

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan year costs ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	\$950	\$1,050	\$1,350	\$1,350	\$1,450	\$2,150	\$1,750	\$1,850	\$2,950	\$2,150	\$2,250	\$3,750
Maximum deductible per family	\$2,100	\$2,100	\$2,700	\$2,900	\$2,900	\$4,300	\$3,700	\$3,700	\$5,900	\$4,500	\$4,500	\$7,500
Out-of-pocket (OOP) maximum per person ³	\$4,000	\$4,400	\$7,150	\$5,000	\$5,400	\$9,150	\$6,000	\$6,400	\$11,150	\$7,850	\$8,250	\$14,850
Out-of-pocket (OOP) maximum per family ³	\$8,800	\$8,800	\$14,300	\$10,800	\$10,800	\$18,300	\$12,800	\$12,800	\$22,300	\$16,500	\$16,500	\$29,700
Preventive care services												
Routine adult, well-child and women’s exams; annual obesity  screening and 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	\$35 ^{1,5}	20% after deductible	50% after deductible	\$35 ^{1,5}	20% after deductible	50% after deductible	\$40 ^{1,5}	25% after deductible	50% after deductible	\$40 ^{1,5}	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$55 ¹	Not applicable	50% after deductible	\$55 ¹	Not applicable	50% after deductible	\$65 ¹	Not applicable	50% after deductible	\$65 ¹	Not applicable	50% after deductible
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	\$55 ¹	20% after deductible	50% after deductible	\$55 ¹	20% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible
Urgent care	\$55 ¹	20% after deductible	20% after deductible	\$55 ¹	20% after deductible	20% after deductible	\$65 ¹	25% after deductible	25% after deductible	\$65 ¹	25% after deductible	25% after deductible

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan year costs ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Mental health and chemical dependency services												
Mental health office visits	\$35 ¹	\$35 ¹	50% after deductible	\$35 ¹	\$35 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible
Mental health inpatient and residential services	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	\$35 ¹	\$35 ¹	50% after deductible	\$35 ¹	\$35 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible
Chemical dependency services (inpatient)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient services												
Outpatient surgery / facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational and speech therapy)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Diagnostic testing												
Labs, x-ray, and imaging	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	\$100 copay + 20% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 20% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible
Alternative care services ⁷												
Acupuncture and Chiropractic ⁷	\$35 ¹	20% after deductible	50% after deductible	\$35 ¹	20% after deductible	50% after deductible	\$40 ¹	25% after deductible	50% after deductible	\$40 ¹	25% after deductible	50% after deductible
Naturopathic office visits	\$55 ¹	20% after deductible	50% after deductible	\$55 ¹	20% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan year costs ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Maternity care												
Routine maternity care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Physician or midwife services and hospital stay, delivery and routine newborn nursery care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Hospital services												
Inpatient care / surgery	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Additional Cost Tier (ACT)												
Moda Plans Only: \$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 + 20% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 20% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible
Moda Plans Only: \$500 ACT: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 20% after deductible	\$500 copay + 20% after deductible	\$500 copay + 50% after deductible	\$500 copay + 20% after deductible	\$500 copay + 20% after deductible	\$500 copay + 50% after deductible	\$500 copay + 25% after deductible	\$500 copay + 25% after deductible	\$500 copay + 50% after deductible	\$500 copay + 25% after deductible	\$500 copay + 25% after deductible	\$500 copay + 50% after deductible
Emergency services												
Emergency room (copay waived if admitted)	\$100 copay + 20% after deductible			\$100 copay + 20% after deductible			\$100 copay + 25% after deductible			\$100 copay + 25% after deductible		
Ambulance	20% after deductible			20% after deductible			25% after deductible			25% after deductible		

