2026–27 Benefits Comparison

Medical and Pharmacy Plans

Contents:

KAISER PERMANENTE®

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

No lifetime maximum on any medical plans.	**Medical Plan 1** Kaiser Permanente Network		**Medical Plan 2A** Kaiser Permanente Network		**Medical Plan 2B** Kaiser Permanente Network		**Medical Plan 3** Kaiser Permanente Network HSA Optional	
	In-Network Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays
Deductible per person	$400	Not applicable	$1,000	Not applicable	$1,400	Not applicable	$1,800[2]	Not applicable
Maximum deductible per family	$800	Not applicable	$2,000	Not applicable	$2,800	Not applicable	$3,600[2]	Not applicable
Out-of-pocket (OOP) maximum per person	$1,700	Not applicable	$4,200	Not applicable	$4,700	Not applicable	$6,750[2]	Not applicable
Out-of-pocket (OOP) maximum per family	$3,400	Not applicable	$8,400	Not applicable	$9,400	Not applicable	$13,500[2]	Not applicable
Preventive care services								
Routine adult, well-child and women's exams; annual obesity screening and immunizations	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered
Office visits and virtual care								
Primary care office visits	$25[1]	Not covered	$30[1]	Not covered	$35[1]	Not covered	20% after deductible	Not covered
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Incentive care office visits (Moda Plans only)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0 after deductible	Not covered
Specialist office visits	$35[1]	Not covered	$40[1]	Not covered	$45[1]	Not covered	20% after deductible	Not covered
Urgent care	$40[1]	See plan handbook	$45[1]	See plan handbook	$50[1]	See plan handbook	20% after deductible	See plan handbook

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network		Medical Plan 2A Kaiser Permanente Network		Medical Plan 2B Kaiser Permanente Network		Medical Plan 3 Kaiser Permanente Network HSA Optional	
	In-Network Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays
Mental health and chemical dependency services								
Mental health office visits	$25[1]	Not covered	$30[1]	Not covered	$35[1]	Not covered	20% after deductible	Not covered
Mental health inpatient and residential services	20% after deductible	Not covered	20% after deductible	Not covered	20% after deductible	Not covered	20% after deductible	Not covered
Chemical dependency services (outpatient or residential)	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	20% after deductible	Not covered
Chemical dependency services (inpatient)	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	20% after deductible	Not covered
Outpatient services								
Outpatient surgery / facility care	20% after deductible	Not covered	20% after deductible	Not covered	20% after deductible	Not covered	20% after deductible	Not covered
Outpatient rehabilitation (physical, occupational and speech therapy)	$35[1] per visit	Not covered	$40[1] per visit	Not covered	$45[1] per visit	Not covered	20% after deductible	Not covered
Diagnostic testing								
Labs, x-ray, and imaging	$35[1] per visit	Not covered	$40[1] per visit	Not covered	$45[1] per visit	Not covered	20% after deductible	Not covered
CT, MRI, PET scans	$100[1] per visit	Not covered	$100[1] per visit	Not covered	$100[1] per visit	Not covered	20% after deductible	Not covered
Alternative care services								
Acupuncture and Chiropractic[7]	$25[1] per service	Not covered	$30[1] per service	Not covered	$35[1] per service	Not covered	20% after deductible	Not covered
Naturopathic office visits	$25[1] per service	Not covered	$30[1] per service	Not covered	$35[1] per service	Not covered	20% after deductible	Not covered
Maternity care								
Routine maternity care	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered
Physician or midwife services and hospital stay, delivery and routine newborn nursery care	20% after deductible	Not covered	20% after deductible	Not covered	20% after deductible	Not covered	20% after deductible	Not covered

