Full-Time Non-Represented and SEIU Plan Comparison 2024-2025 Portland Public Schools

Medical

	Kaiser Medical Plan 1 ;`f?'Gnbf[u	Kaiser Medical Plan 1 @ jfbOtl ? On bf[u	Kaiser Medical Plan3 HSA Optional ; fP gnbf[u	Kaiser Medical Plan3 HSA Optional @IjfbOtl ? Gnbf[u	Moda Medical Plan 1 ; f? Gn bf[u 6bbfNY Hj CNu 6HfO ⁵	Moda Medical Plan 1 ;`f' Ginbf[u ?b`fl 6bbfNY HjONu 6HfO	Moda Medical Plan 1 4`ru@ljflbRi ? Gjn bf[u DOfnYLChu	Moda Medical Plan 6 HDHP HSA Compliant † f7 Gn bf[u 6bbfNY H CNL	Moda Medical Plan 6 HDHP HSA Compliant ; fr Gn bf[u ? b` fl 6bbfNY HJ CNU	Moda Medical Plan 6 HDHP HSA Compliant 4`ru@l jfbotl ? Qin bf[u DOfm\LOhu
Medical Network	<u> </u>	ı	-		•		1		I	
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Kaiser Medical Plan 1 In-Network	Kaiser Medical Plan 1 Out-of- Network	Kaiser Medical Plan3 HSA Optional In-Network	Kaiser Medical Plan3 HSA Optional Out-of-	Moda Medical Plan 1 In-Network Coordinated Care ⁵	Moda Medical Plan 1 In-Network Non- Coordinated Care ⁶	Moda Medical Plan 1 Any Out-of- Network Services	Moda Medical Plan 6 HDHP HSA Compliant In-Network C	Moda Medical Plan 6 HDHP HSA Compliant In-Network Non- Care [%]	Moda Medical Plan 6 HDHP HSA Compliant Any Out-of-
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Kaiser Medical Plan 1 In-Network	Kaiser Medical Plan 1 Out-of- Network	Kaiser Medical Plan3 HSA Optional In-Network	Kaiser Medical Plan3 HSA Optional Out-of- Network	Moda Medical Plan 1 In-Network Coordinated Care ⁵	Moda Medical Plan 1 In-Network Non- Coordinated Care ⁶	Moda Medical Plan 1 Any Out-of- Network Services	Moda Medical Plan 6 HDHP HSA Compliant In-Network Coordinated Care ⁵	Moda Medical Plan 6 HDHP HSA Compliant In-Network Non- Coordinated Care ⁶	Moda Medical Plan 6 HDHP HSA Compliant Any Out-of- Network Services
N/A	N/A	N/A	N/A	\$100 copay+ 20% af er deductible	\$100 copay+ 20% after deductible	\$100 copay+ 50% after deductible	20% after deductible	25% af er deductible	50% after deductible
N/A	N/A	N/A	N/A	\$500 copay+ 20% af er deductible	\$500 copay+ 20% after deductible	\$500 copay+ 50% after deductible	20% after deductible	25% af er deductible	50% after deductible
\$150 per visit (waived if admitted)	\$150 per visit (waived if admitted)	20% af er deductible	20% af er deductible	\$100 copay+ 20% af er deductible	\$100 copay+ 20% after deductible	\$100 copay+ 20% after deductible	20% after deductible	25% af er deductible	See Plan Handbook
\$75	\$75	deductible	deductible	deductible	20% after deductible	20% after deductible	20% after deductible	25% af er deductible	See Plan Handbook
10%	Not covered	20% af er deductible 10 d ê	Not covered	10% af er deductible	10% after deductible	50% af er deductible	20% after if c	25% af er & educti& dedu	50% after dÜ cti& 50 dÜ (

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	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) m axim um	Rx applies toward plan OOPm ax	Rx applies toward plan OOPm ax	Rx applies toward plan OOPm ax	Rx applies toward plan OOPm ax							
Retail						<u> </u>			<u> </u>		
Value	N/A	N/A	\$O°	N/A							
Generic (Kaiser Plans)/ Select generic (Mada Plans)	\$10 per 30- day supply	See Plan Handbook	20% af er deductible	See Plan Handbook							
Preferred brand	\$30 per 30- day supply	See Plan Handbook	20% af er deductible	See Plan Handbook							
Non-preferred brand [*]	\$50 per 30- day supply if criteriam et	See Plan Handbook	20% af er deductible	See Plan Handbook							
Mail	•				•	•		•			
Value	N/A	N/A	N/A	Am /•ZF WA	s€ Z [DÐ ðis€e\@ /G51Ä Z	(A) ST (ŠÁR) WYTHO THE GAY (SEČSWINN DO SSE	5,553 \$\$ 0.7 29 — 527.ð4C DÄZ		/ G 5 1 ¶l &pl@\$Am / G 5 1Ä Z	G8 UÄ Z
Generic (Kaiser Plans)/	\$20 per 90-	See Plan /	<i>9</i> O p	i							- / 2 ZBp
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Dental

Delta Dental Premier Plan 5 ¹	Delta Dental Premier Plan 6	Kaiser Dental Plan
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Full and partial dentures, relines, rebases	50%	50%	\$100 copay ³					
Bridge retainers and pontics	50%	50%	\$250 copay ³					
Orthodontics								
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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Network	VSP Choice Network			
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Plan year maximum	" "/ <			
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Benef t	Plan pays 100% after \$10 copay			
Frequency	Once per plan year			
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Basic lens benef t	\$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, line 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			
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Benef t	Covered in full up to retail allowance of 1, 120% off amount over retail allowance for frames			
Frequency	Once per plan year			
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Benef t	Covered in full up to retail allowance of `,, <			
Frequency	Once per plan year			
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Benef t	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			