# Summary of Medical and Pharmacy Benefits
## 2017-18 Plan Year

| No lifetime maximum on any medical plans. | KAISER PERMANENTE. Med Plan 1 HMO Kaiser Permanente Network | | KAISER PERMANENTE. Med Plan 2 HMO Kaiser Permanente Network | | KAISER PERMANENTE. Med Plan 3 HMO 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 Medical Home) | $0 | NA | $0[1] | NA | $0[1] | NA |
| Includes routine adult, well-child and women's exams, annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services | $0 | Not Covered | $0[1] | Not Covered | $0[1] | Not Covered |
| **Incentive Care Services** (for asthma, heart conditions, cholesterol, high blood pressure, diabetes) | | | | | | |
| Moda Medical Home incentive care | NA | NA | NA | NA | NA | NA |
| Incentive office visits and home visits | NA | NA | NA | NA | NA | NA |
| **Office Services** | | | | | | |
| Moda Medical Home primary care services | NA | NA | NA | NA | NA | NA |
| Primary care office visits | $20 | Not Covered | $25[1] | Not Covered | 20% | Not Covered |
| 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 maximum | 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) Kaiser Plans: Maximum 20 visits per therapy per Plan Year 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. *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 maximum | Not Covered | 20% | Not Covered | 20% | Not Covered |
| **Hospital Services** | | | | | | |
| Inpatient care/surgery | $100 per day, up to $500 per admission maximum | 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 |

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# Summary of Medical and Pharmacy Benefits
## 2017-18 Plan Year

| No lifetime maximum on any medical plans. | KAISER PERMANENTE. Med Plan 1 HMO Kaiser Permanente Network | | KAISER PERMANENTE. Med Plan 2 HMO Kaiser Permanente Network | | KAISER PERMANENTE. Med Plan 3 HMO 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 |
| **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 endoscopes, 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<br>$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 Maximum | $1100<br>Rx max also applies to Medical OOP Max | | $1100<br>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 | $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 | $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 | 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

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit. If these services are performed outside the individual's selected Medical Home, they will be paid at the "Out-of-Network" benefit level

[1] Deductible waived

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

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit. )

