






OEBB Summary of Medical and Pharmacy Benefits 2019-20 Plan Year

No lifetime maximum on any medical plans.	 <b>Medical Plan 2 Connexus Network</b>			 <b>Medical Plan 3 Connexus Network</b>			 <b>Medical Plan 6 Connexus Network (HSA Optional)</b>		
	Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Cordinated Care <sup>6</sup> Member Pays	In-Network Non-Cordinated Care Member Pays	Any Out-of-Network Services Member Pays	In-Network Cordinated Care <sup>6</sup> Member Pays	In-Network Non-Cordinated Care Member Pays	Any Out-of-Network Services Member Pays	In-Network Cordinated Care <sup>6</sup> Member Pays	In-Network Non-Cordinated Care Member Pays
Deductible per person	\$800	\$900	\$1,600	\$1,200	\$1,300	\$2,400	\$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	\$3,900	\$3,900	\$7,200	\$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	\$4,850	\$5,250	\$10,000	\$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	\$15,750	\$15,750	\$27,400	\$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	\$7,900	\$7,900	NA	NA	NA	NA
Maximum cost share per family	\$15,800	\$15,800	NA	\$15,800	\$15,800	NA	NA	NA	NA
<b>Preventive Care Services</b>									
Wellness visit (Moda plans: ages 21 and over, must use PCP 360)	\$0 <sup>1</sup>	\$0 <sup>1</sup>	Not Covered	\$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%	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50%
<b>Primary Care Office Visits</b>									
Primary Care Office Visits	\$20 <sup>1,6</sup>	20%	50%	\$25 <sup>1,6</sup>	25%	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%	\$50 <sup>1</sup>	NA	50%	15%	NA	50%
Specialist office visits	\$40 <sup>1</sup>	20%	50%	\$50 <sup>1</sup>	25%	50%	15%	20%	50%
Urgent care	\$40 <sup>1</sup>	20%	20%	\$50 <sup>1</sup>	25%	25%	15%	20%	20%
<b>Mental Health Services</b>									
Mental health office visits	\$20 <sup>1</sup>	\$20 <sup>1</sup>	50%	\$25 <sup>1</sup>	\$25 <sup>1</sup>	50%	15%	20%	50%
Mental health inpatient and residential services	20%	20%	50%	25%	25%	50%	20%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	\$20 <sup>1</sup>	\$20 <sup>1</sup>	50%	\$25 <sup>1</sup>	\$25 <sup>1</sup>	50%	15%	20%	50%
<b>Outpatient Services</b>									
Outpatient surgery/facility care	20%	20%	50%	25%	25%	50%	20%	25%	50%
Outpatient rehabilitation (physical, occupational & speech therapy) <b>Kaiser Plans:</b> Maximum 20 visits per therapy per Plan Year <b>Moda Plans:</b> 30 sessions per plan year / 60 for spinal or head injury	20%	20%	50%	25%	25%	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%	\$0 <sup>1</sup>	\$0 <sup>1</sup>	50%
Laboratory	20%	20%	50%	25%	25%	50%	20%	25%	50%
X-ray, imaging, and special diagnostic procedures	20%	20%	50%	25%	25%	50%	20%	25%	50%
CT, MRI, PET scans	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	20%	25%	50%
<b>Alternative Care Services (\$2,000 combined maximum)</b>									
Acupuncture, chiropractic & naturopathic services, labs, diagnostics, etc. <i>Cost of supplies &amp; procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum</i>	\$20 <sup>1</sup>	20%	50%	\$25 <sup>1</sup>	25%	50%	20%	25%	50%
<b>Maternity Care</b>									
Outpatient maternity care	20%	20%	50%	25%	25%	50%	20%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	20%	50%	25%	25%	50%	20%	25%	50%

NA = Not applicable

<sup>1</sup> Deductible waived



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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 Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>6</sup> Member Pays	In-Network Non-Coordinated Care Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care <sup>6</sup> Member Pays	In-Network Non-Coordinated Care Member Pays	Any Out-of-Network Services Member Pays
<b>Hospital Services</b>									
Inpatient care/surgery	20%	20%	50%	25%	25%	50%	20%	25%	50%
Skilled nursing facility care (Kaiser Plans: 100 days per plan year, Moda Plans: 60 days per plan year)	20%	20%	50%	25%	25%	50%	20%	25%	50%
<b>Additional Cost Tier</b>									
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 + 20%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	20%	25%	50%
Moda Plans Only: \$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement <sup>4</sup> , knee & shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%	20%	25%	50%
<b>Emergency Services</b>									
Emergency Room (copay waived if admitted)	\$100 copay + 20%	\$100 copay + 20%		\$100 copay + 25%	\$100 copay + 25%		20%	25%	
Abulance	20%	20%		25%	25%		20%	25%	
<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%	20%	25%	50%
Durable Medical Equipment (DME)	20%	20%	50%	25%	25%	50%	20%	25%	50%
Bariatric surgery (Roux-en-Y and gastric sleeve)	\$500 + 20%	\$500 + 20%	Not Covered	\$500 + 25%	\$500 + 25%	Not Covered	\$500 + 20%	\$500 + 25%	Not Covered
<b>Pharmacy Services</b>									
Out-of-Pocket (OOP) Maximum	Rx Applies Toward Max Cost Share			Rx Applies Toward Max Cost Share			Rx applies toward plan OOP max		
<b>Retail</b>									
Value (Moda Plans Only)	\$4 per 31-day Supply			\$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			\$12 per 31-day Supply			20%	25%	
Preferred Brand	25% up to \$75 per \$31-day Supply			25% up to \$75 per \$31-day Supply			20%	25%	
Non-Preferred Brand <sup>5</sup>	50% up to \$175 per 31-day Supply			50% up to \$175 per 31-day Supply			20%	25%	
<b>Mail</b>									
Value (Moda Plans Only)	\$8 per 90-day Supply			\$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			\$24 per 90-day Supply			20%	25%	
Preferred Brand	25% up to \$150 per 90-day Supply			25% up to \$150 per 90-day Supply			20%	25%	
Non-Preferred Brand <sup>5</sup>	50% up to \$450 per 90-day Supply			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			25% up to \$200 per 31-day Supply			20%	25%	
Non-Preferred Brand <sup>5</sup>	50% up to \$500 per 31-day Supply			50% up to \$500 per 31-day Supply			20%	25%	