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Plan year costs ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	
Other covered services													
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	
Durable medical equipment (DME)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	
Pharmacy services													
Out-of-pocket (OOP) maximum	Rx applies toward OOP maximum			Rx applies toward OOP maximum			Rx applies toward OOP maximum			Rx applies toward OOP maximum			
Retail													
Value	\$4 per 31-day supply		See plan handbook	\$4 per 31-day supply		See plan handbook	\$4 per 31-day supply		See plan handbook	\$4 per 31-day supply		See plan handbook	
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31-day supply			\$12 per 31-day supply			\$12 per 31-day supply						
Preferred brand	25% up to \$75 per 31-day supply			25% up to \$75 per 31-day supply			25% up to \$75 per 31-day supply						
Non-preferred brand ⁴	50% up to \$350 per 31-day supply			50% up to \$350 per 31-day supply			50% up to \$350 per 31-day supply						
Mail													
Value	\$8 per 90-day supply		See plan handbook	\$8 per 90-day supply		See plan handbook	\$8 per 90-day supply		See plan handbook	\$8 per 90-day supply		See plan handbook	
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90-day supply			\$24 per 90-day supply			\$24 per 90-day supply						
Preferred brand	25% up to \$150 per 90-day supply			25% up to \$150 per 90-day supply			25% up to \$150 per 90-day supply						
Non-preferred brand ⁴	50% up to \$900 per 90-day supply			50% up to \$900 per 90-day supply			50% up to \$900 per 90-day supply						

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

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan year costs ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Specialty												
Generic (Moda Plans only)	\$12 per 31-day supply or \$36 per 90-day supply when allowed		See plan handbook	\$12 per 31-day supply or \$36 per 90-day supply when allowed		See plan handbook	\$12 per 31-day supply or \$36 per 90-day supply when allowed		See plan handbook	\$12 per 31-day supply or \$36 per 90-day supply when allowed		See plan handbook
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed			25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed			25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed			25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed		
Non-preferred brand ⁴	50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed			50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed			50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed			50% up to \$1,000 per 31-day supply or \$2,000 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 
- 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.**

 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			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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Deductible per person				\$2,550	\$2,650	\$4,550	\$2,150 ²	\$2,250 ²	\$3,750 ²	\$2,550 ²	\$2,650 ²	\$4,550 ²
Maximum deductible per family				\$5,300	\$5,300	\$9,100	\$4,500 ²	\$4,500 ²	\$7,500 ²	\$5,300 ²	\$5,300 ²	\$9,100 ²
Out-of-pocket (OOP) maximum per person ³				\$7,950	\$8,350	\$14,850	\$7,550 ²	\$7,900 ²	\$14,250 ²	\$7,650 ²	\$7,900 ²	\$14,450 ²
Out-of-pocket (OOP) maximum per family ³				\$16,700	\$16,700	\$29,700	\$15,800 ²	\$15,800 ²	\$28,500 ²	\$15,800 ²	\$15,800 ²	\$28,900 ²
Preventive care services												
Routine adult, well-child and women’s exams; annual obesity screening and 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				\$45 ^{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)				\$65 ¹	Not applicable	50% after deductible	15% after deductible	Not applicable	50% after deductible	20% after deductible	Not applicable	50% after deductible
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				\$65 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				\$65 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				\$45 ¹	\$45 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)				\$45 ¹	\$45 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

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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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
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 and speech therapy)				25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Diagnostic testing												
Labs, x-ray, and imaging				25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans 				\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative care services												
Acupuncture and Chiropractic ⁷				\$45 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				\$65 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												
Routine 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 and hospital stay, delivery and 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

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Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Additional cost tier (ACT)									
Moda Plans only: \$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	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Moda Plans only: \$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	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Emergency services									
Emergency room (copay waived if admitted)	\$100 copay + 25% after deductible			20% after deductible	25% after deductible	See plan handbook	20% after deductible	25% after deductible	See plan handbook
Ambulance	25% after deductible			20% after deductible	25% after deductible	See plan handbook	20% after deductible	25% after deductible	See plan handbook
Other covered services									
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Pharmacy services									
Out-of-pocket (OOP) maximum	Rx applies toward OOP maximum			Rx applies toward plan OOP maximum			Rx applies toward plan OOP maximum		
Retail									
Value	\$4 per 31-day supply		See plan handbook	\$4 ¹ per 31-day supply		See plan handbook	\$4 ¹ per 31-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to \$75 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand ⁵	50% up to \$350 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

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Mail									
Value	\$8 per 90-day supply		See plan handbook	\$8 ¹ per 90-day supply		See plan handbook	\$8 ¹ per 90-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to \$150 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand ⁴	50% up to \$900 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Specialty									
Generic (Moda Plans only)	\$12 per 31-day supply or \$36 per 90-day supply when allowed		See plan handbook	20% after deductible	25% after deductible	See plan handbook	20% after deductible	25% after deductible	See plan handbook
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to \$200 per 31-day supply or \$400 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand ⁴	50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

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.