[4] Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

**This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.**

# Summary of Medical and Pharmacy Benefits
## 2017-18 Plan Year

| No lifetime maximum on any medical plans. | Alder CCM™ Synergy or Summit Network | | Birch CCM™ Synergy or Summit Network | | Cedar CCM™ Synergy or Summit Network | | Dogwood CCM™ Synergy or Summit Network | | Evergreen CCM™ Synergy or Summit Network HSA Required | |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 | In Network Member Pays | Out of Network Member Pays | In Network Member Pays | Out of Network Member Pays |
| Deductible per person | $400 | $800 | $800 | $1,600 | $1,200 | $2,400 | $1,600 | $3,200 | $1,600[2] | $3,200[2] |
| Maximum deductible per family | $1,200 | $2,400 | $2,400 | $4,800 | $3,600 | $7,200 | $4,800 | $9,600 | $3,200[2] | $6,400[2] |
| Out-of-pocket (OOP) maximum per person [1] | $3,000 | $6,000 | $4,000 | $8,000 | $5,000 | $10,000 | $6,850 | $13,700 | $6,550[2] | $13,100[2] |
| Out-of-pocket (OOP) maximum per family [1] | $9,000 | $18,000 | $12,000 | $24,000 | $13,700 | $27,400 | $13,700 | $27,400 | $13,100[2] | $26,200[2] |
| Maximum cost share per person | $6,850 | N/A | $6,850 | N/A | $6,850 | N/A | $6,850 | N/A | NA | NA |
| Maximum cost share per family | $13,700 | N/A | $13,700 | N/A | $13,700 | N/A | $13,700 | N/A | NA | NA |
| **Preventive Care Services** | | | | | | | | | | |
| Wellness Visit (Moda plans: ages 21 and over must use Medical Home) | $0[1] | Not covered | $0[1] | Not covered | $0[1] | Not covered | $0[1] | Not covered | $0[1] | Not covered |
| Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% |
| **Incentive Care Services** (for asthma, heart conditions, cholesterol, high blood pressure, diabetes) | | | | | | | | | | |
| Moda Medical Home incentive care | $10 copay[1] | 50% | $15 copay[1] | 50% | $15 copay[1] | 50% | $15 copay[1] | 50% | 20% | 50% |
| Incentive office visits and home visits | see above | 50% | see above | 50% | see above | 50% | see above | 50% | see above | 50% |
| **Office Services** | | | | | | | | | | |
| Moda Medical Home primary care services | $20 copay[1] | 50% | $30 copay[1] | 50% | $30 copay[1] | 50% | $30 copay[1] | 50% | 20% | 50% |
| Primary care office visits | see above | 50% | see above | 50% | see above | 50% | see above | 50% | see above | 50% |
| Specialist office visits | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Urgent Care | $50[1] | | $50[1] | | $50[1] | | $50[1] | | 20% | |
| **Mental Health Services** | | | | | | | | | | |
| Mental health office visits | $20 copay[1] | 50% | $30 copay[1] | 50% | $30 copay[1] | 50% | $30 copay[1] | 50% | 20% | 50% |
| Mental health inpatient and residential services | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Chemical dependency services (inpatient, outpatient or residential) | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | 20% | 50% |
| **Outpatient Services** | | | | | | | | | | |
| Outpatient surgery/facility care | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 sessions per plan year / 60 for spinal or head injury | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| **Tests (outpatient)** | | | | | | | | | | |
| Preventive tests | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% |
| Laboratory | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| X-ray, imaging, and special diagnostic procedures | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| CT, MRI, PET scans | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | 20% | 50% |
| **Alternative Care Services** ($2,000 combined maximum) | | | | | | | | | | |
| Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum* | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| **Maternity Care** | | | | | | | | | | |
| Outpatient Maternity Care | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Physician or midwife services & hospital stay, delivery & routine newborn nursery care | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| **Hospital Services** | | | | | | | | | | |
| Inpatient care/surgery | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |

# Summary of Medical and Pharmacy Benefits
## 2017-18 Plan Year

| No lifetime maximum on any medical plans. | Moda Health Alder CCM™ Synergy or Summit Network | | Moda Health Birch CCM™ Synergy or Summit Network | | Moda Health Cedar CCM™ Synergy or Summit Network | | Moda Health Dogwood CCM™ Synergy or Summit Network | | Moda Health Evergreen CCM™ Synergy or Summit Network HSA Required | |
|---|---|---|---|---|---|---|---|---|---|---|
| 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 | In Network Member Pays | Out of Network Member Pays | In Network Member Pays | Out of Network Member Pays |
| **Additional Cost Tier** | | | | | | | | | | |
| Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopes, sleep studies, lumbar discographies | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | 20% | 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 + 50% | $500 copay + 20% | $500 copay + 50% | $500 copay + 20% | $500 copay + 50% | $500 copay + 20% | $500 copay + 50% | 20% | 50% |
| **Emergency Services** | | | | | | | | | | |
| Emergency room (copay waived if admitted) | $100 copay + 20% | | $100 copay + 20% | | $100 copay + 20% | | $100 copay + 20% | | 20% | |
| Ambulance | 20% | | 20% | | 20% | | 20% | | 20% | |
| **Other Covered Services** | | | | | | | | | | |
| Hearing Aids<br>$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children | 10% | 50% | 10% | 50% | 10% | 50% | 10% | 50% | 20% | 50% |
| Durable Medical Equipment (DME) | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Bariatric Surgery (Roux-en-Y and gastric sleeve) | $500 + 20% | Not covered | $500 + 20% | Not covered | $500 + 20% | Not covered | $500 + 20% | Not covered | $500 + 20% | Not covered |
| **Pharmacy Services** | | | | | | | | | | |
| Out-of-pocket 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 | | Rx applies toward plan OOP Max | |
| **Retail** | | | | | | | | | | |
| Value (Moda Plans Only) | $0 | | $0 | | $0 | | $0 | | $0[1] | |
| Generic (Kaiser plans) / Select generic (Moda Plans) | $8 per 31-day supply | | $8 per 31-day supply | | $8 per 31-day supply | | $8 per 31-day supply | | 20% | |
| Preferred Brand | 25% up to $50 per 31-day supply | | 25% up to $50 per 31-day supply | | 25% up to $50 per 31-day supply | | 25% up to $50 per 31-day supply | | 20% | |
| Non-preferred brand | 50% up to $150 per 31-day supply | | 50% up to $150 per 31-day supply | | 50% up to $150 per 31-day supply | | 50% up to $150 per 31-day supply | | 20% | |
| **Mail** | | | | | | | | | | |
| Value (Moda Plans Only) | $0 | | $0 | | $0 | | $0 | | $0[1] | |
| Generic (Kaiser plans) / Select generic (Moda Plans) | $16 per 90-day supply | | $16 per 90-day supply | | $16 per 90-day supply | | $16 per 90-day supply | | 20% | |
| Preferred Brand | 25% up to $100 per 90-day supply | | 25% up to $100 per 90-day supply | | 25% up to $100 per 90-day supply | | 25% up to $100 per 90-day supply | | 20% | |
| Non-preferred brand | 50% up to $300 per 90-day supply | | 50% up to $300 per 90-day supply | | 50% up to $300 per 90-day supply | | 50% up to $300 per 90-day supply | | 20% | |
| **Specialty** | | | | | | | | | | |
| Select generic (Kaiser plans) / Preferred brand (Moda Plans) | 25% up to $100 per 31-day supply | | 25% up to $100 per 31-day supply | | 25% up to $100 per 31-day supply | | 25% up to $100 per 31-day supply | | 20% | |
| Non-preferred brand | 50% up to $300 per 31-day supply | | 50% up to $300 per 31-day supply | | 50% up to $300 per 31-day supply | | 50% up to $300 per 31-day supply | | 20% | |

N/A - Not applicable

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the "Out-of-Network" benefit level.

[1] Deductible waived

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

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.

[4] Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

**This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.**

# Summary of Medical and Pharmacy Benefits
## 2017-18 Plan Year

| No lifetime maximum on any medical plans. | Moda Health Birch PPO Connexus Network | | Moda Health Cedar PPO Connexus Network | | Moda Health Dogwood PPO Connexus Network | | Moda Health Evergreen PPO Connexus Network *HSA Required* | |
|---|---|---|---|---|---|---|---|---|
| **Plan Year Costs** - Deductibles and copays that 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 | In-Network Member Pays | Out-of-Network Member Pays |
| Deductible per person | $800 | $1,600 | $1,200 | $2,400 | $1,600 | $3,200 | $1,600[2] | $3,200[2] |
| Maximum deductible per family | $2,400 | $4,800 | $3,600 | $7,200 | $4,800 | $9,600 | $3,200[2] | $6400[2] |
| Out-of-pocket (OOP) maximum per person [1] | $4,000 | $8,000 | $5,000 | $10,000 | $6,850 | $13,700 | $6,550[2] | $13,100[3] |
| Out-of-pocket (OOP) maximum per family [1] | $12,000 | $24,000 | $13,700 | $27,400 | $13,700 | $27,400 | $13,100[2] | $26,200[3] |
| Maximum cost share per person | $6,850 | N/A | $6,850 | N/A | $6,850 | N/A | NA | NA |
| Maximum cost share per family | $13,700 | N/A | $13,700 | N/A | $13,700 | N/A | NA | NA |
| **Preventive Care Services** | | | | | | | | |
| Wellness Visit (Moda plans: ages 21 and over, must use Medical Home) | $0[1] | Not covered | $0[1] | Not covered | $0[1] | Not covered | $0[1] | Not covered |
| Includes routine adult, well-child and women's exams, annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% |
| **Incentive Care Services** (for asthma, heart conditions, cholesterol, high blood pressure, diabetes) | | | | | | | | |
| Moda Medical Home incentive care | $15 copay[1] | 50% | $15 copay[1] | 50% | $15 copay[1] | 50% | 20% | 50% |
| Incentive office visits and home visits | 20%[1] | 50% | 20%[1] | 50% | 20%[1] | 50% | 20% | 50% |
| **Office Services** | | | | | | | | |
| Moda Medical Home primary care services | $30 copay[1] | 50% | $30 copay[1] | 50% | $30 copay[1] | 50% | 20% | 50% |
| Primary care office visits | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Specialist office visits | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Urgent Care | $50[1] | | $50[1] | | $50[1] | | 20% | |
| **Mental Health Services** | | | | | | | | |
| Mental health office visits | $30 copay[1] | 50% | $30 copay[1] | 50% | $30 copay[1] | 50% | 20% | 50% |
| Mental health inpatient and residential services | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Chemical dependency services (inpatient, outpatient or residential) | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | 20% | 50% |
| **Outpatient Services** | | | | | | | | |
| Outpatient surgery/facility care | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 sessions per plan year / 60 for spinal or head injury | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| **Tests (outpatient)** | | | | | | | | |
| Preventive tests | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% | $0[1] | 50% |
| Laboratory | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| X-ray, imaging, and special diagnostic procedures | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| CT, MRI, PET scans | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | 20% | 50% |
| **Alternative Care Services ($1,000 combined maximum)** | | | | | | | | |
| Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum* | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| **Maternity Care** | | | | | | | | |
| Outpatient Maternity Care | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Physician or midwife services & hospital stay, delivery & routine newborn nursery care | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| **Hospital Services** | | | | | | | | |
| Inpatient care/surgery | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |

# Summary of Medical and Pharmacy Benefits
# 2017-18 Plan Year

| No lifetime maximum on any medical plans. | moda HEALTH Birch PPO Connexus Network | | moda HEALTH Cedar PPO Connexus Network | | moda HEALTH Dogwood PPO Connexus Network | | moda HEALTH Evergreen PPO Connexus Network *HSA Required* | |
|---|---|---|---|---|---|---|---|---|
| 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 | In-Network Member Pays | Out-of-Network Member Pays |
| **Additional Cost Tier** | | | | | | | | |
| Moda Plans Only. $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | $100 copay + 20% | $100 copay + 50% | 20% | 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 + 50% | $500 copay + 20% | $500 copay + 50% | $500 copay + 20% | $500 copay + 50% | 20% | 50% |
| **Emergency Services** | | | | | | | | |
| Emergency room (copay waived if admitted) | $100 copay + 20% | | $100 copay + 20% | | $100 copay + 20% | | 20% | |
| Ambulance | 20% | | 20% | | 20% | | 20% | |
| **Other Covered Services** | | | | | | | | |
| Hearing Aids<br>$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children | 10% | 50% | 10% | 50% | 10% | 50% | 20% | 50% |
| Durable Medical Equipment (DME) | 20% | 50% | 20% | 50% | 20% | 50% | 20% | 50% |
| Bariatric Surgery (Roux-en-Y and gastric sleeve) | $500 + 20% | Not covered | $500 + 20% | Not covered | $500 + 20% | Not covered | $500 + 20% | Not covered |
| **Pharmacy Services** | | | | | | | | |
| Out-of-pocket Maximum | Rx applies toward Max Cost Share | | Rx applies toward Max Cost Share | | Rx applies toward Max Cost Share | | Rx applies toward plan OOP max | |
| **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 | | 20% | |
| 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 | | 20% | |
| Non-preferred brand | 50% up to $175 per 31-day supply | | 50% up to $175 per 31-day supply | | 50% up to $175 per 31-day supply | | 20% | |
| **Mail** | | | | | | | | |
| Value (Moda Plans Only) | $8 per 90-day supply | | $8 per 90-day supply | | $8 per 90-day supply | | $8[1] 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 | | 20% | |
| 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 | | 20% | |
| Non-preferred brand | 50% up to $450 per 90-day supply | | 50% up to $450 per 90-day supply | | 50% up to $450 per 90-day supply | | 20% | |
| **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 | | 20% | |
| Non-preferred brand | 50% up to $500 per 31-day supply | | 50% up to $500 per 31-day supply | | 50% up to $500 per 31-day supply | | 20% | |

N/A - Not applicable

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit. If these services are performed outside the individual's selected Medical Home, they will be paid at the "Out-of-Network" benefit level

[1] Deductible waived

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

[3] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For CCM plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.