Medical and Pharmacy Plans — continued

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

No lifetime maximum on any medical plans.	**Medical Plan 1** Kaiser Permanente Network		**Medical Plan 2A** Kaiser Permanente Network		**Medical Plan 2B** Kaiser Permanente Network		**Medical Plan 3** Kaiser Permanente Network HSA Optional	
	In-Network Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays
Hospital services								
Inpatient care/surgery	20% after deductible	See plan handbook	20% after deductible	See plan handbook	20% after deductible	See plan handbook	20% after deductible	See plan handbook
Skilled nursing facility care	20% after deductible	Not applicable	20% after deductible	Not applicable	20% after deductible	Not applicable	20% after deductible	Not applicable
Additional Cost Tier (ACT)								
Moda Plans Only: $100 ACT: specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Moda Plans Only: $500 ACT: Spine surgery, knee and hip replacement[3], knee and shoulder arthroscopy, uncomplicated hernia repair	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Emergency services								
Emergency room	20% after deductible		20% after deductible		20% after deductible		20% after deductible	
Ambulance	$75[1]		$100[1]		$100[1]		20% after deductible	
Other covered services								
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for state-mandated benefit for children	10%[1]	Not covered	10%[1]	Not covered	10%[1]	Not covered	20% after deductible	Not covered
Durable medical equipment (DME)	20%[1]	Not covered	20%[1]	Not covered	20%[1]	Not covered	20% after deductible	Not covered
Pharmacy services								
Out-of-pocket (OOP) maximum	Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max	
Retail								
Value	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	$0[1]	Not applicable
Generic (Kaiser Plans) / Select generic (Moda Plans)	$10 per 30-day supply	See plan handbook	$10 per 30-day supply	See plan handbook	$10 per 30-day supply	See plan handbook	20% after deductible	See plan handbook

Medical and Pharmacy Plans — continued

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

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network		Medical Plan 2A Kaiser Permanente Network		Medical Plan 2B Kaiser Permanente Network		Medical Plan 3 Kaiser Permanente Network HSA Optional	
	In-Network Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays	**In-Network** Member Pays	**Out-of-Network** Member Pays
Retail								
Preferred brand	$30 per 30-day supply	See plan handbook	$30 per 30-day supply	See plan handbook	$30 per 30-day supply	See plan handbook	20% after deductible	See plan handbook
Non-preferred brand[4]	$50 per 30-day supply if criteria met	See plan handbook	$50 per 30-day supply if criteria met	See plan handbook	$50 per 30-day supply if criteria met	See plan handbook	20% after deductible	See plan handbook
Mail								
Value	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Generic (Kaiser plans) / Select generic (Moda Plans)	$20 per 90-day supply	See plan handbook	$20 per 90-day supply	See plan handbook	$20 per 90-day supply	See plan handbook	20% after deductible	See plan handbook
Preferred Brand	$60 per 90-day supply	See plan handbook	$60 per 90-day supply	See plan handbook	$60 per 90-day supply	See plan handbook	20% after deductible	See plan handbook
Non-preferred brand[4]	$100 per 90-day supply if criteria met	See plan handbook	$100 per 90-day supply if criteria met	See plan handbook	$100 per 90-day supply if criteria met	See plan handbook	20% after deductible	See plan handbook
Specialty								
Generic (Moda Plans only)	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $150 per 30-day supply	See plan handbook	25% up to $150 per 30-day supply	See plan handbook	25% up to $150 per 30-day supply	See plan handbook	20% after deductible	See plan handbook
Non-preferred brand[4]	25% up to $150 per 30-day supply	See plan handbook	25% up to $150 per 30-day supply	See plan handbook	25% up to $150 per 30-day supply	See plan handbook	20% after deductible	See plan handbook

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

4 A formulary exception must be approved for non-preferred brand prescription medication.

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.

