Summary of Medical and Pharmacy Benefits 2021-22 Plan Year

KAISER PERMANENTE® Plans

No lifetime maximum on any medical plans.	Medical Kaiser Perman			l Plan 2A nente Network		l Plan 2B nente Network	Medical Plan 3 Kaiser Permanente Network HSA Optional		
Plan Year Costs	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	In Network	Out of Network	
Deductibles and copayments apply to the annual out-of-pocket maximum.	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	Member Pays	
Deductible per person Maximum deductible per family	None None	NA	\$800 \$2,400	NA	\$1,200 \$3,600	NA	\$1,600 ² \$3,200 ²	NA NA	
Out-of-pocket (OOP) maximum per person ³	\$1,500	NA NA	\$2,400	NA NA	\$3,800	NA NA	\$6,550 ²	NA	
Out-of-pocket (OOP) maximum per family ³	\$3,000	NA	\$4,000	NA	\$13,500	NA	\$0,550 \$13,100 ²	NA	
Maximum cost share per person	\$3,000 NA	NA	NA	NA	NA	NA	NA	NA	
Maximum cost share per family	NA	NA	NA	NA	NA	NA	NA	NA	
Preventive Care Services	N/A	NA .		NA .	ПA	N/A	ΠA	NA	
Wellness visit	\$0	NA	\$0 ¹	NA	\$0 ¹	NA	\$0 ¹	NA	
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	\$0	Not Covered	\$0 ¹	Not Covered	\$0 ¹	Not Covered	\$0 ¹	Not Covered	
Office Visits and Virtual Care									
Primary care office visits	\$20	Not Covered	\$25 ¹	Not Covered	\$30 ¹	Not Covered	20%	Not Covered	
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	NA	NA	NA	NA	NA	NA	NA	NA	
Incentive Care Office Visits for asthma, heart conditions, cholesterol, high blood pressure, diabetes (Moda Plans only)	NA	NA	NA	NA	NA	NA	NA	NA	
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	\$0	Not Covered	\$0 ¹	Not Covered	\$0 ¹	Not Covered	\$0	Not Covered	
Specialist office visits	\$30	Not Covered	\$35 ¹	Not Covered	\$40 ¹	Not Covered	20%	Not Covered	
Urgent care	\$35	See Plan Handbook	\$40 ¹	See Plan Handbook	\$45 ¹	See Plan Handbook	20%	See Plan Handbook	
Mental Health Services									
Mental health office visits	\$20	Not Covered	\$25 ¹	Not Covered	\$30 ¹	Not Covered	20%	Not Covered	
Mental health inpatient and residential services	\$100 per day, up to \$500 per admission max	Not Covered	20%	Not Covered	20%	Not Covered	20%	Not Covered	
Chemical dependency services (inpatient, outpatient or residential)	\$0	Not Covered	\$0 ¹	Not Covered	\$0 ¹	Not Covered	20%	Not Covered	
Outpatient Services									
Outpatient surgery/facility care	\$75	Not Covered	20%	Not Covered	20%	Not Covered	20%	Not Covered	
Outpatient rehabilitation (physical, occupational & speech therapy)									
Kaiser Plans: Maximum 20 visits per therapy per Plan Year	\$30 per visit	Not Covered	\$351 per visit	Not Covered	\$40 ¹ per visit	Not Covered	20%	Not Covered	
Moda Plans: 30 sessions per plan year / 60 for spinal or head injury									
Tests (outpatient)									
Preventive tests	\$0	Not Covered	\$0 ¹	Not Covered	\$0 ¹	Not Covered	\$0 ¹	Not Covered	
Laboratory	\$20 per visit	Not Covered	\$251 per visit	Not Covered	\$30 ¹ per visit	Not Covered	20%	Not Covered	
X-ray, imaging, and special diagnostic procedures	\$20 per visit	Not Covered	\$251 per visit	Not Covered	\$30 ¹ per visit	Not Covered	20%	Not Covered	
CT, MRI, PET scans	\$20 per visit	Not Covered	\$25 ¹ per visit	Not Covered	\$30 ¹ per visit	Not Covered	20%	Not Covered	
Alternative Care Services ⁸									
Acupuncture, chiropractic & naturopathic services ¹¹	\$20 per service	Not Covered	\$25 ¹ per service	Not Covered	\$30 ¹ per service	Not Covered	20%	Not Covered	
Maternity Care	A C		\$ 21	Nut O	4 21	Not O	6 01		
Outpatient maternity care	\$0 \$100 per day, up to \$500	Not Covered	\$0 ¹	Not Covered	\$0 ¹	Not Covered	\$0 ¹	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%	Not Covered	20%	Not Covered	20%	Not Covered	

