

Summary of Medical and Pharmacy Benefits 2024–2025 Plan Year

Contents:	
Medical and Pharmacy Benefits	1
Kaiser Permanente Plans	1
Moda Health Plans 1–4	3
Moda Health Plans 5–7	5
Dental Benefits	7
Vision Benefits	8



Plans

Please see Plan Handbook for details.

PERMANENTE. Plans Please see Plan	<u> Handbook for detai</u>	<u>IS.</u>						
No lifetime maximum on any medical plans.	Medica Ser Perman	al Plan 1 nente Networ'	Medical Kaiser Permar	Plan 2A nente Network	Medical Kaiser Permar	Plan 2B nente Network	Medical Plan 3 Kaiser Permanente Network HSA Optional	
	In-Net Member Pa	Out cwork er Pays	In-N rk Member	Out-of- ork Me Pays	. twork Mei, oays	Out- twork Ser Pays	In-Netv. Member Pa,	Out-of work Monday
Deductible per person	None	N/A	\$800	N/A	\$1,2	N/A	\$1,600 ²	N/A
Maximum deductible per family	None	N/A	\$2,400	N/A	\$3,600	N/A	\$3,2002	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		Not Co	\$6	Not red		Covered	\$	Not Cov
Office Visits and Virtual Care								
Primary care office visits	\$20	Not Covered	\$25 ¹	Not Covered	\$30¹	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/		M	N/A	N/A
Incentive care office visits (Moda Plans only)	VA.	.√/A	N/A	A	N/A	√A	N/A	N'
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)		vot Covered	\$0 ¹	of Covered	\$0 ¹	of Covered	\$0 after deductible	N vered
Specialist office visits	\$30	Not Covered	\$35¹	Not Covered	\$40¹	Not Covered	20% after deductible	Covered
Urgent care	\$35	See Plan Handbook	\$40¹	See Plan Handbook	\$45 ¹	See Plan Handbook	20% after deductible	Plan Handbook
Mental Health and Chemical Dependency Services			***		****			
Mental health office visits	\$20	Not Covered	\$251	' Covered	\$30¹	' Covered	20% after deductible	No rered
Mental health inpatient and residential services	\$100 per day to \$500 per ar to n max	ot Covered	20% after actible	No. red	20% after auctible	Not red	20% after ded e	Not Cov
Chemical dependency services (outpatient or residential)	\$0	vered	\$0 ¹	Not Covered	\$01	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	Ф7 Г	Not Covered	OOO/ often aladvestible	Net Covered	OOO/ often deducatible	Not Covered	OOO/ after als disable la	Net Cerrened
Outpatient surgery/facility care Outpatient rehabilitation	\$75	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
(physical, occupational & speech therapy)	\$30 per visit	Not Covered	\$35 ¹ per visit	Not Covered	\$40 visit	Not Co	20% after ctible	Not C d
Diagnostic Testing	40		AOS!		4001		000/ () 1 1	
Labs, x-ray, and imaging	\$20 sit	overed	\$25 ¹ p it	Jovered	\$30¹ per visit	of Covered	20% after deductib.	.ot Covered
CT, MRI, PET scans	\$70 per	.ot Covered	\$75 ¹ per v.	vot 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 deducti	† Covered
Naturopathic Office Visits	\$20 per service	Not Covered	\$25° per service	Not Covered	\$30° per service \$30° per ser	Covered	20% after deductive	vered
Maternity Care	Ψ20 μσι 301 νισι	Not oovered	φεο μοι σοι γι	TVOL GOVOICU	ψου μοι σοι	Overeu	20 /0 dittol del	TV VOICU
Routine maternity care	<u></u>	Covered	Ф	overed		Not Cov		Not Covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	\$100 per up to \$500 per augsion max	Not red	20% deductible	Not Cored	20% after deductible	Not Covered	20% after deductible	Not Covered
Hospital Services	por aminosion max							
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