Medical and Pharmacy Plans — continued

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

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan year costs[5]	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays
Deductible per person	$950	$1,050	$1,350	$1,350	$1,450	$2,150	$1,750	$1,850	$2,950	$2,150	$2,250	$3,750
Maximum deductible per family	$2,100	$2,100	$2,700	$2,900	$2,900	$4,300	$3,700	$3,700	$5,900	$4,500	$4,500	$7,500
Out-of-pocket (OOP) maximum per person[3]	$4,000	$4,400	$7,150	$5,000	$5,400	$9,150	$6,000	$6,400	$11,150	$7,850	$8,250	$14,850
Out-of-pocket (OOP) maximum per family[3]	$8,800	$8,800	$14,300	$10,800	$10,800	$18,300	$12,800	$12,800	$22,300	$16,500	$16,500	$29,700
Preventive care services												
Routine adult, well-child and women's exams; annual obesity screening and immunizations	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office visits and virtual care												
Primary care office visits	$35[1,5]	20% after deductible	50% after deductible	$35[1,5]	20% after deductible	50% after deductible	$40[1,5]	25% after deductible	50% after deductible	$40[1,5]	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$55[1]	Not applicable	50% after deductible	$55[1]	Not applicable	50% after deductible	$65[1]	Not applicable	50% after deductible	$65[1]	Not applicable	50% after deductible
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered
Specialist office visits	$55[1]	20% after deductible	50% after deductible	$55[1]	20% after deductible	50% after deductible	$65[1]	25% after deductible	50% after deductible	$65[1]	25% after deductible	50% after deductible
Urgent care	$55[1]	20% after deductible	20% after deductible	$55[1]	20% after deductible	20% after deductible	$65[1]	25% after deductible	25% after deductible	$65[1]	25% after deductible	25% after deductible

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

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

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

No lifetime maximum on any medical plans.	**Medical Plan 1** Connexus Network			**Medical Plan 2** Connexus Network			**Medical Plan 3** Connexus Network			**Medical Plan 4** Connexus Network		
Plan year costs[5]	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays
Maternity care												
Routine maternity care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Physician or midwife services and hospital stay, delivery and routine newborn nursery care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Hospital services												
Inpatient care / surgery	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Additional Cost Tier (ACT)												
Moda Plans Only: $100 ACT: specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible
Moda Plans Only: $500 ACT: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible
Emergency services												
Emergency room (copay waived if admitted)	$100 copay + 20% after deductible			$100 copay + 20% after deductible			$100 copay + 25% after deductible			$100 copay + 25% after deductible		
Ambulance	20% after deductible			20% after deductible			25% after deductible			25% after deductible		

Medical and Pharmacy Plans — continued

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

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan year costs[5]	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays
Other covered services												
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible
Durable medical equipment (DME)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Pharmacy services												
Out-of-pocket (OOP) maximum	Rx applies toward OOP maximum			Rx applies toward OOP maximum			Rx applies toward OOP maximum			Rx applies toward OOP maximum		
Retail												
Value	$4 per 31-day supply		See plan handbook	$4 per 31-day supply		See plan handbook	$4 per 31-day supply		See plan handbook	$4 per 31-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply			$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[4]	50% up to $350 per 31-day supply			50% up to $350 per 31-day supply			50% up to $350 per 31-day supply			50% up to $350 per 31-day supply		
Mail												
Value	$8 per 90-day supply		See plan handbook	$8 per 90-day supply		See plan handbook	$8 per 90-day supply		See plan handbook	$8 per 90-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply			$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[4]	50% up to $900 per 90-day supply			50% up to $900 per 90-day supply			50% up to $900 per 90-day supply			50% up to $900 per 90-day supply		

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

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

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

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This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.