[4] Benefit is subject to a reference price limitation. This is not applicable to CCM Plans.

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# Summary of Dental Benefits
## 2017-18 Plan Year

| Dental | Delta Dental<br>Premier Plan 1 ♦<br>Delta Dental Premier Network | Delta Dental<br>NEW for 2017-18<br>Premier Plan 5♦<br>Delta Dental Premier Network | Delta Dental<br>Premier Plan 6<br>Delta Dental Premier Network | Delta Dental<br>NEW for 2017-18<br>Exclusive PPO Plan ◻<br>Delta Dental PPO Network | Kaiser Permanente<br>Kaiser Dental Plan †<br>Kaiser Permanente Facilities | Willamette Dental Group<br>Willamette Dental Plan ‡<br>Willamette Dental Group Facilities |
|---|---|---|---|---|---|---|
| Dental Office Visit Copayment | NA | NA | NA | NA | $20 * | $20 ** |
| Benefit Maximum | $2,200 | $1,500 | $1,200 | $1,500 | $4,000 *** | NA |
| Deductible | $50 | $50 | $50 | $50 | NA | NA |
| **Preventive and Diagnostic Services * - Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans** | | | | | | |
| Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 100% | 100% | 100% * | 100% * |
| **Restorative Services *** | | | | | | |
| Routine fillings, inlays and stainless steel crowns | 70% + 10% [1] each Plan Year | 70% + 10% [1] each Plan Year | 80% [1] | 90% [1] | 100% [2],* | 100% * |
| **Simple Extraction *** | | | | | | |
| Simple tooth extractions | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 90% | 100% * | 100% * |
| **Oral Surgery *** | | | | | | |
| Surgical tooth extractions, including diagnosis and evaluation | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | [illegible]% | 100% * | 100% * |
| **Periodontics *** | | | | | | |
| Diagnosis, evaluation, and treatment of gum disease including scaling and root planing | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 90[illegible] | 100% * | 100% * |
| **Endodontics *** | | | | | | |
| Root canal and related therapy including diagnosis and evaluation | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 80% | 90% | 100% * | 100% * |
| **Major Restorative Services *** | | | | | | |
| Gold or porcelain crowns and onlays | 70% + 10% each Plan Year | 70% | 50% | 80% | 100% * | 100% * |
| Implants | 70% + 10% each Plan Year | 50% | 50% | 80% | 50% * (limit of 4 per lifetime) | See Certificate of Coverage for copays |
| **Other covered services*** | | | | | | |
| Occlusal guards (night guards) | 50% up to $150 maximum, once every 5 years | 50% up to $150 maximum, once every 5 years | 50% up to $150 maximum, once every 5 years | 80% | 90% | 100% [4] |
| Athletic mouth guards | 50% | 50% | 50% | 50% | 90% | $100* |
| **Fixed and Removable Prosthetic Services *** | | | | | | |
| Full and partial dentures, relines, rebases | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 50% | 80% | 100% * | 100% * |
| Bridge retainers and pontics | 70% + 10% each Plan Year | 70% + 10% each Plan Year | 50% | 80% | 100% * | 100% * |
| **Orthodontics * (All plans except Delta Dental Plan 6)** | | | | | | |
| Orthodontic Treatment | 80% to $1,800 lifetime max | 80% to $1,800 lifetime max | NA | 80% to $1,800 lifetime max | $1,500 copay + $20 per visit | $1,500 copay + $20 per visit ** |

♦ Under Delta Dental Plans 1 and 5, benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year. Switching between incentive plans (1 or 5) and other non-incentive plans will have an effect on benefit level.

