



Medical and Pharmacy Plans — continued

Cost per month:

\$2024.36

\$1877.89

\$1761.81

\$1663.57

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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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



Medical and Pharmacy Plans — continued

Cost per month: \$2024.36 \$1877.89 \$1761.81 \$1663.57

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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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



Medical and Pharmacy Plans — continued

Cost per month: \$2024.36 \$1877.89 \$1761.81 \$1663.57

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

Cost per month:

\$2024.36

\$1877.89

\$1761.81

\$1663.57

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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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						
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						
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						
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						
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						
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						

Cost per month:														\$2024.36	\$1877.89	\$1761.81	\$1663.57
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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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).

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

Cost per month:		\$1536.70			\$1567.51			\$1462.94			
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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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

Cost per month:									
\$1536.70		\$1567.51					\$1462.94		
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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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

Cost per month:									
No lifetime maximum on any medical plans.	\$1536.70			\$1567.51			\$1462.94		
	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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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	

Cost per month:									
No lifetime maximum on any medical plans.	\$1536.70			\$1567.51			\$1462.94		
	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-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated 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.

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.