OEBB Summary of Medical and Pharmacy Benefits 2021-22 Plan Year | Kaiser Permante Plans

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Plans – continued **PERMANENTE**®

KAISER

Plan Year Costs In Network Member Pays Out of Network Member Pays Hospital Services \$100 per day, up to \$500 per admission max See Plan Ham Skilled nursing facility care (Kaiser Plans: 100 days per plan year, Moda Plans: 60 days per plan year) \$0 NA Additional Cost Tier \$0 NA NA Moda Plans Only: \$100 Additional Cost Tier (ACT): specified imaging (MPI, CT, PET), spinal injections, fonsillectomics for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies NA NA Moda Plans Only: \$100 Additional Cost Tier (ACT): specified imaging (MPI, CT, PET), spinal injections, fonsillectomics for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies NA NA Moda Plans Only: \$500 Additional Cost Tier (ACT): Specified imaging (MPI, CT, PET), spinal injections NA NA Emergency: Com (copay waived if admitted) \$100 per visit (waived if admitted) \$100 per visit (waived if admitted) Ambulance \$75 Other Covered Services \$75 Unarbit medical equipment (DME) 20% Not Covern \$200 + Inpatient Care costs Not Covern \$250 per 30-day supply Value NA NA NA N						Plan 2B ente Network	Medical Plan 3 Kaiser Permanente Network <i>HSA Optional</i>	
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Non-preferred brand525% up to \$100 per 30-day supplySee Plan Hand	book 25% up to \$100 per 30-day supply	See Plan Handbook	25% up to \$100 per 30-day supply	See Plan Handbook	20%	See Plan Handboo		
	hanced "coordinated" benefit shown in the that plan when using a provider in the Con		ser plans, acupuncture care, spinal athic substance only accrue toward		or Moda plans, member must s -network specialist to recieve t			

- 1 Deductible waived.
- 2 Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and 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).
- coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share.
- 4 Benefit is subject to a reference price limitation.
- 5 A formulary exception must be approved for non-preferred brand prescription medication.
- 6 If enrolled in a Moda medical plan, each covered individual must choose and use a PCP 360 with Moda for that individual to receive

under that plan when using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit shown in the center column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level (far right column under that plan) regardless of whether or not the individual has chosen a PCP 360 with Moda.

- 7 For value teir list please visit <u>https://my.kp.org/oebb/plans/</u> at bottom of page.
- naturopathic substance only accrue towards your \$2000 benefit maximum. For Moda Plans, acupuncture and spinal manipulation services are subject to 12 visits per plan year.
- 9 For Moda plans, CirrusMD app is covered at no member cost sharing. All other virtual care for primary and urgent care services (defined as 2-way video conferencing visits) is covered at a \$10 copay with deductible waived for plans 1-5. Plans 6 and 7 is a \$10 copay after the deductible has been met.

in-network specialist to recieve the copay benefit.

11 For Moda plans, the copay listed is for acupuncture and spinal manipulation services only. Naturopathic substances are covered. See Plan Handbook for details.

