# OEBB Summary of Medical and Pharmacy Benefits 2019-20 Plan Year

| **No lifetime maximum on any medical plans.** | KAISER PERMANENTE® **Medical Plan 1** **Kaiser Permanente Network** | | KAISER PERMANENTE® **Medical Plan 2** **Kaiser Permanente Network** | | KAISER PERMANENTE® **Medical Plan 3** **Kaiser Permanente Network** ***HSA Optional*** | |
|---|---|---|---|---|---|---|
| **Plan Year Costs** - Deductibles and copayments apply to the annual out-of-pocket maximum. | 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 | None | NA | $800 | NA | $1,600[2] | NA |
| Maximum deductible per family | None | NA | $2,400 | NA | $3,200[2] | NA |
| Out-of-pocket (OOP) maximum per person [3] | $1,500 | NA | $4,000 | NA | $6,550[2] | NA |
| Out-of-pocket (OOP) maximum per family [3] | $3,000 | NA | $12,000 | NA | $13,100[2] | NA |
| Maximum cost share per person | NA | NA | NA | NA | NA | NA |
| Maximum cost share per family | NA | NA | NA | NA | NA | NA |
| **Preventive Care Services** | | | | | | |
| Wellness visit (Moda plans: ages 21 and over, must use PCP 360) | $0 | 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 |
| | | | | | | |
| Primary care office visits | $20 | Not Covered | $25[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 |
| Specialist office visits | $30 | Not Covered | $35[1] | Not Covered | 20% | Not Covered |
| Urgent care | $35 | See Plan Handbook | $40[1] | See Plan Handbook | 20% | See Plan Handbook |
| **Mental Health Services** | | | | | | |
| Mental health office visits | $20 | Not Covered | $25[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 |
| Chemical dependency services (inpatient, outpatient or residential) | $0 | Not Covered | $0[1] | Not Covered | 20% | Not Covered |
| **Outpatient Services** | | | | | | |
| Outpatient surgery/facility care | $75 | Not Covered | 20% | Not Covered | 20% | Not Covered |
| Outpatient rehabilitation (physical, occupational & speech therapy)<br>**Kaiser Plans:** Maximum 20 visits per therapy per Plan Year<br>**Moda Plans:** 30 sessions per plan year / 60 for spinal or head injury | $30 per visit | Not Covered | $35[1] per visit | Not Covered | 20% | Not Covered |
| **Tests (outpatient)** | | | | | | |
| Preventive tests | $0 | Not Covered | $0[1] | Not Covered | $0[1] | Not Covered |
| Laboratory | $20 per visit | Not Covered | $25[1] per visit | Not Covered | 20% | Not Covered |
| X-ray, imaging, and special diagnostic procedures | $20 per visit | Not Covered | $25[1] per visit | Not Covered | 20% | Not Covered |
| CT, MRI, PET scans | $20 per visit | Not Covered | $25[1] per visit | Not Covered | 20% | Not Covered |
| **Alternative Care Services** ($2,000 combined maximum) | | | | | | |
| Acupuncture, chiropractic & naturopathic services, labs, diagnostics, etc.<br>*Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum* | $20 per service | Not Covered | $25[1] per service | Not Covered | 20% | Not Covered |
| **Maternity Care** | | | | | | |
| Outpatient maternity care | $0 | 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 |

NA = Not applicable
[1] Deductible waived
[2] Individual deductible and out-of-pocket (OOP) maximum apply to single coverage only. Family deductible and OOP maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member OOP maximum, which is set at the individual OOP maximum amount. Under this plan, deductible must be met before benefits will be paid (except where [1] indicates deductible waived).
[3] For Moda plans, out-of-pocket (OOP) maximum includes medical copays and coinsurance. Pharmacy copays and coinsurance, and ACT copays, will continue accruing toward Maximum Cost Share.
[4] Benefit is subject to 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 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 under that plan 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.

