



## Medical and Pharmacy Plans — continued

This is a **high-level medical plan** comparison. Please see [plan documents](#) for details.

No lifetime maximum on any medical plans.
<b>Plan year costs<sup>5</sup></b>
Deductible per person
Maximum deductible per family
Out-of-pocket (OOP) maximum per person <sup>3</sup>
Out-of-pocket (OOP) maximum per family <sup>3</sup>
<b>Preventive care services</b>
Routine adult, well-child and women's exams; annual obesity screening and immunizations
<b>Office visits and virtual care</b>
Primary care office visits
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)
Incentive care office visits (Moda plans only)
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)
Specialist office visits
Urgent care

Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
\$1,100	\$1,200	\$1,900	\$1,500	\$1,600	\$2,700	\$1,900	\$2,000	\$3,500
\$2,400	\$2,400	\$3,800	\$3,200	\$3,200	\$5,400	\$4,000	\$4,000	\$7,000
\$4,750	\$5,150	\$8,900	\$5,750	\$6,150	\$10,900	\$7,600	\$8,000	\$14,600
\$10,300	\$10,300	\$17,800	\$12,300	\$12,300	\$21,800	\$16,000	\$16,000	\$29,200
\$0 <sup>1</sup>	\$0 <sup>1</sup>	50% after deductible	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50% after deductible	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50% after deductible
\$25 <sup>1.5</sup>	20% after deductible	50% after deductible	\$30 <sup>1.5</sup>	25% after deductible	50% after deductible	\$30 <sup>1.5</sup>	25% after deductible	50% after deductible
\$45 <sup>1</sup>	Not applicable	50% after deductible	\$55 <sup>1</sup>	Not applicable	50% after deductible	\$55 <sup>1</sup>	Not applicable	50% after deductible
\$20 <sup>1</sup>	20% after deductible	Not applicable	\$25 <sup>1</sup>	25% after deductible	Not applicable	\$25 <sup>1</sup>	25% after deductible	Not applicable
\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not covered	\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not covered	\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not covered
\$45 <sup>1</sup>	20% after deductible	50% after deductible	\$55 <sup>1</sup>	25% after deductible	50% after deductible	\$55 <sup>1</sup>	25% after deductible	50% after deductible
\$45 <sup>1</sup>	20% after deductible	20% after deductible	\$55 <sup>1</sup>	25% after deductible	25% after deductible	\$55 <sup>1</sup>	25% after deductible	25% after deductible



## Medical and Pharmacy Plans — continued

This is a **high-level medical plan** comparison. Please see plan documents for details.

<b>No lifetime maximum on any medical plans.</b>
<b>Plan year costs<sup>5</sup></b>
<b>Mental health and chemical dependence</b>
Mental health office visits
Mental health inpatient and residential services
Chemical dependency services (outpatient or residential)
Chemical dependency services (inpatient)
<b>Outpatient services</b>
Outpatient surgery / facility care
Outpatient rehabilitation (physical, occupational and speech therapy)
<b>Diagnostic testing</b>
Labs, x-ray, and imaging
CT, MRI, PET scans
<b>Alternative care services<sup>7</sup></b>
Acupuncture and Chiropractic <sup>7</sup>
Naturopathic office visits

Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
\$25 <sup>1</sup>	\$25 <sup>1</sup>	50% after deductible	\$30 <sup>1</sup>	\$30 <sup>1</sup>	50% after deductible	\$30 <sup>1</sup>	\$30 <sup>1</sup>	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
\$25 <sup>1</sup>	\$25 <sup>1</sup>	50% after deductible	\$30 <sup>1</sup>	\$30 <sup>1</sup>	50% after deductible	\$30 <sup>1</sup>	\$30 <sup>1</sup>	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
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
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
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
\$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
\$25 <sup>1</sup>	20% after deductible	50% after deductible	\$30 <sup>1</sup>	25% after deductible	50% after deductible	\$30 <sup>1</sup>	25% after deductible	50% after deductible
\$45 <sup>1</sup>	20% after deductible	50% after deductible	\$55 <sup>1</sup>	25% after deductible	50% after deductible	\$55 <sup>1</sup>	25% after deductible	50% after deductible



## Medical and Pharmacy Plans — continued

This is a **high-level medical plan** comparison. Please see [plan documents](#) for details.

