



# Summary of Medical and Pharmacy Benefits 2023–2024 Plan Year

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Please see Plan Handbook for details.

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

| No lifetime maximum on any medical plans.   | Medical Plan 1<br>Kaiser Permanente Network     |                               |  | Medical Plan 2B<br>Kaiser Permanente Network    |                               | Medical Plan 3<br>Kaiser Permanente Network<br><i>HSA Optional</i> |                               |
|---|---|-------------------------------|--|---|-------------------------------|--|-------------------------------|
|   | In-Network<br>Member Pays                       | Out-of-Network<br>Member Pays |  | In-Network<br>Member Pays                       | Out-of-Network<br>Member Pays | In-Network<br>Member Pays  | Out-of-Network<br>Member Pays |
| <b>Additional Cost Tier</b>   |   |                               |  |   |                               |  |                               |
| <b>Moda Plans Only:</b> \$100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies | N/A   | N/A                           |  | N/A   | N/A                           | N/A  | N/A                           |
| <b>Moda Plans Only:</b> \$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement <sup>3</sup> , knee & shoulder arthroscopy, uncomplicated hernia repair   | N/A   | N/A                           |  | N/A   | N/A                           | N/A  | N/A                           |
| <b>Emergency Services</b>   |   |                               |  |   |                               |  |                               |
| Emergency room (copay waived if admitted)   | \$100 per visit (waived if admitted)            |                               |  | 20% after deductible                            |                               | 20% after deductible   |                               |
| Ambulance   | \$75  |                               |  | \$100 <sup>1</sup>                              |                               | 20% 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%   | Not Covered                   |  | 10% <sup>1</sup>                                | Not Covered                   | 20% after deductible   | Not Covered                   |
| Durable medical equipment (DME)   | 20%   | Not Covered                   |  | 20% <sup>1</sup>                                | Not Covered                   | 20% after deductible   | Not Covered                   |
| <b>Pharmacy Services</b>  |   |                               |  |   |                               |  |                               |
| Out-of-pocket (OOP) maximum   | \$1100 - Rx max also applies to Medical OOP Max |                               |  | \$1100 - Rx max also applies to Medical OOP Max |                               | Rx applies toward plan OOP max                                     |                               |
| <b>Retail</b>   |   |                               |  |   |                               |  |                               |
| Value   | N/A   | N/A                           |  | N/A   | N/A                           | \$0 <sup>7</sup>   | N/A                           |
| Generic (Kaiser Plans) / Select generic (Moda Plans)  | \$5 per 30-day supply                           | See Plan Handbook             |  | \$5 per 30-day supply                           | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |
| Preferred brand   | \$25 per 30-day supply                          | See Plan Handbook             |  | \$25 per 30-day supply                          | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |
| Non-preferred brand <sup>4</sup>  | \$45 per 30-day supply if criteria met          | See Plan Handbook             |  | \$45 per 30-day supply if criteria met          | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |
| <b>Mail</b>   |   |                               |  |   |                               |  |                               |
| Value   | N/A   | N/A                           |  | N/A   | N/A                           |  |                               |
| Generic (Kaiser plans) / Select generic (Moda Plans)  | \$10 per 90-day supply                          | See Plan Handbook             |  | \$10 per 90-day supply                          | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |
| Preferred Brand   | \$50 per 90-day supply                          | See Plan Handbook             |  | \$50 per 90-day supply                          | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |
| Non-preferred brand <sup>4</sup>  | \$90 per 90-day supply if criteria met          | See Plan Handbook             |  | \$90 per 90-day supply if criteria met          | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |
| <b>Specialty</b>  |   |                               |  |   |                               |  |                               |
| Generic (Moda Plans only)   | N/A   | N/A                           |  | N/A   | N/A                           | N/A  | N/A                           |
| Select generic (Kaiser plans) / Preferred brand (Moda Plans)  | 25% up to \$100 per 30-day supply               | See Plan Handbook             |  | 25% up to \$100 per 30-day supply               | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |
| Non-preferred brand <sup>4</sup>  | 25% up to \$100 per 30-day supply               | See Plan Handbook             |  | 25% up to \$100 per 30-day supply               | See Plan Handbook             | 20% after deductible   | See Plan Handbook             |