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

MODO Plans 1–4

		Medical Plan 1			Medical Plan 2			Medical Plan 3			Medical Plan 4	
No lifetime maximum on any medical plans.		Connexus Network	ς		Connexus Network	٢		Connexus Networl	k	(Connexus Network	(
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays
Deductible per person	\$400	\$500	\$800	\$800	\$900	\$1,600	\$1,200	\$1,300	\$2,400	\$1,600	\$1,700	\$3,200
Maximum deductible per family	\$1,500	\$1,500	\$2,400	\$2,700	\$2,700	\$4,800	\$3,900	\$3,900	\$7,200	\$5,100	\$5,100	\$9,600
Out-of-pocket (OOP) maximum per person ³	\$2,850	\$3,250	\$6,000	\$3,850	\$4,250	\$8,000	\$4,850	\$5,250	\$10,000	\$6,700	\$7,100	\$13,700
Out-of-pocket (OOP) maximum per family ³	\$9,750	\$9,750	\$18,000	\$12,750	\$12,750	\$24,000	\$15,750	\$15,750	\$27,400	\$15,800	\$15,800	\$27,400
Maximum cost share per person	\$7,900	\$7,900	NA									
Maximum cost share per family	\$15,800	\$15,800	NA									
Preventive Care Services												
Wellness visit	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	\$0 ¹	\$0 ¹	50%									
Office Visits and Virtual Care												
Primary care office visits	\$20 ^{1,6}	20%	50%	\$201,6	20%	50%	\$25 ^{1,6}	25%	50%	\$25 ^{1,6}	25%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$40 ¹	NA	50%	\$40 ¹	NA	50%	\$50 ¹	NA	50%	\$50 ¹	NA	50%
Incentive Care Office Visits for asthma, heart conditions, cholesterol, high blood pressure, diabetes (Moda Plans only)	\$15 ^{1,10}	20%	Not covered	\$15 ^{1,10}	20%	Not covered	\$201,10	25%	Not covered	\$201,10	25%	Not covered
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	\$0 ^{1,9}	\$0 ^{1,9}	Not covered	\$0 ^{1,9}	\$0 ^{1,9}	Not covered	\$0 ^{1,9}	\$0 ^{1,9}	Not covered	\$0 ^{1,9}	\$0 ^{1,9}	Not covered
Specialist office visits	\$40 ¹	20%	50%	\$40 ¹	20%	50%	\$50 ¹	25%	50%	\$50 ¹	25%	50%
Urgent care	\$40 ¹	20%	20%	\$40 ¹	20%	20%	\$50 ¹	25%	25%	\$50 ¹	25%	25%
Mental Health Services												
Mental health office visits	\$20 ¹	\$20 ¹	50%	\$20 ¹	\$20 ¹	50%	\$25 ¹	\$25 ¹	50%	\$25 ¹	\$25 ¹	50%
Mental health inpatient and residential services	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	\$20 ¹	\$20 ¹	50%	\$20 ¹	\$20 ¹	50%	\$25 ¹	\$25 ¹	50%	\$25 ¹	\$25 ¹	50%
Outpatient Services												
Outpatient surgery/facility care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Outpatient rehabilitation (physical, occupational & speech therapy)												
Kaiser Plans: Maximum 20 visits per therapy per Plan Year	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Moda Plans: 30 sessions per plan year / 60 for spinal or head injury												
Tests (outpatient)												
Preventive tests	\$0 ¹	\$0 ¹	50%									
Laboratory	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
X-ray, imaging, and special diagnostic procedures	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
CT, MRI, PET scans		\$100 copay + 20%	\$100 copay + 50%									
Alternative Care Services ⁸												
Acupuncture, chiropractic & naturopathic services ¹¹	\$20 ¹	20%	50%	\$20 ¹	20%	50%	\$25 ¹	25%	50%	\$25 ¹	25%	50%
Maternity Care												
Outpatient maternity care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%