<b>No lifetime maximum on any medical plans.</b>
<b>Plan year costs<sup>5</sup></b>
<b>Maternity care</b>
Routine maternity care
Physician or midwife services and hospital stay, delivery and routine newborn nursery care
<b>Hospital services</b>
Inpatient care / surgery
Skilled nursing facility care
<b>Additional Cost Tier (ACT)</b>
<b>Moda Plans Only:</b> \$100 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
<b>Moda Plans Only:</b> \$500 ACT: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair
<b>Emergency services</b>
Emergency room (copay waived if admitted)
Ambulance

Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
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
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
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
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
\$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
\$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
\$100 copay + 20% after deductible			\$100 copay + 25% after deductible			\$100 copay + 25% after deductible		
20% after deductible			25% after deductible			25% after deductible		



## Medical and Pharmacy Plans — continued

[This is a high-level medical plan comparison. Please see plan documents for details.](#)

<b>No lifetime maximum on any medical plans.</b>
<b>Plan year costs<sup>5</sup></b>
<b>Other covered services</b>
<b>Hearing aids:</b> \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children
Durable medical equipment (DME)
<b>Pharmacy services</b>
Out-of-pocket (OOP) maximum
<b>Retail</b>
Value
Generic (Kaiser Plans) / Select generic (Moda Plans)
Preferred brand
Non-preferred brand <sup>4</sup>
<b>Mail</b>
Value
Generic (Kaiser Plans) / Select generic (Moda Plans)
Preferred brand
Non-preferred brand <sup>4</sup>

Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
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
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
Rx applies toward OOP maximum			Rx applies toward OOP maximum			Rx applies toward OOP maximum		
Retail			Retail			Retail		
\$4 per 31-day supply	See plan handbook	See plan handbook	\$4 per 31-day supply	See plan handbook	See plan handbook	\$4 per 31-day supply	See plan handbook	See plan handbook
\$12 per 31-day supply			\$12 per 31-day supply			\$12 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		
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			Mail			Mail		
\$8 per 90-day supply	See plan handbook	See plan handbook	\$8 per 90-day supply	See plan handbook	See plan handbook	\$8 per 90-day supply	See plan handbook	See plan handbook
\$24 per 90-day supply			\$24 per 90-day supply			\$24 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		
50% up to \$450 per 90-day supply			50% up to \$450 per 90-day supply			50% up to \$450 per 90-day supply		



## Medical and Pharmacy Plans — continued

This is a **high-level medical plan** comparison. Please see [plan documents](#) for details.

<b>No lifetime maximum on any medical plans.</b>
<b>Plan year costs<sup>5</sup></b>
Specialty
Generic (Moda Plans only)
Select generic (Kaiser plans) / Preferred brand (Moda Plans)
Non-preferred brand <sup>4</sup>

Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
\$12 per 31-day supply or \$36 per 90-day supply when allowed			\$12 per 31-day supply or \$36 per 90-day supply when allowed			\$12 per 31-day supply or \$36 per 90-day supply when allowed		
25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed		See plan handbook	25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed		See plan handbook	25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed		See plan handbook
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		

- Deductible waived.
- 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).
- For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.
- A formulary exception must be approved for non-preferred brand prescription medication.



- To receive in-network coordinated care benefits, you must choose and use a PCP 360.
- To receive in-network non-coordinated benefits, you must use Connexus providers.
- 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.**



## Medical and Pharmacy Plans — continued



 This is a **high-level medical plan** comparison. Please see [plan documents for details](#).

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network		
Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	\$2,300	\$2,400	\$4,300
Maximum deductible per family	\$4,800	\$4,800	\$8,600
Out-of-pocket (OOP) maximum per person <sup>3</sup>	\$7,700	\$8,100	\$14,600
Out-of-pocket (OOP) maximum per family <sup>3</sup>	\$16,200	\$16,200	\$29,200
Preventive care services			
Routine adult, well-child and women's exams; annual obesity screening and immunizations 	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50% after deductible
Office visits and virtual care			
Primary care office visits	\$35 <sup>1,5</sup>	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$55 <sup>1</sup>	Not applicable	50% after deductible
Incentive care office visits (Moda plans only)	\$30 <sup>1</sup>	25% after deductible	Not applicable
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans) 	\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not covered
Specialist office visits	\$55 <sup>1</sup>	25% after deductible	50% after deductible
Urgent care	\$55 <sup>1</sup>	25% after deductible	25% after deductible
Mental health services			
Mental health office visits	\$35 <sup>1</sup>	\$35 <sup>1</sup>	50% after deductible
Mental health inpatient and residential services	25% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	\$35 <sup>1</sup>	\$35 <sup>1</sup>	50% after deductible



## Medical and Pharmacy Plans — continued

 This is a **high-level medical plan** comparison. Please see [plan documents for details](#).

