



OEBB Summary of Medical and Pharmacy Benefits 2020-21 Plan Year

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
	In-Network Coordinated Care ⁶ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁶ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁶ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁶ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.												
Deductible per person	\$400	\$500	\$800	\$800	\$900	\$1,600	\$1,200	\$1,300	\$2,400	\$1,600	\$1,700	\$3,200
Maximum deductible per family	\$1,500	\$1,500	\$2,400	\$2,700	\$2,700	\$4,800	\$3,900	\$3,900	\$7,200	\$5,100	\$5,100	\$9,600
Out-of-pocket (OOP) maximum per person ³	\$2,850	\$3,250	\$6,000	\$3,850	\$4,250	\$8,000	\$4,850	\$5,250	\$10,000	\$6,700	\$7,100	\$13,700
Out-of-pocket (OOP) maximum per family ³	\$9,750	\$9,750	\$18,000	\$12,750	\$12,750	\$24,000	\$15,750	\$15,750	\$27,400	\$15,800	\$15,800	\$27,400
Maximum cost share per person	\$7,900	\$7,900	NA									
Maximum cost share per family	\$15,800	\$15,800	NA									
Preventive Care Services												
Wellness visit	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	\$0 ¹	\$0 ¹	50%									
Primary Care Office Visits												
Primary care office visits	\$20 ^{1,6}	20%	50%	\$20 ^{1,6}	20%	50%	\$25 ^{1,6}	25%	50%	\$25 ^{1,6}	25%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$40 ¹	NA	50%	\$40 ¹	NA	50%	\$50 ¹	NA	50%	\$50 ¹	NA	50%
Virtual Care	\$10 ^{1,9}	\$10 ^{1,9}	50%									
Specialist office visits	\$40 ¹	20%	50%	\$40 ¹	20%	50%	\$50 ¹	25%	50%	\$50 ¹	25%	50%
Urgent care	\$40 ¹	20%	20%	\$40 ¹	20%	20%	\$50 ¹	25%	25%	\$50 ¹	25%	25%
Mental Health Services												
Mental health office visits	\$20 ¹	\$20 ¹	50%	\$20 ¹	\$20 ¹	50%	\$25 ¹	\$25 ¹	50%	\$25 ¹	\$25 ¹	50%
Mental health inpatient and residential services	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	\$20 ¹	\$20 ¹	50%	\$20 ¹	\$20 ¹	50%	\$25 ¹	\$25 ¹	50%	\$25 ¹	\$25 ¹	50%
Outpatient Services												
Outpatient surgery/facility care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
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	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Tests (outpatient)												
Preventive tests	\$0 ¹	\$0 ¹	50%									
Laboratory	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
X-ray, imaging, and special diagnostic procedures	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
CT, MRI, PET scans	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%
Alternative Care Services⁸												
Acupuncture, chiropractic & naturopathic services	\$20 ¹	20%	50%	\$20 ¹	20%	50%	\$25 ¹	25%	50%	\$25 ¹	25%	50%
Maternity Care												
Outpatient maternity care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%

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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Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.												
Hospital Services												
Inpatient care/surgery	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Skilled nursing facility care (Kaiser Plans: 100 days per plan year, Moda Plans: 60 days per plan year)	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
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	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%
Moda Plans Only: \$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement ⁴ , knee & shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%
Emergency Services												
Emergency room (copay waived if admitted)	\$100 copay											
Ambulance	20%			20%			25%			25%		
Other Covered Services												
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%	10%	10%	50%	10%	10%	50%
Durable medical equipment (DME)	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Bariatric surgery	\$500 + 20%	\$500 + 20%	Not covered	\$500 + 20%	\$500 + 20%	Not covered	\$500 + 25%	\$500 + 25%	Not covered	\$500 + 25%	\$500 + 25%	Not covered
Pharmacy Services												
Out-of-pocket (OOP) maximum	Rx applies toward Max Cost Share			Rx applies toward Max Cost Share			Rx applies toward Max Cost Share			Rx applies toward Max Cost Share		
Retail												
Value	\$4 per 31-day supply											
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31-day supply											
Preferred brand	25% up to \$75 per 31-day supply			25% up to \$75 per 31-day supply			25% up to \$75 per 31-day supply			25% up to \$75 per 31-day supply		
Non-preferred brand ⁵	50% up to \$175 per 31-day supply			50% up to \$175 per 31-day supply			50% up to \$175 per 31-day supply			50% up to \$175 per 31-day supply		
Mail												
Value	\$8 per 90-day supply											
Generic (Kaiser plans) / Select generic (Moda Plans)	\$24 per 90-day supply											
Preferred Brand	25% up to \$150											
Non-preferred brand ⁵	50% up to \$450 per 90-day supply			50% up to \$450 per 90-day supply			50% up to \$450 per 90-day supply			50% up to \$450 per 90-day supply		
Specialty												
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to \$200 per 31-day supply			25% up to \$200 per 31-day supply			25% up to \$200 per 31-day supply			25% up to \$200 per 31-day supply		
Non-preferred brand ⁵	50% up to \$500 per 31-day supply			50% up to \$500 per 31-day supply			50% up to \$500 per 31-day supply			50% up to \$500 per 31-day supply		

