Hillsboro School District
Summary of **Kaiser** Medical and Pharmacy
Classified Staff
2025-26 Plan Year

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 2B with HRA** Kaiser Permanente Network			**Medical Plan 3** Kaiser Permanente Network **with HRA**		
	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
			Base Plan	**With HRA**		**Base Plan**	**With HRA**	
Deductible per person	$400	Not applicable	~~$1,400~~	$0	Not applicable	~~$1,800~~ [2]	$500 [2]	Not applicable
Maximum deductible per family	$800	Not applicable	~~$2,800~~	$0	Not applicable	~~$3,600~~ [2]	$1,000 [2]	Not applicable
Out-of-pocket (OOP) maximum per person	$1,700	Not applicable	~~$4,700~~	$1,500	Not applicable	~~$6,750~~ [2]	$2,500 [2]	Not applicable
Out-of-pocket (OOP) maximum per family	$3,400	Not applicable	~~$9,400~~	$3,000	Not applicable	~~$13,500~~ [2]	$5,000 [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
Office visits and virtual care								
Primary care office visits	$25 [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
Incentive care office visits (Moda Plans only)	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 after deductible		Not covered
Specialist office visits	$35 [1]	Not covered	$45 [1]		Not covered	20% after deductible		Not covered
Urgent care	$40 [1]	See plan handbook	$50 [1]		See plan handbook	20% after deductible		See plan handbook

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Mental health and chemical dependency services						
Mental health office visits	$25 [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
Chemical dependency services (outpatient or residential)	$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	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
Outpatient rehabilitation (physical, occupational and speech therapy)	$35 [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	$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	20% after deductible	Not covered
Alternative care services						
Acupuncture and Chiropractic [7]	$25 [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	$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
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

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Hospital services						
Inpatient care/surgery	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
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
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
Emergency services						
Emergency room	20% after deductible		20% after deductible		20% after deductible	
Ambulance	$75 [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	20% after deductible	Not covered
Durable medical equipment (DME)	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	
Retail						
Value	Not applicable	Not applicable	Not applicable	Not applicable	$0 [7]	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	20% after deductible	See plan handbook

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Retail						
Preferred brand	$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	20% after deductible	See plan handbook
Mail						
Value	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% after deductible	See plan handbook
Preferred Brand	$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	20% after deductible	See plan handbook
Specialty						
Generic (Moda Plans only)	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	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	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.