

Medical Plan Comparison

CARRIER:	KAISER						MODA																	
PLAN NAMES:	MED PLAN 1		MED PLAN 2A		MED PLAN 3*		PLAN 1			PLAN 2			PLAN 3			PLAN 6*								
					<i>(Health Savings Account (HSA))</i>		Coordinated (CC) / Non-Coordinated (Non-CC)									<i>(Health Savings Account (HSA) Optional)</i>								
Network Available Per Plan	Kaiser HMO		Kaiser HMO		Kaiser HMO		In -Network			Out of Network			In -Network			Out of Network			In -Network			Out of Network		
	InNetwork	OutOfNetwork	InNetwork	OutOfNetwork	InNetwork	OutOfNetwork	CC	Non-CC	Out of Network	CC	Non-CC	Out of Network	CC	Non-CC	Out of Network	CC	Non-CC	Out of Network	CC	Non-CC	Out of Network	CC	Non-CC	Out of Network
Deductible Per Person	None	NA	\$800	NA	\$1,600	NA	\$400	\$500	\$800	\$800	\$900	\$1,600	\$1,200	\$1,300	\$2,400	\$1,600	\$1,700	\$3,200	\$1,600	\$1,700	\$3,200	\$1,600	\$1,700	\$3,200
Max Deduct Per Family	None	NA	\$2,400	NA	\$3,200	NA	\$1,500	\$1,500	\$2,400	\$2,700	\$2,700	\$4,800	\$3,900	\$3,900	\$7,200	\$3,400	\$3,400	\$6,400	\$3,400	\$3,400	\$6,400	\$3,400	\$3,400	\$6,400
Max Out of Pocket Per Person	\$1,500	NA	\$4,000	NA	\$6,550	NA	\$2,850	\$3,250	\$6,000	\$3,850	\$4,250	\$8,000	\$4,850	\$5,250	\$10,000	\$6,400	\$6,750	\$13,100	\$6,400	\$6,750	\$13,100	\$6,400	\$6,750	\$13,100
Max Out of Pocket Per Family	\$3,000	NA	\$12,000	NA	\$13,100	NA	\$9,750	\$9,750	\$18,000	\$12,750	\$12,750	\$24,000	\$15,750	\$15,750	\$27,400	\$13,500	\$13,500	\$26,200	\$13,500	\$13,500	\$26,200	\$13,500	\$13,500	\$26,200
Routine Exam / Wellness	\$0	Not Covered	\$0	Not Covered	\$0	Not Covered	\$0	\$0	50%	\$0	\$0	50%	\$0	\$0	50%	\$0	\$0	50%	\$0	\$0	50%	\$0	\$0	50%
Primary Care Office Visit	\$20	Not Covered	\$25	Not Covered	20%	Not Covered	\$20	20%	50%	\$20	20%	50%	\$25	25%	50%	15%	20%	50%	15%	20%	50%	15%	20%	50%
Virtual Care / Telehealth	\$0	Not Covered	\$0	Not Covered	\$0 after ded.	Not Covered	\$0	\$0	Not Covered	\$0	\$0	Not Covered	\$0	\$0	Not Covered	\$0 after ded.	\$0 after ded.	Not Covered	\$0 after ded.	\$0 after ded.	Not Covered	\$0 after ded.	\$0 after ded.	Not Covered
Specialist Office Visit	\$30	Not Covered	\$35	Not Covered	20%	Not Covered	\$40	20%	50%	\$40	20%	50%	\$50	25%	50%	15%	20%	Not Covered	15%	20%	Not Covered	15%	20%	Not Covered
Mental Health office visits	\$20 per	Not Covered	\$25 per	Not Covered	20%	Not Covered	\$20	\$20	50%	\$20	\$20	50%	\$25	\$25	50%	15%	20%	50%	15%	20%	50%	15%	20%	50%
Labs, x-ray, and imaging	\$20 per	Not Covered	\$25 per	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	25%	25%	50%	20%	25%	50%	20%	25%	50%	20%	25%	50%
CT, MRI, PET scans	\$70 per	Not Covered	\$75 per	Not Covered	20%	Not Covered	\$100 + 20%	\$100 + 20%	\$100 + 50%	\$100 + 20%	\$100 + 20%	\$100 + 50%	\$100 + 25%	\$100 + 25%	\$100 + 50%	20%	25%	50%	20%	25%	50%	20%	25%	50%
Acupuncture and Chiropractic	\$20 per	Not Covered	\$25 per	Not Covered	20%	Not Covered	\$20	20%	20%	\$20	20%	50%	\$25	25%	50%	20%	25%	50%	20%	25%	50%	20%	25%	50%
Naturopathic office visits	\$20 per	Not Covered	\$25 per	Not Covered	20%	Not Covered	\$40	20%	50%	\$40	20%	50%	\$50	25%	50%	15%	20%	50%	15%	20%	50%	15%	20%	50%
Urgent Care Visit	\$35	See Plan Handbook	\$40	See Plan Handbook	20%	See Plan Handbook	\$40	20%	20%	\$40	20%	20%	\$50	25%	25%	15%	20%		15%	20%		15%	20%	See Plan Handbook
Emergency Room	\$150 per visit, waived if admitted		20%		20%		\$100 copay, plus 20%			\$100 copay, plus 20%			\$100 copay, plus 25%			20%	25%		20%	25%		20%	25%	
Ambulance	\$75		\$100		20%		20%			20%			25%			20%	25%		20%	25%		20%	25%	

All Moda Plans: If you select the CC (Coordinated Care) = PCP 360 network, each person on the plan must select a PCP 360 Provider (each person can have a different provider) to receive enhanced benefits and savings. For more information on the CC (Coordinated Care) = PCP 360 plans, please call OEGB at 1-888-469-6322.

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.