

Classified & Management 2020-21 Medical/Rx Plans	Kaiser Medical Plan 1		Moda Medical Plan 1		
Plan Year: October 1 - September 30 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 Coordinated Care <sup>6</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Out-of-Network Services Member Pays
Deductible per person	None	NA	\$400	\$500	\$800
Maximum deductible per family	None	NA	\$1,500	\$1,500	\$2,400
Out-of-pocket (OOP) maximum per person <sup>3</sup>	\$1,500	NA	\$2,850	\$3,250	\$6,000
Out-of-pocket (OOP) maximum per family <sup>3</sup>	\$3,000	NA	\$9,750	\$9,750	\$18,000
Maximum cost share per person	NA	NA	\$7,900	\$7,900	NA
Maximum cost share per family	NA	NA	\$15,800	\$15,800	NA
<b>Preventive Care Services</b>					
Wellness visit	\$0	NA	\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not covered
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 <sup>1</sup>	\$0 <sup>1</sup>	50%
<b>Primary Care, Specialist, and Urgent Care</b>					
Primary care office visits	\$20	Not Covered	\$20 <sup>1,6</sup>	20%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	NA	NA	\$40 <sup>1</sup>	NA	50%
Virtual care	\$0	Not Covered	\$10 <sup>1,9</sup>	\$10 <sup>1,9</sup>	50%
Specialist office visits	\$30	Not Covered	\$40 <sup>1</sup>	20%	50%
Urgent care	\$35	See Plan Handbook	\$40 <sup>1</sup>	20%	20%
<b>Mental Health Services</b>					
Mental health office visits	\$20	Not Covered	\$20 <sup>1</sup>	\$20 <sup>1</sup>	50%
Mental health inpatient and residential services	\$100 per day, up to \$500 per admission	Not Covered	20%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	\$0	Not Covered	\$20 <sup>1</sup>	\$20 <sup>1</sup>	50%
<b>Outpatient Services</b>					
Outpatient surgery/facility care	\$75	Not Covered	20%	20%	50%
Outpatient rehabilitation (physical, occupational & speech therapy)	\$30 per visit	Not Covered	20%	20%	50%
<b>Tests (Outpatient)</b>					
Preventive tests	\$0	Not Covered	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50%
Laboratory	\$20 per visit	Not Covered	20%	20%	50%
X-ray, imaging, and special diagnostic procedures	\$20 per visit	Not Covered	20%	20%	50%
CT, MRI, PET scans	\$20 per visit	Not Covered	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%
<b>Alternative Care Services<sup>8</sup></b>					
Acupuncture, chiropractic & naturopathic services	\$20 per service	Not Covered	\$20 <sup>1,8</sup>	20% <sup>8</sup>	50% <sup>8</sup>
<b>Maternity Care</b>					
Outpatient maternity care	\$0	Not Covered	20%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	\$100 per day, up to \$500 per admission	Not Covered	20%	20%	50%
<b>Hospital Services</b>					
Inpatient care/surgery	\$100 per day, up to \$500 per admission	See Plan Handbook	20%	20%	50%
Skilled nursing facility care (Kaiser Plans: 100 days per plan year, Moda Plans: 60 days per plan year)	\$0	NA	20%	20%	50%
<b>Emergency Services</b>					
Emergency room (copay waived if admitted)	\$100 per visit (waived if admitted)		\$100 copay + 20%		
Ambulance	\$75		20%		