MODO Plans 1–4 – continued

No lifetime maximum on any medical plans.	(Medical Plan 1 Connexus Networ	k		Medical Plan 2 Connexus Networ	<		Medical Plan 3 Connexus Networ	k	Medical Plan 4 Connexus Network		vork	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out-of Network Services Member Pays	
Hospital Services													
Inpatient care/surgery	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%	
Skilled nursing facility care (Kaiser Plans: 100 days per plan													
year,	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%	
Moda Plans: 60 days per plan year)													
Additional Cost Tier													
Moda Plans Only: \$100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	
Moda Plans Only: \$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement ⁴ , knee & shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%	
Emergency Services													
Emergency room (copay waived if admitted)		\$100 copay + 20%			\$100 copay + 20%		\$100 copay + 25%			\$100 copay + 25%			
Ambulance		20%			20%			25%			25%		
Other Covered Services													
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	10%	50%	10%	10%	50%	10%	10%	50%	10%	10%	50%	
Durable medical equipment (DME)	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%	
Bariatric surgery	\$500 + 20%	\$500 + 20%	Not covered	\$500 + 20%	\$500 + 20%	Not covered	\$500 + 25%	\$500 + 25%	Not covered	\$500 + 25%	\$500 + 25%	Not covered	
Pharmacy Services													
Out-of-pocket (OOP) maximum	Rx ap	plies toward Max Cost	Share	Rx ap	plies toward Max Cost	Share	Rx ap	plies toward Max Cost	Share	Rx ap	plies toward Max Cost	Share	
Retail													
Value	\$4 per 31-	-day supply		\$4 per 31-	-day supply		\$4 per 31-	-day supply		\$4 per 31-	-day supply	See Plan Handbook	
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31	-day supply	See Plan	\$12 per 31	-day supply	See Plan	\$12 per 31	-day supply	See Plan	\$12 per 31	-day supply		
Preferred brand	25% up to \$75 p	per 31-day supply	Handbook	25% up to \$75 p	per 31-day supply	Handbook	25% up to \$75 p	per 31-day supply	Handbook	25% up to \$75 p	per 31-day supply		
Non-preferred brand ⁵	50% up to \$175	per 31-day supply		50% up to \$175	per 31-day supply		50% up to \$175	per 31-day supply			per 31-day supply		
Mail													
Value	\$8 per 90-	-day supply		\$8 per 90	-day supply		\$8 per 90	-day supply		\$8 per 90	-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90	-day supply	See Plan	\$24 per 90	-day supply	See Plan	\$24 per 90	-day supply	See Plan	\$24 per 90	-day supply	See Plan	
Preferred brand	25% up to \$150	per 90-day supply	Handbook	25% up to \$150 per 90-day supply		Handbook	25% up to \$150	per 90-day supply	Handbook	25% up to \$150	per 90-day supply	Handbook	
Non-preferred brand ⁵	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		
Specialty													
Generic (Moda Plans only)		ly or \$36 per 90-day en allowed			oly or \$36 per 90-day en allowed			oly or \$36 per 90-day en allowed			oly or \$36 per 90-day en allowed		
Select generic (Kaiser plans) / Preferred brand (Moda Plans)		er 31-day supply or upply when allowed	See Plan Handbook	25% up to \$200 p \$400 for 90-day s		See Plan Handbook		er 31-day supply or upply when allowed	See Plan Handbook	25% up to \$200 p \$400 for 90-day s	er 31-day supply or upply when allowed	See Plan Handbook	
Non-preferred brand ⁵	50% up to \$500 or \$1,000 for 90-day	per 31-day supply supply when allowed.		50% up to \$500 or \$1,000 for 90-day	per 31-day supply supply when allowed.		50% up to \$500 p \$1,000 for 90-day s	er 31-day supply or supply when allowed.			er 31-day supply or supply when allowed.		