N/A – Not applicable

After ded – 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 and is not intended to fully describe the benefits of each plan. Refer to your  member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.**

| No lifetime maximum on any medical plans.   |  |  |   |  |  |   |  |  |   |  |  |   |
|---|--|--|---|--|--|---|--|--|---|--|--|---|
| Plan Year Costs <sup>5</sup>  | Medical Plan 1<br>Connexus Network                   |  |   | Medical Plan 2<br>Connexus Network                   |  |   | Medical Plan 3<br>Connexus Network                   |  |   | Medical Plan 4<br>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 | 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   | \$400  | \$500  | \$800                                   | \$800  | \$900  | \$1,600                                 | \$1,200  | \$1,300  | \$2,400                                 | \$1,600  | \$1,700  | \$3,200                                 |
| Maximum deductible per family   | \$1,500  | \$1,500  | \$2,400                                 | \$2,700  | \$2,700  | \$4,800                                 | \$3,900  | \$3,900  | \$7,200                                 | \$5,100  | \$5,100  | \$9,600                                 |
| Out-of-pocket (OOP) maximum per person <sup>3</sup>   | \$2,850  | \$3,250  | \$6,000                                 | \$3,850  | \$4,250  | \$8,000                                 | \$4,850  | \$5,250  | \$10,000                                | \$6,700  | \$7,100  | \$13,700                                |
| Out-of-pocket (OOP) maximum per family <sup>3</sup>   | \$9,750  | \$9,750  | \$18,000                                | \$12,750   | \$12,750   | \$24,000                                | \$15,750   | \$15,750   | \$27,400                                | \$15,800   | \$15,800   | \$27,400                                |
| <b>Preventive Care Services</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| Routine adult, well-child and women's exams; annual obesity screening & immunizations.      | \$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                    | \$0 <sup>1</sup>                                     | \$0 <sup>1</sup>   | 50% after deductible                    |
| <b>Office Visits and Virtual Care</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| Primary care office visits  | \$20 <sup>1.5</sup>                                  | 20% after deductible                                     | 50% after deductible                    | \$20 <sup>1.5</sup>                                  | 20% after deductible                                     | 50% after deductible                    | \$25 <sup>1.5</sup>                                  | 25% after deductible                                     | 50% after deductible                    | \$25 <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) | \$40 <sup>1</sup>                                    | N/A  | 50% after deductible                    | \$40 <sup>1</sup>                                    | N/A  | 50% after deductible                    | \$50 <sup>1</sup>                                    | N/A  | 50% after deductible                    | \$50 <sup>1</sup>                                    | N/A  | 50% after deductible                    |
| Incentive care office visits (Moda plans only)  | \$15 <sup>1</sup>                                    | 20% after deductible                                     | N/A                                     | \$15 <sup>1</sup>                                    | 20% after deductible                                     | N/A                                     | \$20 <sup>1</sup>                                    | 25% after deductible                                     | N/A                                     | \$20 <sup>1</sup>                                    | 25% after deductible                                     | N/A                                     |
| Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)                              | \$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                             | \$0 <sup>1</sup>                                     | \$0 <sup>1</sup>   | Not covered                             |
| Specialist office visits  | \$40 <sup>1</sup>                                    | 20% after deductible                                     | 50% after deductible                    | \$40 <sup>1</sup>                                    | 20% after deductible                                     | 50% after deductible                    | \$50 <sup>1</sup>                                    | 25% after deductible                                     | 50% after deductible                    | \$50 <sup>1</sup>                                    | 25% after deductible                                     | 50% after deductible                    |