Plans – continued

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network		Medical Kaiser Permar	ente Network	Medical Kaiser Permar	nente Network	Medical Plan 3 Kaiser Permanente Network <i>HSA Optional</i>	
	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			4	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)		ivea [:] tted)		deduch		deu	20 00	t 'hle
Ambulance	\$7	5	\$10	001	\$10	001	after	dedu
Other Covered Services								
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for state-mandated benefit for children	J%	Not Covere	10%1	Not Covered	/o ¹	Not Cove	20° deductible	Not Co.
Durable medical equipment (DME)	20%	Not Covered	20%1	Not Covered	20%1	Not Covered	20% after deductible	Not Coverea
Pharmacy Services								
Out-of-pocket (OOP) maximum	Rx applies toward	d plan OOP max	Rx applies towar	d plan OOP max	Rx applies towar	d plan OOP max	Rx applies towar	d plan OOP max
Retail							_	
Value	N/A	N/A	N/A	N/A	N/A	N/A	\$07	N/A
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$10 day supply	See Plan H Jk	\$10 pc ay supply	See Plan H ok	\$ 30-day supply	See Plan Lok	2 or deductible	See Plan H
Preferred brand	\$30 per supply \$50 per 30-a sly if	See Plands abook	\$30 per 30 do hy if	See Pl dbook	\$30 day supply	See P' dbook	20% ductible	See Pla Joook
Non-preferred brand ⁴	criteria me	S Handbook	\$50 per 30-day v if criteria met	9 Handbook	\$50 per 3 supply if criteria.	n Handbook	20% after 'ble	S 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 sur	Plan Handbook	\$20 per 90-day su	Plan Handbook	\$20 per 90-day sv	See Plan Handbook	20% after deductib	See Plan Handbook
Preferred Brand	\$60 per 90-day	n Handbook	\$60 per 90-day	S. Handbook	\$60 per 90-d2 ,y	Plan Handbook	20% after ded	Plan Handbook
Non-preferred brand⁴	\$100 per 90 apply if critical et	See Fig. 2dbook	\$100 per 90 apply if crimet	See Pla. 1book	\$100 per 90 apply if	Se Handbook	20% afte uble	Sec Yandbook
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.



Plans 1-4

Please see Plan Handbook for details.

No lifetime maximum on any medical plans.		Medical Plan 1 Connexus Netwo		Medical Plan 2 Connexus Network				Medical Plan 3 Connexus Networ	k	Medical Plan 4 Connexus Network		
Plan Year Costs ⁵	In-Network Coordinated Cark Member Pays	In-Network `nn-Coordine' Care ⁶	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		\$800	\$800	\$900	\$1,600	\$1,200	\$1,300	\$2,400	\$1,600	\$1,700	\$3,200
Maximum deductible per family	\$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	\$3,25	\$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	ofter u le	\$0 ¹	\$0 ¹	50% after deductible	\$0 ¹	\$0 ¹	50% after deductible	\$O ¹	\$0 ¹	50% after deductible
Office Visits and Virtual Care												
Primary care office visits	\$201,5	20% after deductible	e 50% after deductible	\$201,5	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)		N/A	50% ductible	\$40¹	N/A	50% after deductible	\$50¹	N/A	50% after deductible	\$50¹	N/A	50% after deductible
Incentive care office visits (Moda plans only)	\$15	20% after deductible	e 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	\$401	after dec'	50% after deductible	\$40¹	20% after deductible	50% after deductible	\$50¹	25% after deductible	50% after deductible	\$50¹	25% after deductible	50% after deductible
Urgent care	\$401	الاال عد	e 20% after deductible	\$40¹	20% after deductible	20% after deductible	\$50¹	25% after deductible	25% after deductible	\$50¹	25% after deductible	25% after deductible
Mental Health and Chemical Dependency Services												
Mental health office visits	\$201		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	after de	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)	\$201	\$20 ¹	% 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 d .e	20% after deductible	e fter 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%eductible	20% after deductible	e 50% a Juctible	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	e 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% ductible	20% after deductible	e 50% ductible	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 cu, 20% after deal	\$100 copay + 20% after deductible	yay + 50% 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	after de	50% after deductible	\$20¹	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	\$40¹	alble	e 50% after deductible	\$40¹	20% after deductible	50% after deductible	\$50¹	25% after deductible	50% after deductible	\$50¹	25% after deductible	50% after deductible
Maternity Care												
Routine maternity care	20% after deductible	الم الم	e 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 deduct	% after dedu	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							50% after deductible			
Skilled nursing facility care	20%eductible	20% after deductible	e 50% a Juctible	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