MOGO Plans 5–7

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network				Medical Plan 6 Connexus Network HDHP HSA Complian		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 ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out of Network Services Member Pays	
Deductible per person	\$2,000	\$2,100	\$4,000	\$1,600 ²	\$1,700 ²	\$3,200 ²	\$2,000 ²	\$2,100 ²	\$4,000 ²	
Maximum deductible per family	\$6,300	\$6,300	\$12,600	\$3,400 ²	\$3,400 ²	\$6,400 ²	\$4,200 ²	\$4,200 ²	\$8,000 ²	
Out-of-pocket (OOP) maximum per person ³	\$6,800	\$7,200	\$13,700	\$6,400 ²	\$6,750 ²	\$13,100 ²	\$6,500 ²	\$6,750 ²	\$13,300 ²	
Out-of-pocket (OOP) maximum per family ³	\$15,800	\$15,800	\$27,400	\$13,500 ²	\$13,500 ²	\$26,200 ²	\$13,500 ²	\$13,500 ²	\$26,600 ²	
Maximum cost share per person	\$7,900	\$7,900	NA	NA	NA	NA	NA	NA	NA	
Maximum cost share per family	\$15,800	\$15,800	NA	NA	NA	NA	NA	NA	NA	
Preventive Care Services										
Wellness visit	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%	
Office Visits and Virtual Care										
Primary care office visits	\$30 ^{1,6}	25%	50%	15%	20%	50%	20%	25%	50%	
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$50 ¹	NA	50%	15%	NA	50%	20%	NA	50%	
Incentive Care Office Visits for asthma, heart conditions, cholesterol, high blood pressure, diabetes (Moda Plans only)	\$251,10	25%	Not covered	15% ¹⁰	20%	Not covered	20%10	25%	Not covered	
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	\$0 ^{1,9}	\$0 ^{1,9}	Not covered	\$0 ^{1,9}	\$0 ^{1,9}	Not covered	\$0 ^{1,9}	\$0 ^{1,9}	Not covered	
Specialist office visits	\$50 ¹	25%	50%	15%	20%	50%	20%	25%	50%	
Urgent care	\$50 ¹	25%	25%	15%	20%	See Plan Handbook	20%	25%	See Plan Handbook	
Mental Health Services										
Mental health office visits	\$30 ¹	\$30 ¹	50%	15%	20%	50%	20%	25%	50%	
Mental health inpatient and residential services	25%	25%	50%	20%	25%	50%	20%	25%	50%	
Chemical dependency services (inpatient, outpatient or residential)	\$30 ¹	\$30 ¹	50%	15%	20%	50%	20%	25%	50%	
Outpatient Services										
Outpatient surgery/facility care	25%	25%	50%	20%	25%	50%	20%	25%	50%	
Outpatient rehabilitation (physical, occupational & speech therapy)										
Kaiser Plans: Maximum 20 visits per therapy per Plan Year	25%	25%	50%	20%	25%	50%	20%	25%	50%	
Moda Plans: 30 sessions per plan year / 60 for spinal or head injury										
Tests (outpatient)										
Preventive tests	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%	
Laboratory	25%	25%	50%	20%	25%	50%	20%	25%	50%	
X-ray, imaging, and special diagnostic procedures	25%	25%	50%	20%	25%	50%	20%	25%	50%	
CT, MRI, PET scans	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	20%	25%	50%	20%	25%	50%	
Alternative Care Services ⁸										
Acupuncture, chiropractic & naturopathic services ¹¹	\$30 ¹	25%	50%	20%	25%	50%	20%	25%	50%	
Maternity Care										
Outpatient maternity care	25%	25%	50%	20%	25%	50%	20%	25%	50%	
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	25%	25%	50%	20%	25%	50%	20%	25%	50%	
Hospital Services										
Inpatient care/surgery	25%	25%	50%	20%	25%	50%	20%	25%	50%	
Skilled nursing facility care (Kaiser Plans: 100 days per plan year,	2070	2070	0070	2070	2070	0070	2070	2070	0070	
Moda Plans: 60 days per plan year)	25%	25%	50%	20%	25%	50%	20%	25%	50%	

OEBB Summary of Medical and Pharmacy Benefits 2021-22 Plan Year | Moda Health Plans 5–7