| Urgent care   | \$40 <sup>1</sup>                                    | 20% after deductible                                     | 20% after deductible                    | \$40 <sup>1</sup>                                    | 20% after deductible                                     | 20% after deductible                    | \$50 <sup>1</sup>                                    | 25% after deductible                                     | 25% after deductible                    | \$50 <sup>1</sup>                                    | 25% after deductible                                     | 25% after deductible                    |
| <b>Mental Health and Chemical Dependency Services</b>                                       |  |  |   |  |  |   |  |  |   |  |  |   |
| Mental health office visits   | \$20 <sup>1</sup>                                    | \$20 <sup>1</sup>  | 50% after deductible                    | \$20 <sup>1</sup>                                    | \$20 <sup>1</sup>  | 50% after deductible                    | \$25 <sup>1</sup>                                    | \$25 <sup>1</sup>  | 50% after deductible                    | \$25 <sup>1</sup>                                    | \$25 <sup>1</sup>  | 50% after deductible                    |
| Mental health inpatient and residential services  | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    |
| Chemical dependency services (outpatient or residential)                                    | \$20 <sup>1</sup>                                    | \$20 <sup>1</sup>  | 50% after deductible                    | \$20 <sup>1</sup>                                    | \$20 <sup>1</sup>  | 50% after deductible                    | \$25 <sup>1</sup>                                    | \$25 <sup>1</sup>  | 50% after deductible                    | \$25 <sup>1</sup>                                    | \$25 <sup>1</sup>  | 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                    |
| <b>Outpatient Services</b>  |  |  |   |  |  |   |  |  |   |  |  |   |
| Outpatient surgery/facility care  | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    |
| Outpatient rehabilitation (physical, occupational & speech therapy)                         | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    |
| <b>Tests (outpatient)</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| 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      |
| <b>Alternative Care Services<sup>7</sup></b>  |  |  |   |  |  |   |  |  |   |  |  |   |
| Acupuncture and Chiropractic <sup>7</sup>   | \$20 <sup>1</sup>                                    | 20% after deductible                                     | 50% after deductible                    | \$20 <sup>1</sup>                                    | 20% after deductible                                     | 50% after deductible                    | \$25 <sup>1</sup>                                    | 25% after deductible                                     | 50% after deductible                    | \$25 <sup>1</sup>                                    | 25% after deductible                                     | 50% after deductible                    |
| Naturopathic office visits  | \$40 <sup>1</sup>                                    | 20% after deductible                                     | 50% after deductible                    | \$40 <sup>1</sup>                                    | 20% after deductible                                     | 50% after deductible                    | \$50 <sup>1</sup>                                    | 25% after deductible                                     | 50% after deductible                    | \$50 <sup>1</sup>                                    | 25% after deductible                                     | 50% after deductible                    |
| <b>Maternity Care</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| Routine maternity care  | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    |
| Physician or midwife services & hospital stay, delivery & routine newborn nursery care      | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    |
| <b>Hospital Services</b>  |  |  |   |  |  |   |  |  |   |  |  |   |
| Inpatient care/surgery  | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    |
| Skilled nursing facility care   | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 20% after deductible                                 | 20% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    | 25% after deductible                                 | 25% after deductible                                     | 50% after deductible                    |