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network		
Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
<b>Mental health services</b>			
Chemical dependency services (inpatient)	25% after deductible	25% after deductible	50% after deductible
<b>Outpatient services</b>			
Outpatient surgery / facility care	25% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational and speech therapy)	25% after deductible	25% after deductible	50% after deductible
<b>Diagnostic testing</b>			
Labs, x-ray, and imaging	25% 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
<b>Alternative care services</b>			
Acupuncture and Chiropractic <sup>7</sup>	\$35 <sup>1</sup>	25% after deductible	50% after deductible
Naturopathic services	\$55 <sup>1</sup>	25% after deductible	50% after deductible
<b>Maternity care</b>			
Routine maternity care	25% after deductible	25% after deductible	50% after deductible
Physician or midwife services and hospital stay, delivery and routine newborn nursery care	25% after deductible	25% after deductible	50% after deductible
<b>Hospital services</b>			
Inpatient care / surgery	25% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care 	25% after deductible	25% after deductible	50% after deductible



## Medical and Pharmacy Plans — continued

This is a **high-level medical plan** comparison. Please see [plan documents for details](#).

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network		
	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordi- nated Care <sup>6</sup> Member Pays	Any Out-of- Network Services Member Pays
<b>Plan year costs</b> – deductibles and copayments apply to the annual out-of-pocket maximum			
<b>Additional cost tier (ACT)</b>			
<b>Moda Plans only:</b> \$100 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
<b>Moda Plans only:</b> \$500 ACT: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 25% after deductible	\$500 copay + 25% after deductible	\$500 copay + 50% after deductible
<b>Emergency services</b>			
Emergency room (copay waived if admitted)	\$100 copay + 25% after deductible		
Ambulance	25% after deductible		
<b>Other covered services</b>			
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
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible
<b>Pharmacy services</b>			
Out-of-pocket (OOP) maximum	Rx applies toward OOP maximum		
<b>Retail</b>			
Value	\$4 per 31-day supply	See plan handbook	
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31-day supply		
Preferred brand	25% up to \$75 per 31-day supply		
Non-preferred brand <sup>5</sup>	50% up to \$175 per 31-day supply		



## Medical and Pharmacy Plans — continued

This is a **high-level medical plan** comparison. Please see [plan documents for details](#).

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network		
Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	In-Network Coordinated Care <sup>5</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Any Out-of-Network Services Member Pays
<b>Mail</b>			
Value	\$8 per 90-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90-day supply		
Preferred brand	25% up to \$150 per 90-day supply		
Non-preferred brand <sup>4</sup>	50% up to \$450 per 90-day supply		
<b>Specialty</b>			
Generic (Moda Plans only)	\$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		
Non-preferred brand <sup>4</sup>	50% up to \$500 per 31-day supply or \$1,000 for 90-day supply when allowed		

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.

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.**



# 2025–26 Benefits Comparison

## Dental Plans

This is a **high-level dental plan** comparison. Please see [plan documents](#) for details.



Dental	Premier Plan 1 <sup>1</sup>	Premier Plan 5 <sup>1</sup>	Premier Plan 6
<b>Network</b>	<b>Delta Dental Premier</b>	<b>Delta Dental Premier</b>	<b>Delta Dental Premier</b>
Dental office visit copay	Not applicable	Not applicable	Not applicable
Benefit maximum	\$2,200 <sup>4</sup>	\$1,700 <sup>4</sup>	\$1,200
Deductible	\$50	\$50	\$50
<b>Preventive and diagnostic services – deductible waived for preventive and diagnostic services on Delta Dental Plans<sup>5</sup></b>			
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each plan year <sup>6</sup>	70% + 10% each plan year <sup>6</sup>	100% <sup>6</sup>
<b>Restorative services</b>			
Routine fillings, inlays and stainless steel crowns	70% + 10% <sup>1</sup> each plan year	70% + 10% <sup>1</sup> each plan year	80% <sup>1</sup>
<b>Simple extraction</b>			
Simple tooth extractions	70% + 10% each plan year	70% + 10% each plan year	80%
<b>Oral surgery</b>			
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each plan year	70% + 10% each plan year	80%
<b>Periodontics</b>			
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each plan year	70% + 10% each plan year	80%
<b>Endodontics</b>			
Root canal and related therapy including diagnosis and evaluation	70% + 10% each plan year	70% + 10% each plan year	80%