**Classified & Management  
2020-21 Medical/Rx Plans**

**Kaiser Medical Plan 1**

**Moda Medical Plan 1**

<b>Plan Year: October 1 - September 30</b> <b>Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.</b>	<b>Kaiser Medical Plan 1</b>		<b>Moda Medical Plan 1</b>		
	<b>In-Network Member Pays</b>	<b>Out-of-Network Member Pays</b>	<b>In-Network Coordinated Care<sup>6</sup> Member Pays</b>	<b>In-Network Non-Coordinated Care<sup>6</sup> Member Pays</b>	<b>Out-of-Network Services Member Pays</b>
<b>Additional Cost Tier (Applies to Moda Plans Only)</b>					
Specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, scosupplementation, upper endoscopies, sleep studies, lumbar discographies	NA	NA	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%
Spine surgery, knee & hip replacement <sup>4</sup> , knee & shoulder arthroscopy, uncomplicated hernia repair	NA	NA	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%
<b>Other Covered Services</b>					
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	Not Covered	10%	10%	50%
Durable medical equipment (DME)	20%	Not Covered	20%	20%	50%
Bariatric surgery	\$500 + Inpatient Care costs	Not Covered	\$500 + 20%	\$500 + 20%	Not covered
<b>Pharmacy Services</b>					
Out-of-pocket (OOP) maximum	\$1100 Rx max also applies to Medical OOP		Rx applies toward Max Cost Share		
<b>Retail</b>					
Value	NA	NA	\$4 per 31-day supply		
Generic (Kaiser Plans) Select Generic (Moda Plans)	\$5 per 30-day supply	See Plan Handbook	\$12 per 31-day supply		
Preferred Brand	\$25 per 30-day supply	See Plan Handbook	25% up to \$75 per 31-day supply		
Non-Preferred Brand <sup>5</sup>	\$45 per 30-day supply if criteria met	See Plan Handbook	50% up to \$175 per 31-day supply		
<b>Mail</b>					
Value	NA	NA	\$8 per 90-day supply		
Generic (Kaiser Plans) Select Generic (Moda Plans)	\$10 per 90-day supply	See Plan Handbook	\$24 per 90-day supply		
Preferred Brand	\$50 per 90-day supply	See Plan Handbook	25% up to \$150		
Non-Preferred Brand <sup>5</sup>	\$90 per 90-day supply if criteria met	See Plan Handbook	50% up to \$450 per 90-day supply		
<b>Specialty</b>					
Select Generic (Kaiser Plans) Preferred Brand (Moda Plans)	25% up to \$100 per 30-day supply	See Plan Handbook	25% up to \$200 per 31-day supply		
Non-Preferred Brand <sup>5</sup>	25% up to \$100 per 30-day supply	See Plan Handbook	50% up to \$500 per 31-day supply		

Classified & Management 2020-21 Medical/Rx Plans	Moda Medical Plan 2			Moda Medical Plan 6 w/ Optional H.S.A.		
Plan Year: October 1 - September 30 Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care <sup>6</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>6</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Out-of-Network Services Member Pays
Deductible per person	\$800	\$900	\$1600	\$1,600 <sup>2</sup>	\$1,700 <sup>2</sup>	\$3,200 <sup>2</sup>
Maximum deductible per family	\$2,700	\$2,700	\$4,800	\$3,400 <sup>2</sup>	\$3,400 <sup>2</sup>	\$6,400 <sup>2</sup>
Out-of-pocket (OOP) maximum per person <sup>3</sup>	\$3,850	\$4,250	\$8,000	\$6,400 <sup>2</sup>	\$6,750 <sup>2</sup>	\$13,100 <sup>2</sup>
Out-of-pocket (OOP) maximum per family <sup>3</sup>	\$12,750	\$12,750	\$24,000	\$13,500 <sup>2</sup>	\$13,500 <sup>2</sup>	\$26,200 <sup>2</sup>
Maximum cost share per person	\$7,900	\$7,900	NA	NA	NA	NA
Maximum cost share per family	\$15,800	\$15,800	NA	NA	NA	NA
<b>Preventive Care Services</b>						
Wellness visit	\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not covered	\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not covered
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50%	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50%
<b>Primary Care, Specialist, and Urgent Care</b>						
Primary care office visits	\$20 <sup>1,6</sup>	20%	50%	15%	20%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$40 <sup>1</sup>	NA	50%	15%	NA	50%
Virtual care	\$10 <sup>1,9</sup>	\$10 <sup>1,9</sup>	50%	\$10 <sup>9</sup>	\$10 <sup>9</sup>	50%
Specialist office visits	\$40 <sup>1</sup>	20%	50%	15%	20%	50%
Urgent care	\$40 <sup>1</sup>	20%	20%	15%	20%	See Plan Handbook
<b>Mental Health Services</b>						
Mental health office visits	\$20 <sup>1</sup>	\$20 <sup>1</sup>	50%	15%	20%	50%
Mental health inpatient and residential services	20%	20%	50%	20%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	\$20 <sup>1</sup>	\$20 <sup>1</sup>	50%	15%	20%	50%
<b>Outpatient Services</b>						
Outpatient surgery/facility care	20%	20%	50%	20%	25%	50%
Outpatient rehabilitation (physical, occupational & speech therapy)	20%	20%	50%	20%	25%	50%
<b>Tests (Outpatient)</b>						
Preventive tests	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50%	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50%
Laboratory	20%	20%	50%	20%	25%	50%
X-ray, imaging, and special diagnostic procedures	20%	20%	50%	20%	25%	50%
CT, MRI, PET scans	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	20%	25%	50%
<b>Alternative Care Services<sup>8</sup></b>						
Acupuncture, chiropractic & naturopathic services	\$20 <sup>1,8</sup>	20% <sup>8</sup>	50% <sup>8</sup>	20% <sup>8</sup>	25% <sup>8</sup>	50% <sup>8</sup>
<b>Maternity Care</b>						
Outpatient maternity care	20%	20%	50%	20%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	20%	50%	20%	25%	50%
<b>Hospital Services</b>						
Inpatient care/surgery	20%	20%	50%	20%	25%	50%
Skilled nursing facility care ( <b>Kaiser Plans:</b> 100 days per plan year, <b>Moda Plans:</b> 60 days per plan year)	20%	20%	50%	20%	25%	50%
<b>Emergency Services</b>						
Emergency room (copay waived if admitted)	\$100 copay + 20%			20%	25%	See Plan Handbook
Ambulance	20%			20%	25%	See Plan Handbook

Classified & Management 2020-21 Medical/Rx Plans	Moda Medical Plan 2			Moda Medical Plan 6 w/ Optional H.S.A.		
Plan Year: October 1 - September 30 Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care <sup>6</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>6</sup> Member Pays	In-Network Non-Coordinated Care <sup>6</sup> Member Pays	Out-of-Network Services Member Pays
<b>Additional Cost Tier (Applies to Moda Plans)</b>						
Specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, scosupplementation, upper endoscopies, sleep studies, lumbar discographies	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	20%	25%	50%
Spine surgery, knee & hip replacement <sup>4</sup> , knee & shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%	20%	25%	50%
<b>Other Covered Services</b>						
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%
Durable medical equipment (DME)	20%	20%	50%	25%	25%	50%
Bariatric surgery	\$500 + 20%	\$500 + 20%	Not covered	\$500 + 25%	\$500 + 25%	Not covered
<b>Pharmacy Services</b>						
Out-of-pocket (OOP) maximum	Rx applies toward Max Cost Share			Rx applies toward OOP Max		
<b>Retail</b>						
Value	\$4 per 31-day supply			\$4 <sup>1</sup> per 31-day supply		
Generic (Kaiser Plans) Select Generic (Moda Plans)	\$12 per 31-day supply			20%	25%	
Preferred Brand	25% up to \$75 per 31-day supply			20%	25%	
Non-Preferred Brand <sup>5</sup>	50% up to \$175 per 31-day supply			20%	25%	
<b>Mail</b>						
Value	\$8 per 90-day supply			\$8 <sup>1</sup> per 90-day supply		
Generic (Kaiser Plans) Select Generic (Moda Plans)	\$24 per 90-day supply			20%	25%	
Preferred Brand	25% up to \$150			20%	25%	
Non-Preferred Brand <sup>5</sup>	50% up to \$450 per 90-day supply			20%	25%	
<b>Specialty</b>						
Select Generic (Kaiser Plans) Preferred Brand (Moda Plans)	25% up to \$200 per 31-day supply			20%	25%	
Non-Preferred Brand <sup>5</sup>	50% up to \$500 per 31-day supply			20%	25%	

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.

This document is for comparison purposes only. The full benefits of each plan are described in the member handbooks. In the case of a conflict between this comparison and the member handbook, the member handbook will prevail.