| No lifetime maximum on any medical plans.   | Medical Plan 1<br>Connexus Network   |  |   | Medical Plan 2<br>Connexus Network   |  |   | Medical Plan 3<br>Connexus Network   |  |   | Medical Plan 4<br>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 | 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>Plan Year Costs<sup>5</sup></b>  |  |  |   |  |  |   |  |  |   |  |  |   |
| <b>Additional Cost Tier</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| <b>Moda Plans Only:</b> \$100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies | \$100 copay + 20% after deductible   | \$100 copay + 20% after deductible                       | \$100 copay + 50% after deductible      | \$100 copay + 20% after deductible   | \$100 copay + 20% after deductible                       | \$100 copay + 50% after deductible      | \$100 copay + 25% after deductible   | \$100 copay + 25% after deductible                       | \$100 copay + 50% after deductible      | \$100 copay + 25% after deductible   | \$100 copay + 25% after deductible                       | \$100 copay + 50% after deductible      |
| <b>Moda Plans Only:</b> \$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair   | \$500 copay + 20% after deductible   | \$500 copay + 20% after deductible                       | \$500 copay + 50% after deductible      | \$500 copay + 20% after deductible   | \$500 copay + 20% after deductible                       | \$500 copay + 50% after deductible      | \$500 copay + 25% after deductible   | \$500 copay + 25% after deductible                       | \$500 copay + 50% after deductible      | \$500 copay + 25% after deductible   | \$500 copay + 25% after deductible                       | \$500 copay + 50% after deductible      |
| <b>Emergency Services</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| 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   |  |   |
| <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                    | 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                    |
| <b>Pharmacy Services</b>  |  |  |   |  |  |   |  |  |   |  |  |   |
| Out-of-pocket (OOP) maximum   | Rx applies toward OOP Max  |  |   | Rx applies toward OOP Max  |  |   | Rx applies toward OOP Max  |  |   | Rx applies toward OOP Max  |  |   |
| <b>Retail</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| Value   | \$4 per 31-day supply  |  | See Plan Handbook                       | \$4 per 31-day supply  |  | See Plan Handbook                       | \$4 per 31-day supply  |  | See Plan Handbook                       | \$4 per 31-day supply  |  | See Plan Handbook                       |
| Generic (Kaiser Plans) / Select generic (Moda Plans)  | \$12 per 31-day supply   |  |   | \$12 per 31-day supply   |  |   | \$12 per 31-day supply   |  |   | \$12 per 31-day supply   |  |   |
| Preferred brand   | 25% up to \$75 per 31-day supply   |  |   | 25% up to \$75 per 31-day supply   |  |   | 25% up to \$75 per 31-day supply   |  |   | 25% up to \$75 per 31-day supply   |  |   |
| Non-preferred brand <sup>4</sup>  | 50% up to \$175 per 31-day supply  |  |   | 50% up to \$175 per 31-day supply  |  |   | 50% up to \$175 per 31-day supply  |  |   | 50% up to \$175 per 31-day supply  |  |   |
| <b>Mail</b>   |  |  |   |  |  |   |  |  |   |  |  |   |
| Value   | \$8 per 90-day supply  |  | See Plan Handbook                       | \$8 per 90-day supply  |  | See Plan Handbook                       | \$8 per 90-day supply  |  | See Plan Handbook                       | \$8 per 90-day supply  |  | See Plan Handbook                       |
| Generic (Kaiser Plans) / Select generic (Moda Plans)  | \$24 per 90-day supply   |  |   | \$24 per 90-day supply   |  |   | \$24 per 90-day supply   |  |   | \$24 per 90-day supply   |  |   |
| Preferred brand   | 25% up to \$150 per 90-day supply  |  |   | 25% up to \$150 per 90-day supply  |  |   | 25% up to \$150 per 90-day supply  |  |   | 25% up to \$150 per 90-day supply  |  |   |
| Non-preferred brand <sup>4</sup>  | 50% up to \$450 per 90-day supply  |  |   | 50% up to \$450 per 90-day supply  |  |   | 50% up to \$450 per 90-day supply  |  |   | 50% up to \$450 per 90-day supply  |  |   |
| <b>Specialty</b>  |  |  |   |  |  |   |  |  |   |  |  |   |
| 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 <sup>4</sup>  | 50% up to \$500 per 31-day supply or \$1,000 for 90-day supply when allowed. |  |   | 50% up to \$500 per 31-day supply or \$1,000 for 90-day supply when allowed. |  |   | 50% up to \$500 per 31-day supply or \$1,000 for 90-day supply when allowed. |  |   | 50% up to \$500 per 31-day supply or \$1,000 for 90-day supply when allowed. |  |   |