2026–27 Benefits Comparison

Dental Plans

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



Dental	Premier Plan 1 ¹	Premier Plan 5 ¹	Premier Plan 6	Willamette Dental Plan
Network	Delta Dental Premier	Delta Dental Premier	Delta Dental Premier	Limited Network Plan Willamette Dental Facilities ²
Dental office visit copay	Not applicable	Not applicable	Not applicable	\$20 ³
Benefit maximum	\$2,200 ⁴	\$1,700 ⁴	\$1,200	Not applicable
Deductible	\$50	\$50	\$50	Not applicable
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%
Routine fillings, inlays and stainless steel crowns	70% + 10% ¹ each plan year	70% + 10% ¹ each plan year	80% ¹	100% ³
Simple tooth extractions	70% + 10% each plan year	70% + 10% each plan year	80%	100% ³
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each plan year	70% + 10% each plan year	80%	\$50 copay ³
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each plan year	70% + 10% each plan year	80%	100% ³
Root canal and related therapy including diagnosis and evaluation	70% + 10% each plan year	70% + 10% each plan year	80%	\$50 copay ³

Dental Plans — continued

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

 DELTA DENTAL[®]  DELTA DENTAL[®] Delta Dental of Oregon & Alaska  DELTA DENTAL[®] Delta Dental of Oregon & Alaska  Willamette Dental				
Dental	Premier Plan 1 ¹	Premier Plan 5 ¹	Premier Plan 6	Willamette Dental Plan
Gold or porcelain crowns and onlays	70% + 10% each plan year	70%	50%	\$250 copay ^{3, 5}
Implants	70% + 10% each plan year	50%	50%	Implant surgery up to \$1,500 calendar year maximum ⁵
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	100% once every 2 years
Athletic mouth guards	50%	50%	50%	\$100 copay ³
Nitrous Oxide	50%	50%	50%	\$15 copay ³
Full and partial dentures, relines, rebases	70% + 10% each plan year	50%	50%	\$100 copay ^{3, 5}
Bridge retainers and pontics	70% + 10% each plan year	50%	50%	\$250 copay ^{3, 5}
Orthodontic treatment	80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	No ortho coverage on this plan	\$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  If you have a dental emergency outside our service area, you may go to the nearest dental office  Member pays the cost share that normally applies for non-emergency dental care services, plus amounts that exceed Usual and Customary Charges for qualifying claims 
- 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 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.**

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



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	Not applicable	Not applicable
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	Once per plan year	Once per plan year	Once per plan year
Basic lens benefit	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	\$20 copay (applied towards lenses and 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 and frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full  Scratch resistant and UV coatings covered in full  Polycarbonate lenses covered in full for dependent children
Lens enhancements				\$0 copay for standard progressive lenses \$15 copay for anti-reflective coating and premium/custom progressive lenses	\$0 copay for standard progressive lenses Discounts for polycarbonate for adults, anti-reflective coating, and premium/custom progressive lenses
Frequency	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year
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 after \$20 copay up to retail allowance of \$300; 20% off amount over retail allowance for frames	Covered in full after \$20 copay up to retail allowance of \$150; 20% off amount over retail allowance for frames

Vision Plans — continued

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

					
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
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
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; up to \$60 copay for contact lens fitting and evaluation exam	Covered in full up to retail allowance of \$150; up to \$60 copay for contact lens fitting and evaluation exam
Frequency	Up to the plan maximum	Up to the plan maximum	Up to the plan maximum	Once per plan year	Once per plan year
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

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

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