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).
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	In-Network Coordinated Care ⁶ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁶ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁶ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.									
Deductible per person	\$2,000	\$2,100	\$4,000	\$1,600 ²	\$1,700 ²	\$3,200 ²	\$2,000 ²	\$2,100 ²	\$4,000 ²
Maximum deductible per family	\$6,300	\$6,300	\$12,600	\$3,400 ²	\$3,400 ²	\$6,400 ²	\$4,200 ²	\$4,200 ²	\$8,000 ²
Out-of-pocket (OOP) maximum per person ³	\$6,800	\$7,200	\$13,700	\$6,400 ²	\$6,750 ²	\$13,100 ²	\$6,500 ²	\$6,750 ²	\$13,300 ²
Out-of-pocket (OOP) maximum per family ³	\$15,800	\$15,800	\$27,400	\$13,500 ²	\$13,500 ²	\$26,200 ²	\$13,500 ²	\$13,500 ²	\$26,600 ²
Maximum cost share per person	\$7,900	\$7,900	NA	NA	NA	NA	NA	NA	NA
Maximum cost share per family	\$15,800	\$15,800	NA	NA	NA	NA	NA	NA	NA
Preventive Care Services									
Wellness visit	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%
Primary Care Office Visits									
Primary care office visits	\$30 ^{1,6}	25%	50%	15%	20%	50%	20%	25%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$50 ¹	NA	50%	15%	NA	50%	20%	NA	50%
Virtual Care	\$10 ^{1,9}	\$10 ^{1,9}	50%	\$10 ⁹	\$10 ⁹	50%	\$10 ⁹	\$10 ⁹	50%
Specialist office visits	\$50 ¹	25%	50%	15%	20%	50%	20%	25%	50%
Urgent care	\$50 ¹	25%	25%	15%	20%	See Plan Handbook	20%	25%	See Plan Handbook
Mental Health Services									
Mental health office visits	\$30 ¹	\$30 ¹	50%	15%	20%	50%	20%	25%	50%
Mental health inpatient and residential services	25%	25%	50%	20%	25%	50%	20%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	\$30 ¹	\$30 ¹	50%	15%	20%	50%	20%	25%	50%
Outpatient Services									
Outpatient surgery/facility care	25%	25%	50%	20%	25%	50%	20%	25%	50%
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	25%	25%	50%	20%	25%	50%	20%	25%	50%
Tests (outpatient)									
Preventive tests	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%	\$0 ¹	\$0 ¹	50%
Laboratory	25%	25%	50%	20%	25%	50%	20%	25%	50%
X-ray, imaging, and special diagnostic procedures	25%	25%	50%	20%	25%	50%	20%	25%	50%
CT, MRI, PET scans	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	20%	25%	50%	20%	25%	50%
Alternative Care Services⁸									
Acupuncture, chiropractic & naturopathic services	\$30 ¹	25%	50%	20%	25%	50%	20%	25%	50%
Maternity Care									
Outpatient maternity care	25%	25%	50%	20%	25%	50%	20%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	25%	25%	50%	20%	25%	50%	20%	25%	50%

NA - Not applicable
 1 Deductible waived.
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Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.									
Hospital Services									
Inpatient care/surgery	25%	25%	50%	20%	25%	50%	20%	25%	50%
Skilled nursing facility care (Kaiser Plans: 100 days per plan year, Moda Plans: 60 days per plan year)	25%	25%	50%	20%	25%	50%	20%	25%	50%
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	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%	20%	25%	50%	20%	25%	50%
Moda Plans Only: \$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement ⁴ , knee & shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%	20%	25%	50%	20%	25%	50%
Emergency Services									
Emergency room (copay waived if admitted)	\$100 copay ± 25%			20%	25%	See Plan Handbook	20%	25%	See Plan Handbook
Ambulance	25%			20%	25%	See Plan Handbook	20%	25%	See Plan Handbook
Other Covered Services									
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	10%	50%	20%	25%	50%	20%	25%	50%
Durable medical equipment (DME)	25%	25%	50%	20%	25%	50%	20%	25%	50%
Bariatric surgery	\$500 + 25%	\$500 + 25%	Not covered	\$500 + 20%	\$500 + 25%	Not covered	\$500 + 20%	\$500 + 25%	Not covered
Pharmacy Services									
Out-of-pocket (OOP) maximum	Rx applies toward Max Cost Share			Rx applies toward plan OOP max			Rx applies toward plan OOP max		
Retail									
Value	\$4 per 31-day supply			\$4 ¹ per 31-day supply			\$4 ¹ per 31-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31-day supply			20%	25%		20%	25%	
Preferred brand	25% up to \$75 per 31-day supply			20%	25%		20%	25%	
Non-preferred brand ⁵	50% up to \$175 per 31-day supply			20%	25%		20%	25%	
Mail									
Value	\$8 per 90-day supply			\$8 ¹ per 90-day supply			\$8 ¹ per 90-day supply		
Generic (Kaiser plans) / Select generic (Moda Plans)	\$24 per 90-day supply			20%	25%		20%	25%	
Preferred Brand	25% up to \$150			20%	25%		20%	25%	
Non-preferred brand ⁵	50% up to \$450 per 90-day supply			20%	25%		20%	25%	
Specialty									
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to \$200 per 31-day supply			20%	25%		20%	25%	
Non-preferred brand ⁵	50% up to \$500 per 31-day supply			20%	25%		20%	25%	

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