Willamette Dental Plan
Limited Network Plan <b>Willamette Dental Facilities<sup>2</sup></b>
\$20 <sup>3</sup>
Not applicable
Not applicable
100%
100% <sup>3</sup>
100% <sup>3</sup>
\$50 copay <sup>3</sup>
100% <sup>3</sup>
\$50 copay <sup>3</sup>

# Dental Plans — continued



Dental	Premier Plan 1 <sup>1</sup>	Premier Plan 5 <sup>1</sup>	Premier Plan 6
<b>Major restorative services</b>			
Gold or porcelain crowns and onlays	70% + 10% each plan year	70%	50%
Implants	70% + 10% each plan year	50%	50%
<b>Other covered services</b>			
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
Athletic mouth guards	50%	50%	50%
Nitrous Oxide	50%	50%	50%
<b>Fixed and removable prosthetic services</b>			
Full and partial dentures, relines, rebases	70% + 10% each plan year	50%	50%
Bridge retainers and pontics	70% + 10% each plan year	50%	50%
<b>Orthodontics</b>			
Orthodontic treatment	80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	<b>No ortho coverage on this plan</b>

This is a **high-level dental plan** comparison. Please see [plan documents](#) for details.



Willamette Dental Plan
\$250 copay <sup>3, 5</sup>
Implant surgery up to \$1,500 calendar year maximum <sup>5</sup>
100% once every 2 years
\$100 copay <sup>3</sup>
\$15 copay <sup>3</sup>
\$100 copay <sup>3, 5</sup>
\$250 copay <sup>3, 5</sup>
\$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.

**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.**



# 2025–26 Benefits Comparison

## Vision Plans

[This is a high-level vision plan comparison. Please see plan documents for details.](#)



Vision	Kaiser Vision Plan <sup>1</sup> 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
Plan year maximum	\$250	\$600	\$400	\$250
<b>Routine eye exam</b>				
Benefit	Covered under the Kaiser Permanente medical plan. Does not apply to the vision plan. Annual maximum.	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)
Frequency	As needed	Once per plan year	Once per plan year	Once per plan year
<b>Lenses</b>				
Basic lens benefit	<b>Under age 19:</b> No charge for one pair of standard frames and lenses for contacts.	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)
Lens enhancements	<b>Age 19+:</b> Plan pays up to plan maximum.			
Frequency	Once per plan year	Once per plan year	Once per plan year	Once per plan year
<b>Frames</b>				
Benefit	<b>Under age 19:</b> No charge for one pair of standard frames and lenses. <b>Age 19+:</b> 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)

# Vision Plans — continued

This is a **high-level vision plan** comparison. Please see [plan documents for details](#).

	<b>Kaiser Vision Plan<sup>1</sup></b> Kaiser Permanente Facilities	<b>Moda Opal Plan</b> May use any licensed provider	<b>Moda Pearl Plan</b> May use any licensed provider	<b>Moda Quartz Plan</b> May use any licensed provider
<b>Frames</b>				
Frequency	Once per plan year	<b>Age 0–16:</b> Once per plan year <b>Age 17+:</b> Once every two plan years	<b>Age 0–16:</b> Once per plan year <b>Age 17+:</b> Once every two plan years	<b>Age 0–16:</b> Once per plan year <b>Age 17+:</b> Once every two plan years
<b>Contacts (in lieu of frames and lenses)</b>				
Benefit	<b>Under age 19:</b> No charge for contacts <b>Age 19+:</b> 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)
Frequency	Once per plan year	Up to the plan maximum	Up to the plan maximum	Up to the plan maximum
<b>Non-Prescription Benefit</b>				
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

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

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