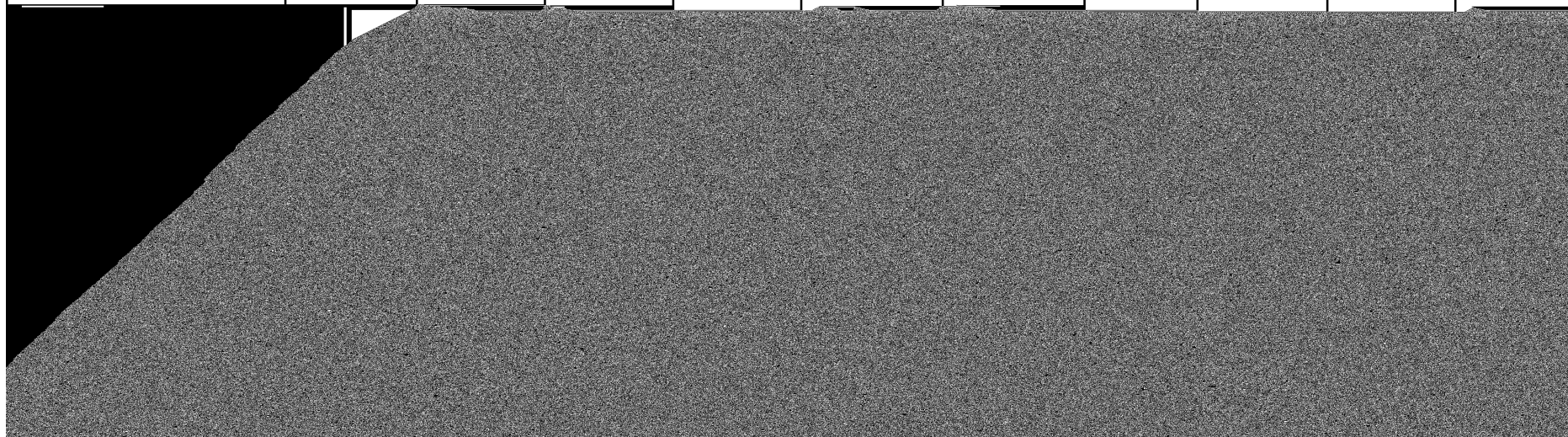




								Moda		





	Kaiser Medical Plan 1 In-Network	Kaiser Medical Plan 1 Out-of-Network	Kaiser Medical Plan 3 HSA Optional In-Network	Kaiser Medical Plan 3 HSA Optional Out-of-Network	Moda Medical Plan 1 In-Network Coordinated Care <sup>5</sup>	Moda Medical Plan 1 In-Network Non-Coordinated Care <sup>6</sup>	Moda Medical Plan 1 Any Out-of-Network Services	Moda Medical Plan 6 HDHP HSA Compliant In-Network Coordinated Care <sup>5</sup>	Moda Medical Plan 6 HDHP HSA Compliant In-Network Non-Coordinated Care <sup>6</sup>	Moda Medical Plan 6 HDHP HSA Compliant Any Out-of-Network Services
	N/A	N/A	N/A	N/A	\$100 copay+ 20% after deductible	\$100 copay+ 20% after deductible	\$100 copay+ 50% after deductible	20% after deductible	25% after deductible	50% after deductible
	N/A	N/A	N/A	N/A	\$500 copay+ 20% after deductible	\$500 copay+ 20% after deductible	\$500 copay+ 50% after deductible	20% after deductible	25% after deductible	50% after deductible
	\$150 per visit (waived if admitted)	\$150 per visit (waived if admitted)	20% after deductible	20% after deductible	\$100 copay+ 20% after deductible	\$100 copay+ 20% after deductible	\$100 copay+ 20% after deductible	20% after deductible	25% after deductible	See Plan Handbook
	\$75	\$75	<del>20% after deductible</del>	<del>20% after deductible</del>	<del>20% after deductible</del>	20% after deductible	20% after deductible	20% after deductible	25% after deductible	See Plan Handbook
	10%	Not covered	20% after deductible	Not covered	10% after deductible	10% after deductible	50% after deductible	20% after if	25% after deductible	50% after deductible

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deductible

	Kaiser Medical Plan 1 In-Network	Kaiser Medical Plan 1 Out-of-Network	Kaiser Medical Plan 3 HSA Optional In-Network	Kaiser Medical Plan 3 HSA Optional Out-of-Network						
Out-of-pocket (OOP) maximum	Rx applies toward plan OOPmax	Rx applies toward plan OOPmax	Rx applies toward plan OOPmax	Rx applies toward plan OOPmax						
Retail										
Value	N/A	N/A	\$0	N/A						
Generic (Kaiser Plans)/ Select generic (Mada Plans)	\$10 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook						
Preferred brand	\$30 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook						
Non-preferred brand	\$50 per 30-day supply if criteriam et	See Plan Handbook	20% after deductible	See Plan Handbook						
Mail										
Value	N/A	N/A	N/A	N/A						
Generic (Kaiser Plans)/	\$20 per 90-	See Plan /	90 p	i						
			Value	N/A	N/A	N/A	5	É	c	\\Tik
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Full and partial dentures, relines, rebases	50%	50%	\$100 copay <sup>3</sup>
Bridge retainers and pontics	50%	50%	\$250 copay <sup>3</sup>
<b>Orthodontics</b>			
Orthodontic treatment	80% to \$1,800 lifetime max	NO ORTHO COVERAGE on this plan	\$2,500 copay + \$20 per visit

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## Vision

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&.6.324 + 79 35' <	
Network	VSP Choice Network
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Plan year maximum	" / <
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Benefit	Plan pays 100% after \$10 copay
Frequency	Once per plan year
Z + 26 + 6 <	
Basic lens benefit	\$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Polycarbonate lenses, scratch resistant and UV coatings covered in full
Lens enhancements	\$0 copay for standard progressive lenses; \$15 copay for anti-ref ective coating or premium/custom progressive lenses
Frequency	Once per plan year
I 5 1 + 6 <	
Benefit	Covered in full up to retail allowance of . . . 20% off amount over retail allowance for frames
Frequency	Once per plan year
f i 3 2 7 ) 7 &#x2264; . 2 &#x2013; 8 &#x2264; , &#x2264; 5 ( 1 + 6 &#x2264; 2 * &#x2264; 2 6 + 6 &#x2264;	
Benefit	Covered in full up to retail allowance of . . . <
Frequency	Once per plan year
! 3 2 # 5 + 6 ) 5 4 7 3 2 &#x2264; i + 2 + , . 7 <	
Benefit	OEBB members can use their frame allowance to pay for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts