OEBB Summary of Medical and Pharmacy Benefits 2020-21 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	$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
Virtual Care	$0	Not Covered	$0[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 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) **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[8]						
Acupuncture, chiropractic & naturopathic services	$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 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 Moda plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share.
4 Benefit is subject to a 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 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.
7 For value tier list please visit https://my.kp.org/oebb/plans/ at bottom of page.
8 For Kaiser plans, acupuncture care, spinal manipulation and naturopathic substance only accrue towards your $2000 benefit maximum. For Moda Plans, alternative care services are subject to 12 visits annually.
9 For Moda plans, virtual care (defined as 2-way video conferencing visits) is covered for primary care and urgent care services only.

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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	$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	NA	NA	NA	NA	$0 [7]	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	NA	NA	NA	NA	$0 [7]	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

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