Plans 1-4 – continued

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 Cool of Care ⁵ Mei vs In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of- Ne* *k s r Pays	I CONTRINSTAN I STAS	In-Network Ion-Coordinated Care ⁶ Member Pays	Any Out-of- Network Services Member Pays	In-Network Coordinated Care⁵ Member Pays	In-Network Non-Coordinated Care ^s 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 + 50% 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 + 50% after deductible	\$500 copay + 20% \$5 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 deduct	lu.	\$100 copa	ay + 20% after ded	uctible	\$100 c	copay + 25% after dec	luctible	\$100 0	copay + 25% after ded	uctible	
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 00P Max		Rx app	plies toward OOP M	ax	Rx	applies toward OOP M	lax	Rx	applies toward OOP M	ax	
Retail												
Value	or 31-day supply		\$4 per 31-day	/ supply		\$4 per 31-	day supply		\$4 per 31-	day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$1 day supply	see Plan	\$12 per 31-day		See Plan	\$12 per 31-	- ' ' '	See Plan	\$12 per 31-		See Plan	
Preferred brand	25% up to \$ 31-day supply	Handbook	25% up to \$75 per 3		Handbook	25% up to \$75 p		Handbook	25% up to \$75 p		Handbook	
Non-preferred brand ⁴	50% up to \$175, day sur		50% up to \$175 per	31-day supply		50% up to \$175 p	per 31-day supply		50% up to \$175 p	per 31-day supply		
Mail												
Value	\$8 per 90-day 9		\$8 per 90-day			\$8 per 90-			\$8 per 90-			
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90-	See Plan	\$24 per 90-da		See Plan	\$24 per 90		See Plan	\$24 per 90	, ,,,	See Plan	
Preferred brand	25% up to \$15	Handbook	25% up to \$150 per	90-day supply	Handbook	25% up to \$150 p		Handbook	25% up to \$150 p	per 90-day supply	Handbook	
Non-preferred brand ⁴	50% up toer 90-day supply		50% up to \$450 per	90-day supply		50% up to \$450 p	per 90-day supply		50% up to \$450 p	per 90-day supply		
Specialty												
Generic (Moda Plans only)	\$12 r ay supply or \$36 per 90-day supply when allowed		\$12 per 31-day supply o supply when a	allowed		\$12 per 31-day supp supply whe	en allowed		\$12 per 31-day supp supply who	en allowed		
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed	See Plan Handbook	25% up to \$200 per 3 \$400 for 90-day supp		See Plan Handbook	25% up to \$200 pe \$400 for 90-day su		See Plan Handbook	25% up to \$200 pe \$400 for 90-day su		See Plan Handbook	
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 or \$1,000 for 90-day sup			50% up to \$500 pe \$1,000 for 90-day s			50% up to \$500 pe \$1,000 for 90-day s		напироок	

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.