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|---|---|---|---|---|---|---|
| **Plan Year Costs** - Deductibles and copayments apply to the annual out-of-pocket maximum. | 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 | $100 per day, up to $500 per admission max | See Plan Handbook | 20% | See Plan Handbook | 20% | See Plan Handbook |
| Skilled nursing facility care (**Kaiser Plans:** 100 days per plan year, **Moda Plans:** 60 days per plan year) | $0 | NA | 20% | NA | 20% | NA |
| **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 | NA | NA | NA | NA | NA | NA |
| **Moda Plans Only:** $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[4], knee & shoulder arthroscopy, uncomplicated hernia repair | NA | NA | NA | NA | NA | NA |
| **Emergency Services** | | | | | | |
| Emergency room (copay waived if admitted) | $100 per visit (waived if admitted) | | 20% | | 20% | |
| Ambulance | $75 | | $100[1] | | 20% | |
| **Other Covered Services** | | | | | | |
| Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children | 10% | Not Covered | 10%[1] | Not Covered | 20% | Not Covered |
| Durable medical equipment (DME) | 20% | Not Covered | 20%[1] | Not Covered | 20% | Not Covered |
| Bariatric surgery (Roux-en-Y and gastric sleeve) | $500 + Inpatient Care costs | Not Covered | $500 + 20% | Not Covered | $500 + 20% | Not Covered |
| **Pharmacy Services** | | | | | | |
| 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 | |
| **Retail** | | | | | | |
| Value (Moda Plans Only) | NA | NA | NA | NA | NA | NA |
| Generic (Kaiser Plans) / Select generic (Moda Plans) | $5 per 30-day-supply | See Plan Handbook | $5 per 30-day supply | See Plan Handbook | 20% | See Plan Handbook |
| Preferred brand | $25 per 30-day supply | See Plan Handbook | $25 per 30-day supply | See Plan Handbook | 20% | See Plan Handbook |
| Non-preferred brand[5] | $45 per 30-day supply if criteria met | See Plan Handbook | $45 per 30-day supply if criteria met | See Plan Handbook | 20% | See Plan Handbook |
| **Mail** | | | | | | |
| Value (Moda Plans Only) | NA | NA | NA | NA | NA | NA |
| Generic (Kaiser plans) / Select generic (Moda Plans) | $10 per 90-day supply | See Plan Handbook | $10 per 90-day supply | See Plan Handbook | 20% | See Plan Handbook |
| Preferred Brand | $50 per 90-day supply | See Plan Handbook | $50 per 90-day supply | See Plan Handbook | 20% | See Plan Handbook |
| Non-preferred brand[5] | $90 per 90-day supply if criteria met | See Plan Handbook | $90 per 90-day supply if criteria met | See Plan Handbook | 20% | See Plan Handbook |
| **Specialty** | | | | | | |
| 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% | See Plan Handbook |
| Non-preferred brand[5] | 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 Handbook |

NA = Not applicable

[1] Deductible waived

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

[3] For Moda plans, out-of-pocket (OOP) maximum includes medical copays and coinsurance. Pharmacy copays and coinsurance, and ACT copays, will continue accruing toward Maximum Cost Share.

[4] Benefit is subject to 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 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 under that plan 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.

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| **No lifetime maximum on any medical plans.** | moda HEALTH **Medical Plan 1 Connexus Network** | | | moda HEALTH **Medical Plan 2 Connexus Network** | | | moda HEALTH **Medical Plan 3 Connexus Network** | | | moda HEALTH **Medical Plan 4 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 | $7,900 | $7,900 | NA | $7,900 | $7,900 | NA | $7,900 | $7,900 | NA |
| Maximum cost share per family | $15,800 | $15,800 | NA | $15,800 | $15,800 | NA | $15,800 | $15,800 | NA | $15,800 | $15,800 | NA |
| **Preventive Care Services** | | | | | | | | | | | | |
| Wellness visit (Moda plans: ages 21 and over, must use PCP 360) | $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% | $0[1] | $0[1] | 50% | $0[1] | $0[1] | 50% | $0[1] | $0[1] | 50% |
| | | | | | | | | | | | | |
| Primary care office visits | $20[1,6] | 20% | 50% | $20[1,6] | 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% |
| 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)<br>**Kaiser Plans:** Maximum 20 visits per therapy per Plan Year<br>**Moda Plans:** 30 sessions per plan year / 60 for spinal or head injury | 20% | 20% | 50% | 20% | 20% | 50% | 25% | 25% | 50% | 25% | 25% | 50% |
| **Tests (outpatient)** | | | | | | | | | | | | |
| Preventive tests | $0[1] | $0[1] | 50% | $0[1] | $0[1] | 50% | $0[1] | $0[1] | 50% | $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 + 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% |
| **Alternative Care Services** ($2,000 combined maximum) | | | | | | | | | | | | |
| Acupuncture, chiropractic & naturopathic services, labs, diagnostics, etc.<br>*Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum* | $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% |

NA = Not applicable

[1] Deductible waived

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[4] Benefit is subject to reference price limitation.

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|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **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, **Moda Plans:** 60 days per plan year) | 20% | 20% | 50% | 20% | 20% | 50% | 25% | 25% | 50% | 25% | 25% | 50% |
| **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 + 20% | $100 copay + 20% | | $100 copay + 25% | $100 copay + 25% | | $100 copay + 25% | $100 copay + 25% | |
| Ambulance | 20% | 20% | | 20% | 20% | | 25% | 25% | | 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 (Roux-en-Y and gastric sleeve) | $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 applies toward Max Cost Share | | | Rx applies toward Max Cost Share | | | Rx applies toward Max Cost Share | | | Rx applies toward Max Cost Share | | |
| **Retail** | | | | | | | | | | | | |
| Value (Moda Plans Only) | $4 per 31-day supply | | | $4 per 31-day supply | | | $4 per 31-day supply | | | $4 per 31-day supply | | |
| Generic (Kaiser Plans) / Select generic (Moda Plans) | $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[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 | | | 50% up to $175 per 31-day supply | | |
| **Mail** | | | | | | | | | | | | |
| Value (Moda Plans Only) | $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 | | | $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[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** | | | | | | | | | | | | |
| Select generic (Kaiser plans) / Preferred brand (Moda Plans) | 25% up to $200 per 31-day supply | | | 25% up to $200 per 31-day supply | | | 25% up to $200 per 31-day supply | | | 25% up to $200 per 31-day supply | | |
| Non-preferred brand[5] | 50% up to $500 per 31-day supply | | | 50% up to $500 per 31-day supply | | | 50% up to $500 per 31-day supply | | | 50% up to $500 per 31-day supply | | |