N/A – Not applicable

After ded – 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 and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.**



| No lifetime maximum on any medical plans.   | Medical Plan 5<br>Connexus Network                         |  |   |  | Medical Plan 7<br>Connexus Network<br>HDHP HSA Compliant   |   |   |
|---|--|--|---|--|--|---|---|
|   | In-Network<br>Coordinated Care <sup>5</sup><br>Member Pays | In-Network<br>Non-Coordinated<br>Care <sup>6</sup> Member Pays | Any Out-of-Network<br>Services<br>Member Pays |  | In-Network<br>Coordinated Care <sup>5</sup><br>Member Pays | In-Network<br>Non-Coordinated<br>Care <sup>6</sup><br>Member Pays | Any Out-of-Network<br>Services<br>Member Pays |
| <b>Plan Year Costs</b> - Deductibles and copayments apply to the annual out-of-pocket maximum.  |  |  |   |  |  |   |   |
| Deductible per person   | \$2,000  | \$2,100  | \$4,000                                       |  | \$2,000 <sup>2</sup>                                       | \$2,100 <sup>2</sup>  | \$4,000 <sup>2</sup>                          |
| Maximum deductible per family   | \$6,300  | \$6,300  | \$12,600                                      |  | \$4,200 <sup>2</sup>                                       | \$4,200 <sup>2</sup>  | \$8,000 <sup>2</sup>                          |
| Out-of-pocket (OOP) maximum per person <sup>3</sup>   | \$6,800  | \$7,200  | \$13,700                                      |  | \$6,500 <sup>2</sup>                                       | \$6,750 <sup>2</sup>  | \$13,300 <sup>2</sup>                         |
| Out-of-pocket (OOP) maximum per family <sup>3</sup>   | \$15,800   | \$15,800   | \$27,400                                      |  | \$13,500 <sup>2</sup>                                      | \$13,500 <sup>2</sup>   | \$26,600 <sup>2</sup>                         |
| <b>Preventive Care Services</b>   |  |  |   |  |  |   |   |
| Routine adult, well-child and women's exams; annual obesity screening & immunizations.  | \$0 <sup>1</sup>   | \$0 <sup>1</sup>   | 50% after deductible                          |  | \$0 <sup>1</sup>   | \$0 <sup>1</sup>  | 50% after deductible                          |
| <b>Office Visits and Virtual Care</b>   |  |  |   |  |  |   |   |
| Primary care office visits  | \$30 <sup>1,5</sup>  | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)   | \$50 <sup>1</sup>  | N/A  | 50% after deductible                          |  | 20% after deductible                                       | N/A   | 50% after deductible                          |
| Incentive care office visits (Moda plans only)  | \$25 <sup>1</sup>  | 25% after deductible   | N/A   |  | 20% after deductible                                       | 25% after deductible  | N/A   |
| Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)  | \$0 <sup>1</sup>   | \$0 <sup>1</sup>   | Not covered                                   |  | \$0 after deductible                                       | \$0 after deductible  | Not covered                                   |
| Specialist office visits  | \$50 <sup>1</sup>  | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| Urgent care   | \$50 <sup>1</sup>  | 25% after deductible   | 25% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | See Plan Handbook                             |
| <b>Mental Health Services</b>   |  |  |   |  |  |   |   |
| Mental health office visits   | \$30 <sup>1</sup>  | \$30 <sup>1</sup>  | 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                          |
| Chemical dependency services (outpatient or residential)  | \$30 <sup>1</sup>  | \$30 <sup>1</sup>  | 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                          |
| <b>Outpatient Services</b>  |  |  |   |  |  |   |   |
| Outpatient surgery/facility care  | 25% after deductible                                       | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| Outpatient rehabilitation (physical, occupational & speech therapy)   | 25% after deductible                                       | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| <b>Diagnostic Testing</b>   |  |  |   |  |  |   |   |
| Labs, x-ray, and imaging  | 25% 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                          |
| <b>Alternative Care Services</b>  |  |  |   |  |  |   |   |
| Acupuncture and Chiropractic <sup>7</sup>   | \$30 <sup>1</sup>  | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| Naturopathic Services   | \$50 <sup>1</sup>  | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| <b>Maternity Care</b>   |  |  |   |  |  |   |   |
| Outpatient maternity care   | 25% after deductible                                       | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| Physician or midwife services & hospital stay, delivery & routine newborn nursery care  | 25% after deductible                                       | 25% after deductible   | 50% after deductible                          |  | 20% after deductible                                       | 25% after deductible  | 50% after deductible                          |
| <b>Hospital Services</b>  |  |  |   |  |  |   |   |
| Inpatient care/surgery  | 25% 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                          |
| <b>Additional Cost Tier</b>   |  |  |   |  |  |   |   |
| <b>Moda Plans Only:</b> \$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                          |
| <b>Moda Plans Only:</b> \$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                          |