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	\$1,6002	\$1,700 ²	\$3,2002	\$2,000 ²	\$2,100 ²	\$4,000²
Maximum deductible per family	\$6,300	\$6,300	\$12,600	\$3,4002	\$3,4002	¢6,400²	\$4	\$4,200 ²	$3,000^2$
Out-of-pocket (OOP) maximum per person ³	\$6,800	\$7,200	\$13,700	\$6,4	\$6,7502	3,1002	\$6,5	\$6,7502	13,300 ²
Out-of-pocket (OOP) maximum per family ³	\$15,800	\$15,800	\$27,400	\$13,500	\$13,500 ²	\$26,2002	\$13,500	\$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	\$301,5	25% after deductible	50% after deductible	15% after deductible	20% ductible	50% after deductible	20% after deductible	25% auctible	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		50% after deductible	20% after deductible		50% after deductible
Incentive care office visits (Moda plans only)	\$25 ¹	25% after deductible	N/A	15% after deductible	after de	N/A	20% after deductible	after de	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	\$0 ¹	\$0 ¹	Not covered	\$0 after deductible		Not covered	\$0 after deductible	φ0 after deduct.	Not covered
Specialist office visits	\$50 ¹	25% after deductible	50% after deductible	15% after dedu	20% after deductible	% after deductible	20% after dedy	25% after deductible	% after deductible
Urgent care	\$50 ¹	25% after deductible	25% after deductible	15% after d	20% after deductible	'an Handbook	20% after c' sie	25% after deductible	'an Handbook
Mental Health Services									
Mental health office visits	\$301	\$301	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	\$30¹	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 o	25% after deductible	50° deductible	20% after ble	25% after deductible	5° deductible
Outpatient rehabilitation (physical, occupational & speech therapy)	25% after deductible	25% after deductible	50% after deductible	20% after deduc	25% after deductible	ater deductible	20% after deal	25% after deductible	after deductible
Diagnostic Testing									
Labs, x-ray, and imaging	25% after deductible	25% after deductible	50% after deductible	20% after deductible	fter deduc	50% after deductible	20% after deductible	after dedu	50% after deductible
CT, MRI, PET scans	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	20% after deductible	25% Je	50% after deductible	20% after deductible	24	50% after deductible
	after deductible	after deductible	after deductible	20 % after deductible	25/6	50 % arter deductible	20 % arter deductible	2.5	50 % arter deductible
Alternative Care Services									
Acupuncture and Chiropractic ⁷	\$30¹	25% after deductible	50% after deductible	20% after deductible	2' deu.	50% after deductible	20% after deductible	er ac	50% after deductible
Naturopathic Services	\$50¹	25% after deductible	50% after deductible	15% after deductible	after deduct.	50% after deductible	20% after deductible	s after deduc	50% after deductible
Maternity Care									
Outpatient maternity care	25% after deductible	25% after deductible	50% after deductible	20% after ded	25% after deductible	or deductible	20% after deg	25% after deductible	fter deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	25% after deductible	25% after deductible	50% after deductible	20% after sole	25% after deductible	50% ductible	20% afte able	25% after deductible	50 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



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-No Coordinate 5 Member Pa,	In-Network Non-Coordinate Care ⁶ Member	ny Out-of-Network Services Member Pays	In-Network Coordinated Care Member Pays	In-Network Non-Coordinated Care ⁶ mber Pays	c-of-Network Services Member Pays
Emergency Services									
Emergency room (copay waived if admitted)	\$100) copay + 25% after dedu	ctible	20% after deductible	Jeductible	See Plan Handbook	20% after deductible	25% aıole	See Plan Handbook
Ambulance		25% after deductible		20% after deductible	deductible	See Plan Handbook	20% after deductible	25% le	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 deduc	25% after dec	50% after deductible	20% after deductible	₀ after deductible	% after deductible
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible	20% after sole	25% after deductib.	50% after deductible	20% after dedu	25% after deductible	or deductible
Pharmacy Services									
Out-of-pocket (OOP) maximum	Rx applies toward OOP max			Rx applies toward plan 00P max			Rx	applies toward plan OOP r	max
Retail									
Value	\$4 per 31	-day supply		\$4 ¹ per 31-day supply				l-day supply	
Generic (Kaiser Plans) / Select generic (Moda Plans)	·	-day supply	See Plan		25% after deductible	See Plan Handbook	20% after tible	25% after deductible	an
Preferred brand		per 31-day supply	Handbook	20% after deductible	25% 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 deduction 25% after deductible		
Mail									
Value	\$8 per 90			\$8 ¹ pe	'ay supply		\$8 ¹ per 90		
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90	-day supply	See Plan	20% after deductible	% after deductible	See Plan	20% after deductible	25%le	See Plan
Preferred brand	25% up to \$150	per 90-day supply	Handbook	20% after deductible	∠ 'er deducti ⁱ	Handbook	20% after deductible	25% * tible	Handbook
Non-preferred brand ⁴	50% up to \$450	per 90-day supply		20% after deductible	25% '-c'		20% after deductible	25 . dt	
Specialty									
Generic (Moda Plans only)	\$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			20% after deductible	25% dedu.		20% after deducti	25% after deductible	
Select generic (Kaiser plans) / Preferred brand (Moda Plans)			See Plan Handbook	20% after deductible	₀ after deductible	See Plan Handbook	20% after Jie	25% after deductible	Plan bok
Non-preferred brand ⁴		day supply or \$1,000 for when allowed		20% after dedur	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