NA = Not applicable

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| **No lifetime maximum on any medical plans.** | moda HEALTH **Medical Plan 5 Connexus Network** | | | moda HEALTH **Medical Plan 6 Connexus Network** *HSA optional* | | | moda HEALTH **Medical Plan 7 Connexus Network** *HSA optional* | | |
|---|---|---|---|---|---|---|---|---|---|
| **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 (Moda plans: ages 21 and over, must use PCP 360) | $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% |
| | | | | | | | | | |
| 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% |
| Specialist office visits | $50[1] | 25% | 50% | 15% | 20% | 50% | 20% | 25% | 50% |
| Urgent care | $50[1] | 25% | 25% | 15% | 20% | 20% | 20% | 25% | 25% |
| **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)<br>**Kaiser Plans:** Maximum 20 visits per therapy per Plan Year<br>**Moda Plans:** 30 sessions per plan year / 60 for spinal or head injury | 25% | 25% | 50% | 20% | 25% | 50% | 20% | 25% | 50% |
| **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** ($2,000 combined maximum) | | | | | | | | | |
| Acupuncture, chiropractic & naturopathic services, labs, diagnostics, etc.<br>*Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum* | $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% |

NA = Not applicable

[1] Deductible waived

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

[3] For Moda plans, out-of-pocket (OOP) maximum includes medical copays and coinsurance. Pharmacy copays and coinsurance, and ACT copays, will continue accruing toward Maximum Cost Share.

[4] Benefit is subject to 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 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 under that plan 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.

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# OEBB Summary of Medical and Pharmacy Benefits 2019-20 Plan Year

| **No lifetime maximum on any medical plans.** | moda HEALTH **Medical Plan 5 Connexus Network** | | | moda HEALTH **Medical Plan 6 Connexus Network *HSA optional*** | | | moda HEALTH **Medical Plan 7 Connexus Network *HSA optional*** | | |
|---|---|---|---|---|---|---|---|---|---|
| **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 |
| **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, **Moda Plans:** 60 days per plan year) | 25% | 25% | 50% | 20% | 25% | 50% | 20% | 25% | 50% |
| **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% | $100 copay + 25% | | 20% | 25% | | 20% | 25% | |
| Ambulance | 25% | 25% | | 20% | 25% | | 20% | 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% | 20% | 25% | 50% | 20% | 25% | 50% |
| Durable medical equipment (DME) | 25% | 25% | 50% | 20% | 25% | 50% | 20% | 25% | 50% |
| Bariatric surgery (Roux-en-Y and gastric sleeve) | $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 applies toward Max Cost Share | | | Rx applies toward plan OOP max | | | Rx applies toward plan OOP max | | |
| **Retail** | | | | | | | | | |
| Value (Moda Plans Only) | $4 per 31-day supply | | | $4[1] per 31-day supply | | | $4[1] per 31-day supply | | |
| Generic (Kaiser Plans) / Select generic (Moda Plans) | $12 per 31-day supply | | | 20% | 25% | | 20% | 25% | |
| Preferred brand | 25% up to $75 per 31-day supply | | | 20% | 25% | | 20% | 25% | |
| Non-preferred brand[5] | 50% up to $175 per 31-day supply | | | 20% | 25% | | 20% | 25% | |
| **Mail** | | | | | | | | | |
| Value (Moda Plans Only) | $8 per 90-day supply | | | $8[1] per 90-day supply | | | $8[1] per 90-day supply | | |
| Generic (Kaiser plans) / Select generic (Moda Plans) | $24 per 90-day supply | | | 20% | 25% | | 20% | 25% | |
| Preferred Brand | 25% up to $150 per 90-day supply | | | 20% | 25% | | 20% | 25% | |
| Non-preferred brand[5] | 50% up to $450 per 90-day supply | | | 20% | 25% | | 20% | 25% | |
| **Specialty** | | | | | | | | | |
| Select generic (Kaiser plans) / Preferred brand (Moda Plans) | 25% up to $200 per 31-day supply | | | 20% | 25% | | 20% | 25% | |
| Non-preferred brand[5] | 50% up to $500 per 31-day supply | | | 20% | 25% | | 20% | 25% | |

NA = Not applicable

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