| No lifetime maximum on any medical plans.  | Medical Plan 5<br>Connexus Network   |  |   |                      | Medical Plan 7<br>Connexus Network<br>HDHP HSA Compliant   |   |   |
|--|--|--|---|----------------------|--|---|---|
|  | In-Network<br>Coordinated Care <sup>5</sup><br>Member Pays                   | In-Network<br>Non-Coordinated<br>Care <sup>6</sup> Member Pays | Any Out-of-Network<br>Services<br>Member Pays |                      | In-Network<br>Coordinated Care <sup>5</sup><br>Member Pays | In-Network<br>Non-Coordinated<br>Care <sup>6</sup><br>Member Pays | Any Out-of-Network<br>Services<br>Member Pays |
| <b>Plan Year Costs</b> - Deductibles and copayments apply to the annual out-of-pocket maximum.                         |  |  |   |                      |  |   |   |
| <b>Emergency Services</b>  |  |  |   |                      |  |   |   |
| Emergency room (copay waived if admitted)  | \$100 copay + 25% after deductible   |  |   |                      | 20% after deductible                                       | 25% after deductible  | See Plan Handbook                             |
| Ambulance  | 25% after deductible   |  |   |                      | 20% after deductible                                       | 25% after deductible  | See Plan Handbook                             |
| <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                          |                      | 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                          |
| <b>Pharmacy Services</b>   |  |  |   |                      |  |   |   |
| Out-of-pocket (OOP) maximum  | Rx applies toward OOP max  |  |   |                      | Rx applies toward plan OOP max                             |   |   |
| <b>Retail</b>  |  |  |   |                      |  |   |   |
| Value  | \$4 per 31-day supply  |  | See Plan Handbook                             |                      | \$4 <sup>1</sup> 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                                       |   |   |
| Preferred brand  | 25% up to \$75 per 31-day supply   |  |   | 20% after deductible | 25% after deductible                                       |   |   |
| Non-preferred brand <sup>5</sup>   | 50% up to \$175 per 31-day supply  |  |   | 20% after deductible | 25% after deductible                                       |   |   |
| <b>Mail</b>  |  |  |   |                      |  |   |   |
| Value  | \$8 per 90-day supply  |  | See Plan Handbook                             |                      | \$8 <sup>1</sup> 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                                       |   |   |
| Preferred brand  | 25% up to \$150 per 90-day supply  |  |   | 20% after deductible | 25% after deductible                                       |   |   |
| Non-preferred brand <sup>4</sup>   | 50% up to \$450 per 90-day supply  |  |   | 20% after deductible | 25% after deductible                                       |   |   |
| <b>Specialty</b>   |  |  |   |                      |  |   |   |
| 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                             |
| 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                                       |   |   |
| Non-preferred brand <sup>4</sup>   | 50% up to \$500 per 31-day supply or \$1,000 for 90-day supply when allowed. |  |   | 20% after deductible | 25% after deductible                                       |   |   |

N/A – Not applicable

After ded – 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.

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# Summary of Dental Benefits 2023–2024 Plan Year

Please see Plan Handbook for details.



| Dental   | Premier Plan 1 <sup>1</sup>             | Premier Plan 5 <sup>1</sup>             | Premier Plan 6                          | Exclusive PPO – Incentive Plan <sup>1</sup>          | Exclusive PPO Plan                                   | Kaiser Dental Plan   | Willamette Dental Plan   |
|--|---|---|---|--|--|--|--|
| Network  | Delta Dental Premier                    | Delta Dental Premier                    | Delta Dental Premier                    | Limited Network Plan – Delta Dental PPO <sup>2</sup> | Limited Network Plan – Delta Dental PPO <sup>2</sup> | Limited Network Plan – Kaiser Permanente Facilities <sup>2</sup> | Limited Network Plan – Willamette Dental Group Facilities <sup>2</sup> |
| Dental Office Visit Copay  | N/A                                     | N/A                                     | N/A                                     | N/A  | N/A  | \$20 <sup>3</sup>  | \$20 <sup>3</sup>  |
| Benefit Maximum  | \$2,200 <sup>4</sup>                    | \$1,700 <sup>4</sup>                    | \$1,200                                 | \$2,300 <sup>4</sup>                                 | \$1,500 <sup>4</sup>                                 | \$4,000 <sup>4</sup>   | N/A  |
| Deductible   | \$50                                    | \$50                                    | \$50                                    | \$50   | \$50   | N/A  | N/A  |
| <b>Preventive &amp; Diagnostic Services – Deductible Waived for Preventive &amp; Diagnostic Services on Delta Dental Plans<sup>6</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>                       | 100% <sup>6</sup>                                    | 100% <sup>6</sup>                                    | 100% <sup>6</sup>  | 100%   |
| <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>                        | 70% + 10% <sup>1</sup> each Plan Year                | 90% <sup>1</sup>                                     | 100% <sup>3</sup>  | 100% <sup>3</sup>  |
| <b>Simple Extraction</b>   |   |   |   |  |  |  |  |
| Simple tooth extractions   | 70% + 10% each Plan Year                | 70% + 10% each Plan Year                | 80%                                     | 70% + 10% each Plan Year                             | 90%  | 100% <sup>3</sup>  | 100% <sup>3</sup>  |
| <b>Oral Surgery</b>  |   |   |   |  |  |  |  |
| Surgical tooth extractions, including diagnosis and evaluation   | 70% + 10% each Plan Year                | 70% + 10% each Plan Year                | 80%                                     | 70% + 10% each Plan Year                             | 90%  | \$50 Copay <sup>3</sup>  | \$50 Copay <sup>3</sup>  |
| <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%                                     | 70% + 10% each Plan Year                             | 90%  | 100% <sup>3</sup>  | 100% <sup>3</sup>  |
| <b>Endodontics</b>   |   |   |   |  |  |  |  |
| 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 <sup>3</sup>  | \$50 Copay <sup>3</sup>  |
| <b>Major Restorative Services</b>  |   |   |   |  |  |  |  |
| Gold or porcelain crowns and onlays  | 70% + 10% each Plan Year                | 70%                                     | 50%                                     | 70% + 10% each Plan Year                             | 80%  | \$250 Copay <sup>3</sup>   | \$250 Copay <sup>3,5</sup>   |
| Implants   | 70% + 10% each Plan Year                | 50%                                     | 50%                                     | 70% + 10% each Plan Year                             | 80%  | 50% <sup>3</sup> (limit of 4 per lifetime)                       | Implant surgery up to \$1,500 calendar year maximum <sup>5</sup>       |
| <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 | 50% up to \$250 max, once every 5 years              | 50% up to \$250 max, once every 5 years              | 90%, once every 5 years  | 100% once every 2 years  |
| Athletic mouth guards  | 50%                                     | 50%                                     | 50%                                     | 50%  | 50%  | 90%  | \$100 Copay <sup>3</sup>   |
| Nitrous Oxide  | 50%                                     | 50%                                     | 50%                                     | 50%  | 50%  | \$0 copay (Age 12 & Under)<br>\$25 copay (Age 13 & Up)           | \$15 Copay <sup>3</sup>  |
| <b>Fixed and Removable Prosthetic Services</b>   |   |   |   |  |  |  |  |
| Full and partial dentures, relines, rebases  | 70% + 10% each Plan Year                | 50%                                     | 50%                                     | 70% + 10% each Plan Year                             | 80%  | \$100 Copay <sup>3</sup>   | \$100 Copay <sup>3,5</sup>   |
| Bridge retainers and pontics   | 70% + 10% each Plan Year                | 50%                                     | 50%                                     | 70% + 10% each Plan Year                             | 80%  | \$250 Copay <sup>3</sup>   | \$250 Copay <sup>3,5</sup>   |
| <b>Orthodontics</b>  |   |   |   |  |  |  |  |
| 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.