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

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network HDHP HSA Compliant			Medical Plan 7 Connexus Network HDHP HSA Compliant		
Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays
Deductible per person	$2,550	$2,650	$4,550	$2,150[2]	$2,250[2]	$3,750[2]	$2,550[2]	$2,650[2]	$4,550[2]
Maximum deductible per family	$5,300	$5,300	$9,100	$4,500[2]	$4,500[2]	$7,500[2]	$5,300[2]	$5,300[2]	$9,100[2]
Out-of-pocket (OOP) maximum per person[3]	$7,950	$8,350	$14,850	$7,550[2]	$7,900[2]	$14,250[2]	$7,650[2]	$7,900[2]	$14,450[2]
Out-of-pocket (OOP) maximum per family[3]	$16,700	$16,700	$29,700	$15,800[2]	$15,800[2]	$28,500[2]	$15,800[2]	$15,800[2]	$28,900[2]
Preventive care services									
Routine adult, well-child and women's exams; annual obesity screening and immunizations	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office visits and virtual care									
Primary care office visits	$45[1,5]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$65[1]	Not applicable	50% after deductible	15% after deductible	Not applicable	50% after deductible	20% after deductible	Not applicable	50% after deductible
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0 after deductible	$0 after deductible	Not covered	$0 after deductible	$0 after deductible	Not covered
Specialist office visits	$65[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Urgent care	$65[1]	25% after deductible	25% after deductible	15% after deductible	20% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Mental health services									
Mental health office visits	$45[1]	$45[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Mental health inpatient and residential services	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	$45[1]	$45[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (inpatient)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

Medical and Pharmacy Plans — continued

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

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network HDHP HSA Compliant			Medical Plan 7 Connexus Network HDHP HSA Compliant		
Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	**In-Network Coordinated Care**[5] Member Pays	**In-Network Non-Coordinated Care**[6] Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care**[5] Member Pays	**In-Network Non-Coordinated Care**[6] Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care**[5] Member Pays	**In-Network Non-Coordinated Care**[6] Member Pays	**Any Out-of-Network Services** Member Pays
Outpatient services									
Outpatient surgery / facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational and speech therapy)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Diagnostic testing									
Labs, x-ray, and imaging	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative care services									
Acupuncture and Chiropractic[7]	$45[1]	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Naturopathic services	$65[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Maternity care									
Routine maternity care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Physician or midwife services and hospital stay, delivery and routine newborn nursery care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Hospital services									
Inpatient care / surgery	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

Medical and Pharmacy Plans — continued

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

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network HDHP HSA Compliant			Medical Plan 7 Connexus Network HDHP HSA Compliant		
Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care[5]** Member Pays	**In-Network Non-Coordinated Care[6]** Member Pays	**Any Out-of-Network Services** Member Pays
Additional cost tier (ACT)									
Moda Plans only: $100 ACT: specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Moda Plans only: $500 ACT: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Emergency services									
Emergency room (copay waived if admitted)	$100 copay + 25% after deductible			20% after deductible	25% after deductible	See plan handbook	20% after deductible	25% after deductible	See plan handbook
Ambulance	25% after deductible			20% after deductible	25% after deductible	See plan handbook	20% after deductible	25% after deductible	See plan handbook
Other covered services									
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Pharmacy services									
Out-of-pocket (OOP) maximum	Rx applies toward OOP maximum			Rx applies toward plan OOP maximum			Rx applies toward plan OOP maximum		
Retail									
Value	$4 per 31-day supply		See plan handbook	$4[1] per 31-day supply		See plan handbook	$4[1] per 31-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to $75 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[5]	50% up to $350 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

Medical and Pharmacy Plans — continued

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No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network HDHP HSA Compliant			Medical Plan 7 Connexus Network HDHP HSA Compliant		
Plan year costs – deductibles and copayments apply to the annual out-of-pocket maximum	**In-Network Coordinated Care**[5] Member Pays	**In-Network Non-Coordinated Care**[6] Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care**[5] Member Pays	**In-Network Non-Coordinated Care**[6] Member Pays	**Any Out-of-Network Services** Member Pays	**In-Network Coordinated Care**[5] Member Pays	**In-Network Non-Coordinated Care**[6] Member Pays	**Any Out-of-Network Services** Member Pays
Mail									
Value	$8 per 90-day supply		See plan handbook	$8[1] per 90-day supply		See plan handbook	$8[1] per 90-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to $150 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $900 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Specialty									
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed		See plan handbook	20% after deductible	25% after deductible	See plan handbook	20% after deductible	25% after deductible	See plan handbook
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $1,000 per 31-day supply or $2,000 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

1 Deductible waived.

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