

# MEDICAL PLAN OPTIONS

## Kaiser Permanente HMO Summary of Benefits\*

All copayments for medical and hospital services including prescription drugs will be applied to the annual Out-of-Pocket Limit

Plan Provisions	Standard Plan	Wise Consumer Plan HSA-qualified	** Minimum Value Plan
Deductible	\$250 individual; \$750 family	\$1,500 employee only; \$3,000 if 1 or more family member is covered	\$3,500 employee only; \$7,000 if 1 or more family member is covered
Out-of-Pocket Limit (co-payments paid for hospital and most medical services, including prescriptions accumulate towards the out of pocket maximum)	\$1,250 per person; \$3,750 family	\$2,500 individual; \$5,000 family	\$6,550 per individual; \$13,100 per family
Preventive Health Care (for adult women and men, and children)	100% covered	100% covered	100% covered
Hospital Services room and board	10% after deductible	10% after deductible	50% after deductible
Outpatient Emergency	10% after deductible	10% after deductible	50% after deductible
Primary Care Office Visits	\$15 copay	10% after deductible	50% after deductible
Specialist Office Visits	\$25 copay	10% after deductible	50% after deductible
Ambulance	10% after deductible	10% after deductible	50% after deductible
Skilled Nursing	10% after deductible, up to 100 days per calendar year	10% after deductible	50% after deductible
X-ray and Lab	\$15 copay	10% after deductible	50% after deductible
Preatal and Post-Natal Maternity	\$0 copay, for scheduled prenatal care and first post partum visit	100% covered	no charge for prenatal care 50% after deductible for labor and delivery
Rehabilitation (Outpatient Therapy)	\$25 copay, up to 20 visits per therapy per calendar year	10% after deductible	50% after deductible
Durable Medical Equipment	10% after deductible	20% after deductible	50% after deductible
Mental Health and Chemical Dependency	\$15 copay for outpatient visits, inpatient is same as any other hospitalization	10% after deductible	50% after deductible
Chiropractic, massage therapy, naturopathic and acupuncture	\$15 copay for each chiropractic, acupuncture, and naturopathy visit \$25 copay for massage therapy, up to 12 visits \$1,000 annual max for all combined services	After deductible, \$15 alternative care, \$25 massage therapy (up to 12 visits). \$1,000 combined maximum benefit	no coverage
High Tech Imaging. CT, MRI, Pet Scan	\$100 copay	10% after deductible	50% after deductible
<b>Prescription Drugs:</b>			
Retail pharmacy—30-day supply Mail Order—31- to 90-day supply	\$15 copay for generic, \$30 copay preferred brand, \$50 copay non preferred brand  Up to a 90-day supply of maintenance drugs for two co-payments	After deductible, \$15 copay for generic, \$30 preferred, \$50 non-preferred brand  Up to a 90-day supply of maintenance drugs for two co-payments	After deductible, \$15 copay for generic, \$30 copay for preferred, \$50 for non-preferred brand  Rx Mail Order 31 - 90 days Specialty may be limited to 30 days \$30 copay for generic, \$60 copay for non-preferred, \$100 for non-preferred
<b>Hearing:</b>			
Hearing Exams Hearing Aids	\$15 copay after deductible up to \$500 / 3 yrs	\$15 copay after deductible up to \$500 / 3 yrs	no coverage no coverage
<b>Vision</b>			
Eye Exams Hardware (eyeglass lenses, contacts, and frames)	\$15 copay per exam Adult: \$150 credit every 24 months at KP Vision Essentials, children under 19: 1 pair of glasses every 12 months	10% after deductible per exam Adult: \$150 credit every 24 months at KP Vision Essentials, children under 19: 1 pair of glasses every 12 months	Children to age 19 only 50% after deductible

\*This Kaiser Permanente summary identifies the benefit provisions applicable to the most commonly received types of care. Care that is received from providers or facilities outside of Kaiser Permanente (except for emergencies) **may not be covered** or may require that you pay a **significantly larger share** of the costs. Please refer to the Plan Evidence of Coverage or Carrier's information for a description of other benefits and complete information.

