50% up to \$200 p \$400 for 90-day supply wh	applies toward OOP M day supply -day supply ber 31-day supply per 31-day supply -day supply -day supply ber 90-day supply per 90-day supply per 90-day supply	Aax See Plan Handbook See Plan	Rx \$4 per 31 \$12 per 31 25% up to \$75 p 50% up to \$175 \$8 per 90 \$24 per 90 \$24 per 90 \$25% up to \$150 50% up to \$450 \$12 per 31-day supp supply wh 25% up to \$200 p	 c applies toward OOP M -day supply l-day supply per 31-day supply per 31-day supply -day supply per 90-day supply 	50% after deductible Max See Plan Handbook See Plan

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 outof-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 co-payments, coinsurance, ACT co-payments and pharmacy expenses.

4. A formulary exception must be approved for nonpreferred brand prescription medication.

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

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

7. 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.

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
	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%						
CT, MRI, PET scans	after deductible	after deductible	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,	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%						
$(A \cup I)$. Opline surgery, where $A \cup I$ is the formula of the theory of the surgery, where $A \cup I$ is the formula of the theory of the surgery of the surg	after deductible	after deductible	after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductib

Plans 5–7 – continued

mod

	en 1			h						
No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network				Medical Plan 6 Connexus Network HDHP HSA Complian	t	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 Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care⁵ 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 dedu	ctible	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	F	Rx applies toward OOP ma	IX	Rx applies toward plan OOP max			Rx applies toward plan OOP max			
Retail										
Value	\$4 per 31-	-day supply		\$41 per 31	-day supply		\$41 per 31	\$4 ¹ per 31-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31	-day supply	See Plan	20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	
Preferred brand	25% up to \$75 p	per 31-day supply	Handbook	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		\$8 ¹ per 90-day supply			\$81 per 90	-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90	-day supply	See Plan	20% after deductible	25% after deductible	See Plan	20% after deductible	25% after deductible	See Plan	
Preferred brand	25% up to \$150 p	per 90-day supply	Handbook	20% after deductible	25% after deductible	Handbook	20% after deductible	25% after deductible	Handbook	
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		20% after deductible	25% after deductible		20% after deductible	25% after deductible		
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	90-day supply	-day supply or \$400 for when allowed	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	
Non-preferred brand ⁴	50% up to \$500 per 31- 90-day supply	day supply or \$1,000 for 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 outof-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 co-payments, coinsurance, ACT co-payments and pharmacy expenses.

4. A formulary exception must be approved for nonpreferred brand prescription medication.

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

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

7. 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.

OCO Summary of Dental Benefits 2024–2025 Plan Year

M <u>Please see Plan Handbook for details.</u>	Delta Dental	Delta Dental Delta Dental of Oregon & Alaska	DELTA DENTAL ^a Delta Dentai of Oregon & Alaska	Delta Dental	Delta Dental	Willamette Marchan Dental Group
Dental	Premier Plan 1 ¹	Premier Plan 5 ¹	Premier Plan 6	Exclusive PPO – Incentive Plan ¹	Exclusive PPO Plan	Willamette Dental Plan
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 – Willamette Dental Group Facilities ²
Dental Office Visit Copay	N/A	N/A	N/A	N/A	N/A	\$20 ³
Benefit Maximum	\$2,2004	\$1,7004	\$1,200	\$2,3004	\$1,500 ⁴	N/A
Deductible	\$50	\$50	\$50	\$50	\$50	N/A
Preventive & Diagnostic Services – Deductible Waived for Preventive	& Diagnostic Services on Delta Denta	al 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%
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
Simple Extraction						
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	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
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
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
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, 5}
Implants	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	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	100% once every 2 years
Athletic mouth guards	50%	50%	50%	50%	50%	\$100 Copay ³
Nitrous Oxide	50%	50%	50%	50%	50%	\$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, 5}
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	\$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

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 pallative 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.

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.

oebb

Summary of Vision Benefits 2024–2025 Plan Year

	moda	MODO	MODO	VS O Vision Care			
Vision	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	\$600	\$400	\$250	N/A	N/A		
Routine Eye Exam:							
Benefit:	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:	Once per plan year	Once per plan year					
Lenses:							
Basic lens benefit:	Plan pays 100% (up to plan	Plan pays 100% (up to plan	Plan pays 100% (up to plan	\$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:	maximum)	maximum)	maximum)	\$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					
Frames							
Benefit:	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:	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 le	enses)						
Benefit:	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:	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:	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		

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.

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact OEBB Member Services at 888-4My-OEBB (888-469-6322) or email <u>oebb.benefits@odhsoha.oregon.gov</u>. We accept all relay calls or you can dial 711.