Please see Plan Handbook for details.	Delta Dental of Oregon & Alaska	Delta Dental of Oregon & Alaska	△ DELTA DENTAL Delta Dental of Oregon & Alaska	△ DELTA DENTAL* Delta Dental of Oregon & Alaska	Delta Dental of Oregon & Alaska	KAISER PERMANENTE»	Willamette Willamette Dental Group
Dental	Premier Plan 1 ¹	Premier Plan 5¹	Premier Plan 6	Exclusive PPO – Incentive Plan ¹	Exclusive PPO Plan	Kaiser Dental Plan	Willamette Dental Plan
Network	Delta Dental Premier	Delta Dental Premier	Delta Dental Premier	L. od Network Plan – D Oental PPO ²	Limited Network Plan – Delta Dental PPO ²	Lin. Network Plan – Ko Pe. nente Faciliti	Limited Network Plan – Willamette Dental Group Facilities ²
Dental Office Visit Copay	N/A	N/A	N/A	N/A	N/A	203	\$20 ³
Benefit Maximum	\$2,2004	\$1,7004	\$1,200	\$2	500	\$4	N/A
Deductible	\$50	\$50	\$50	ال		./A	N/A
Preventive & Diagnostic Services – Deductible Waived for Preventive	e & 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%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	30%1	100%³	100%³
Simple Extraction							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% 0% each 7 Year	90%	700	100%³
Oral Surgery							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10° Plan Year	90%	Cop	\$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%	7' + 10% each Plan r	1/6	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 r	80%	\$250 Copay ³	\$250 Copay ^{3, 5}
Implants	70% + 10% each Plan Year	50%	50%	7c 10% each 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 5 ye.	50% up to \$\text{\$\text{\$\text{\$\text{\$}}}\$ once every \$\text{\$\text{\$\text{\$years}}\$}	65%, onc 5 years	100% once every 2 years
Athletic mouth guards	50%	50%	50%	50%	50%	65% e every 12. ths	\$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	\$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.

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 Dental Benefits 2024–2025 Plan Year



Summary of Vision Benefits 2024–2025 Plan Year













	PERMANENTE _®	HEALTH	HEALTH	HEALTH	Vision Care	Vision Care		
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 the Kaiser Permaner al plan (does not applied the vice olan year maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pa₃ 10% ₅10 copay	Plan pays after \$10 copay		
Frequency:	As needed	Once per plan year	Once per plan year	Once per plan year	pêl, rear	once per plan		
Lenses:								
Basic lens benefit:	Under age 19: No charge for one pair of standard frames and lenses or contacts	Plan pays 100% (up to plan	Plan pays 100% (up to plan	Plan pays 100% (up to plan	\$20 copay (ar owards lenses & frame, s or plastic single vision, lined al, lined trifocal, or lenticular covered in full. Polycarbonate lenses, scratch resistant and UV coaungs covered in full	\$20 copay (applied towards lenses & frame): colors or plastic single vision, lined thifocal, lined trifocal, or lenticular lenses covered in full. Scratch resistand UV coatings covered to all. Polycarbonate lenses ared in full for deposited children		
Lens enhancements:	Age 19+: Plan p. 100% (un plan	Age 19+: maximum)		maximum)	\$0 cc for standard progressive es \$15 cc for anti-reflective ing or premium tom progre lenses	\$0 cope stap progressive lenses Discounts for polyca or adults, anti-reflective coating or premium m progressive lenses		
Frequency:	Once pic ear	Once per plan year	Once per plan year	Once per plan year	Once ,	Once per vear		
Frames								
Benefit:	Ur age 19: No charge 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 up to retail allowant \$300; 20% off unt over retail allowance mes	Covered in full up to retail allowance of \$150; 20% off amount over retail allowance for frames		
Frequency:	e 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	On er plan year	e per pl dr		
Contacts (in lieu of frames an								
Benefit:	Under age tharge for ntacts Age 1° Plan pays 100% 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 tail allowater \$300	Covere all up to retail allonge 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.

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 oebb.benefits@odhsoha.oregon.gov. We accept all relay calls or you can dial 711.

200-560903_MSC 3707_25 (05/2024)

OEBB Summary of Vision Benefits 2024–2025 Plan Year