Plans 5–7 – continued

No lifetime maximum on any medical plans.		Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network HDHP HSA Compliar			at a start		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out of Network Services Member Pays	In Network Coordinated Care ⁶ Member Pays	In Network Non Coordinated Care ⁶ Member Pays	Any Out of Network Services Member Pays	
Additional Cost Tier		,	, 		,			,	•	
Moda Plans Only: \$100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	20%	25%	50%	20%	25%	50%	
Moda Plans Only: \$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement ⁴ , knee & shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%	20%	25%	50%	20%	25%	50%	
Emergency Services										
Emergency room (copay waived if admitted)		\$100 copay + 25%		20%	25%	See Plan Handbook	20%	25%	See Plan Handbook	
Ambulance		25%		20% 25%		See Plan Handbook	20%	25%	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%	10%	50%	20%	25%	50%	20%	25%	50%	
Durable medical equipment (DME)	25%	25%	50%	20%	25%	50%	20%	25%	50%	
Bariatric surgery	\$500 + 25%	\$500 + 25%	Not covered	\$500 + 20%	\$500 + 25%	Not covered	\$500 + 20%	\$500 + 25%	Not covered	
Pharmacy Services										
Out-of-pocket (OOP) maximum	Rx a	applies toward Max Cost S	Share	Rx	applies toward plan OOP	max	Rx	applies toward plan OOP	max	
Retail										
Value	\$4 per 31-	-day supply		\$4 ¹ per 31-	-day supply		\$4 ¹ per 31	-day supply	See Plan	
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31	-day supply	See Plan	20%	25%	See Plan	20%	25%		
Preferred brand	25% up to \$75 p	per 31-day supply	Handbook	20%	25%	Handbook	20%	25%	Handbook	
Non-preferred brand ⁵	50% up to \$175	per 31-day supply		20%	25%		20%	25%		
Mail										
Value	\$8 per 90-	-day supply		\$81 per 90	-day supply		\$81 per 90			
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90	-day supply	See Plan	20%	25%	See Plan	20%	25%	See Plan	
Preferred brand	25% up to \$150	per 90-day supply	Handbook	20%	25%	Handbook	20%	25%	Handbook	
Non-preferred brand ⁵	50% up to \$450	per 90-day supply		20%	25%		20%	25%		
Specialty										
Generic (Moda Plans only)	\$12 per 31-day supply or \$36 per 90-day supply when allowed			20%	25%		20%	25%		
Select generic (Kaiser plans) / Preferred brand (Moda Plans)		-day supply or \$400 for when allowed	See Plan Handbook	20%	25%	See Plan Handbook	20%	25%	See Plan Handbook	
Non-preferred brand ⁵	50% up to \$500 per 31- 90-day supply			20%	25%		20%	25%		

NA – Not applicable

mode

- 1 Deductible waived.
- 2 Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and 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 max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share.
- 4 Benefit is subject to a reference price limitation.
- 5 A formulary exception must be approved for non-preferred brand prescription medication.
- 6 If enrolled in a Moda medical plan, each covered individual must choose and use a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the far left column
- under that plan when using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit shown in the center column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level (far right column under that plan) regardless of whether or not the individual has chosen a PCP 360 with Moda.
- 7 For value teir list please visit <u>https://my.kp.org/oebb/plans/</u> at bottom of page.
- 8 For Kaiser plans, acupuncture care, spinal manipulation and naturopathic substance only accrue towards your \$2000 benefit maximum. For Moda Plans, acupuncture and spinal manipulation services are subject to 12 visits per plan year.
- 9 For Moda plans, CirrusMD app is covered at no member cost sharing. All other virtual care for primary and urgent care services (defined as 2-way video conferencing visits) is covered at a \$10 copay with deductible waived for plans 1-5. Plans 6 and 7 is a \$10 copay after the deductible has been met.

- 10 For Moda plans, member must see their chosen PCP 360 or any in-network specialist to recieve the copay benefit.
- 11 For Moda plans, the copay listed is for acupuncture and spinal manipulation services only. Naturopathic substances are covered. See Plan Handbook for details.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to vour 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.