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

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

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

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

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# Summary of Vision Benefits 2023–2024 Plan Year



| Vision   | Kaiser Vision Plan <sup>1</sup><br>Kaiser Permanente<br>Facilities   | Moda Opal Plan<br>May use any<br>licensed provider                               | Moda Pearl Plan<br>May use any<br>licensed provider                              | Moda Quartz Plan<br>May use any<br>licensed provider                             | VSP Choice Plus Plan<br>VSP Choice Network  | VSP Choice Plan<br>VSP Choice Network  |
|--|--|--|--|--|---|--|
| Plan Year Maximum                              | \$250  | \$600  | \$400  | \$250  | N/A   | N/A  |
| <b>Routine Eye Exam:</b>                       |  |  |  |  |   |  |
| Benefit:                                       | Covered under the Kaiser Permanente medical plan (does not apply to the vision plan year maximum)                                | Plan pays 100% (up to plan maximum)  | Plan pays 100% (up to plan maximum)  | Plan pays 100% (up to plan maximum)  | Plan pays 100% after \$10 copay   | Plan pays 100% after \$10 copay  |
| Frequency:                                     | As needed  | Once per Plan Year   | Once per Plan Year   | Once per Plan Year   | Once per plan year  | Once per plan year   |
| <b>Lenses:</b>                                 |  |  |  |  |   |  |
| Basic lens benefit:                            | <b>Under age 19:</b><br>No charge for one pair of standard frames and lenses or contacts   | Plan pays 100% (up to plan maximum)  | Plan pays 100% (up to plan maximum)  | Plan pays 100% (up to plan maximum)  | \$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Polycarbonate lenses, scratch resistant and UV coatings covered in full | \$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Scratch resistant and UV coatings covered in full    |
| Lens enhancements:                             | <b>Age 19+:</b><br>Plan pays 100% (up to plan maximum)   |  |  |  |   |  |
| Frequency:                                     | Once per Plan Year   | Once per Plan Year   | Once per Plan Year   | Once per Plan Year   | Once every 12 months  | Once every 12 months   |
| <b>Frames</b>                                  |  |  |  |  |   |  |
| Benefit:                                       | <b>Under age 19:</b> No charge for one pair of standard frames and lenses<br><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)  | Covered in full up to retail allowance of <b>\$300</b> ; 20% off amount over retail allowance for frames  | Covered in full up to retail allowance of <b>\$150</b> ; 20% off amount over retail allowance for frames   |
| Frequency:                                     | Once per Plan Year   | <b>Age 0–16:</b> Once per plan year<br><b>Age 17+:</b> Once every two plan years | <b>Age 0–16:</b> Once per plan year<br><b>Age 17+:</b> Once every two plan years | <b>Age 0–16:</b> Once per plan year<br><b>Age 17+:</b> Once every two plan years | Once per plan year  | Once per plan year   |
| <b>Contacts (in lieu of frames and lenses)</b> |  |  |  |  |   |  |
| Benefit:                                       | <b>Under age 19:</b> No charge for contacts<br><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)  | Covered in full up to retail allowance of <b>\$300</b>  | Covered in full up to retail allowance of <b>\$150</b>   |
| 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   |
| <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  | 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. |

<sup>1</sup> Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

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