\*\* The Minimum Value Plan is intended to provide basic, affordable coverage for employees who work enough hours to qualify for coverage under ACA or work part-time. A health savings account (HSA) is not offered.

## Moda Health Summary of Medical Plan Benefits\*

The deductible and all copayments or coinsurance for medical, hospital and prescription drugs will be applied to the annual Out-of-Pocket Limit

Plan Provisions	Standard Plan	Wise Consumer HSA-qualified Plan
Deductible ( <i>accumulates towards the Out-of-Pocket Limit</i> )	\$650 per person; \$1,950 family	\$2,600 per individual, but not more than \$5,200 per family
Deductible <b>Credit</b> ( <i>applied when the employee completes suggested wellness tasks</i> ).	\$100 <b>Credit</b> per person; \$300 <b>Credit</b> per family	\$100 <b>Credit</b> employee only coverage; \$200 <b>Credit</b> employee +1 or more
Out-of-Pocket Limit ( <i>all deductibles, all co-insurance for medical and prescription services and all copayments for hospital services apply to this limit</i> )	\$3,000 per person \$9,000 family	\$6,350 per individual, but not more than \$12,700 per family
Preventive Health Care ( <i>for adults and children</i> )	100% covered; no deductible	100% covered; no deductible
Hospital Services, ambulance, skilled nursing, x-ray, lab, maternity, rehabilitation, durable medical equipment	After deductible, 80% in-network / 60% out-of-network	After deductible, 80% in-network / 60% out-of-network
Emergency Room	\$200 copay, then paid at 80% after deductible; copay waived if admitted into hospital	After deductible, 80% in or out-of-network
Primary Care Office Visit	\$30 copay per visit	After deductible, 80% in-network / 60% out-of-network
Specialist Office Visit, including chiropractic, naturopathic and acupuncture office visits	\$40 copay per visit	After deductible, 80% in-network / 60% out-of-network
Chiropractic, naturopathic and acupuncture services and supplies other than the office visit	After deductible, 80% in-and out-of-network	After deductible, 80% in-network / 60% out-of-network
Mental Health and Chemical Dependency	\$30 copay per visit for outpatient; inpatient is the same as any other hospitalization	After deductible, 80% in-network / 60% out-of-network for both inpatient and outpatient services
<b>Prescription Drugs:</b>		
Value Based Medication Program:	<b>Standard Plan:</b> The deductible and copay is waived for generic and preferred brand drugs used to treat asthma, diabetes, high blood pressure, high cholesterol or tobacco addiction. <b>Wise Consumer Plan:</b> The deductible is waived for generic and preferred brand drugs to treat asthma, diabetes, high blood pressure, high cholesterol or tobacco addiction. The member pays only 20% coinsurance.	
Retail pharmacy 30-day supply	\$100 deductible <b>Generic:</b> \$20 copay <b>Brand:</b> \$50 copay, plus difference in cost if a generic is available <b>Brand Non-Formulary:</b> \$100 copay, plus difference in cost if a generic is available	After deductible, 80%
Mail Order or Retail 90-day supply	<b>Generic:</b> \$60 copay <b>Brand:</b> \$150 copay, plus difference in cost if a generic is available <b>Brand Non-Formulary:</b> \$300 copay, plus difference in cost if a generic is available.	After deductible, 80%
<b>Hearing: One exam per calendar year</b>		
In-Network	100% covered, deductible waived	100% covered, deductible waived
Out-of-Network	After deductible, 60%	After deductible, 60%
Hearing Aids: In-Network	After deductible, 80%	After deductible, 80%
Out-of-Network	After deductible, 60%, plus the full amount that exceeds the contracted amount	After deductible, 60%, plus the full amount that exceeds the contracted amount
<b>Vision: Provided by VSP</b>		

\* Care that is received from a provider that does not participate as a part of the Connexus network will require that you pay a larger share of the costs, generally an additional 20% coinsurance as well as payment of the full amount of charges which exceeds the Moda contracted amount for that service. Refer to Moda materials.