† The Kaiser Dental Plan does NOT require enrollment in a Kaiser medical plan. Services must be provided by a contracted Kaiser provider in order for benefits to be payable. See handbook for details.

‡ Under the Willamette Dental Plan, services must be provided by a Willamette Dental Group provider in order for benefits to be payable. See handbook for details.

◻ The Delta Dental Exclusive PPO plan has no out-of-network benefit. Services performed by providers outside the Delta Dental PPO network are not covered unless for a dental emergency. Covered emergencies consist of problem focused exam, palliative treatment and x-rays. All other services are considered non-covered.

* For Kaiser Permanente and Willamette Dental Group plans: Office visit copayment applies at each visit, in addition to any plan copayments for services.
** Pre-Orthodontic Service fee of $150 is credited toward the orthodontic benefit if patient accepts treatment plan.
*** Preventive care and orthodontia do not accrue to this maximum.

[1] Posterior fillings paid to amalgam fee.

[2] Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and one-surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Kaiser Permanente directly for actual fees.

[3] The office visit copayment is waived for participants in the Chronic Condition Dental Management program for specific preventive services.

[4] Replacement of lost or stolen appliance once every 2 years; replacement or repair of broken appliance as needed.

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# Summary of Vision Benefits
## 2017-18 Plan Year

| | KAISER PERMANENTE | moda HEALTH | moda HEALTH | moda HEALTH | NEW for 2017-18 vsp | NEW for 2017-18 vsp |
|---|---|---|---|---|---|---|
| Vision | Kaiser Vision Plan** Kaiser Permanente Facilities | Open Plan May use any licensed provider | Pearl Plan May use any licensed provider | Quartz Plan May use any licensed provider | VSP Choice Plus Plan VSP Choice Network | VSP Choice Plan VSP Choice Network |
| Plan Year Maximum | $250 | $600* | $400* | $250* | N/A | N/A |
| **Routine Eye Exam:** | | | | | | |
| Benefit: | Covered under the medical plan | Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | Plan pays 100% after $10 copay | Plan pays 100% after $10 copay |
| Frequency: | As needed | Once per Plan Year | Once per Plan Year | Once per Plan Year | Every 12 months | Every 12 months |
| **Lenses:** | | | | | | |
| Basic lens benefit: | **Under age 19:** No charge for one pair of standard frames and lenses or contacts once per Plan Year<br>**Age 19+:** Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | $20 copay (applied towards lenses & frame):<br>Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Polycarbonate lenses, scratch resistant and UV coatings covered in full | $20 copay (applied towards lenses & frame):<br>Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Scratch resistant and UV coatings covered in full |
| Lens enhancements | | | | | $15 copay for anti-reflective coating or progressive lenses | Discounts for polycarbonate, anti-reflective coating or progressive lenses |
| Frequency: | Once per Plan Year | Once per Plan Year | Once per Plan Year | Once per Plan Year | Once every 12 months | Once every 12 months |
| **Frames / Contacts:** | | | | | | |
| Benefit: | **Under age 19:** No charge for one pair of standard frames and lenses or contacts once per Plan Year<br>**Age 19+:** Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | Plan pays 100% (up to plan maximum) | Covered in full up to retail allowance of $300; 20% off amount over retail allowance for frames | Covered in full up to retail allowance of $150; 20% off amount over retail allowance for frames |
| Frequency: | Once per Plan Year | **Frames:**<br>*Age 0-16*: Once per Plan Year<br>*Age 17+*: Once every two Plan Years<br>**Contacts:** Once per Plan Year | **Frames:**<br>*Age 0-16*: Once per Plan Year<br>*Age 17+*: Once every two Plan Years<br>**Contacts:** Once per Plan Year | **Frames:**<br>*Age 0-16*: Once per Plan Year<br>*Age 17+*: Once every two Plan Years<br>**Contacts:** Once per Plan Year | Once every 12 months | Once every 12 months |

*Exam and hardware charges all apply to the plan year maximum on Moda Plans
**Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

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