NA = Not applicable

<sup>1</sup> Deductible waived

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

<sup>3</sup> For Moda plans, out-of-pocket (OOP) maximum includes medical copays and coinsurance. Pharmacy copays and coinsurance, and ACT copays, will continue accruing toward Maximum Cost Share.

<sup>4</sup> Benefit is subject to reference price limitation.

<sup>5</sup> A formulary exception must be approved for non-preferred brand prescription medication.

<sup>6</sup> 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 under that plan 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.

**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 document and your member handbook, the member handbook will prevail.**

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

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	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
Deductible per person	None	NA	\$800	NA	\$1,600 <sup>2</sup>	NA
Maximum Deductible per family	None	NA	\$2,400	NA	\$3,200 <sup>2</sup>	NA
Out-of-pocket (OOP) maximum per person <sup>3</sup>	\$1,500	NA	\$4,000	NA	\$6,550 <sup>2</sup>	NA
Out-of-pocket (OOP) maximum per family <sup>3</sup>	\$3,000	NA	\$12,000	NA	\$13,100 <sup>2</sup>	NA
Maximum cost share per person	NA	NA	NA	NA	NA	NA
Maximum cost share per family	NA	NA	NA	NA	NA	NA
<b>Preventive Care Services</b>						
Wellness visit (Moda plans: ages 21 and over, must use PCP 360)	\$0	NA	\$0 <sup>1</sup>	NA	\$0 <sup>1</sup>	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 <sup>1</sup>	Not Covered	\$0 <sup>1</sup>	Not Covered
<b>Primary Care Office Visits</b>						
Primary Care Office Visits	\$20	Not Covered	\$25 <sup>1</sup>	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
<b>Specialist Office Visits</b>						
Specialist office visits	\$30	Not Covered	\$35 <sup>1</sup>	Not Covered	20%	Not Covered
<b>Urgent Care</b>						
Urgent care	\$35	See Plan Handbook	\$40 <sup>1</sup>	See Plan Handbook	20%	See Plan Handbook
<b>Mental Health Services</b>						
Mental health office visits	\$20	Not Covered	\$25 <sup>1</sup>	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 <sup>1</sup>	Not Covered	20%	Not Covered
<b>Outpatient Services</b>						
Outpatient surgery/facility care	\$75	Not Covered	20%	Not Covered	20%	Not Covered
Outpatient rehabilitation (physical, occupational & speech therapy)	\$30 per visit	Not Covered	\$35 <sup>1</sup> per visit	Not Covered	20%	Not Covered
<b>Kaiser Plans:</b> Maximum 20 visits per therapy per Plan Year <b>Moda Plans:</b> 30 sessions per plan year / 60 for spinal or head injury						
<b>Tests (outpatient)</b>						
Preventive tests	\$0	Not Covered	\$0 <sup>1</sup>	Not Covered	\$0 <sup>1</sup>	Not Covered
Laboratory	\$20 per visit	Not Covered	\$25 <sup>1</sup> per visit	Not Covered	20%	Not Covered
X-ray, imaging, and special diagnostic procedures	\$20 per visit	Not Covered	\$25 <sup>1</sup> per visit	Not Covered	20%	Not Covered
CT, MRI, PET scans	\$20 per visit	Not Covered	\$25 <sup>1</sup> per visit	Not Covered	20%	Not Covered
<b>Alternative Care Services (\$2,000 combined maximum)</b>						
Acupuncture, chiropractic & naturopathic services, labs, diagnostics, etc. <i>Cost of supplies &amp; procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum</i>	\$20 per service	Not Covered	\$25 <sup>1</sup> per service	Not Covered	20%	Not Covered
<b>Maternity Care</b>						
Outpatient maternity care	\$0	Not Covered	\$0 <sup>1</sup>	Not Covered	\$0 <sup>1</sup>	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

<sup>1</sup> Deductible waived

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

<sup>3</sup> For Moda plans, out-of-pocket (OOP) maximum includes medical copays and coinsurance. Pharmacy copays and coinsurance, and ACT copays, will continue accruing toward Maximum Cost Share.

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<sup>5</sup> A formulary exception must be approved for non-preferred brand prescription medication.

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	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
<b>Hospital Services</b>						
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
<b>Additional Cost Tier</b>						
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 <sup>4</sup> , knee & shoulder arthroscopy, uncomplicated hernia repair	NA	NA	NA	NA	NA	NA
<b>Emergency Services</b>						
Emergency Room (copay waived if admitted)	\$100 per visit (waived if admitted)		20%		20%	
Abulance	\$75		\$100 <sup>1</sup>		20%	
<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% <sup>1</sup>	Not Covered	20%	Not Covered
Durable Medical Equipment (DME)	20%	Not Covered	20% <sup>1</sup>	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
<b>Pharmacy Services</b>						
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	
<b>Retail</b>						
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 <sup>5</sup>	\$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
<b>Mail</b>						
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 <sup>5</sup>	\$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
<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 \$100 per 30-day-supply	See Plan Handbook	20%	See Plan Handbook
Non-Preferred Brand <sup>5</sup>	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

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