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

Moda 866-223-2375
Group # 10006726

Kaiser 866-923-0409
Group # 018050

Medical

	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[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
Medical Network										
Network	Kaiser Permanente Facilities	Kaiser Permanente Facilities	Kaiser Permanente Facilities	Kaiser Permanente Facilities	Connexus Network	Connexus Network	Connexus Network	Connexus Network	Connexus Network	Connexus Network
Deductibles & Out-of-Pocket Maximums										
Deductible per person	None	N/A	$1,600[2]	N/A	$400	$500	$800	$1,600[2]	$1,700[2]	$3,200[2]
Maximum deductible per family	None	N/A	$3,200[2]	N/A	$1,500	$1,500	$2,400	$3,400[2]	$3,400[2]	$6,400[2]
Out-of-pocket (OOP) maximum per person	$1,500	N/A	$6,550[2]	N/A	$2,850[3]	$3,250[3]	$6,000[3]	$6,400[2,3]	$6,750[2,3]	$13,100[2,3]
Out-of-pocket (OOP) maximum per family	$3,000	N/A	$13,100[2]	N/A	$9,750[3]	$9,750[3]	$18,000[3]	$13,500[2,3]	$13,500[2,3]	$26,200[2,3]
Preventive Care Services										
Routine adult, well-child and women's exams; annual obesity screening & immunizations	$0	Not covered	$0[1]	Not covered	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office Visits and Virtual Care										
Primary care office visits	$20	Not covered	20% after deductible	Not covered	$20[1,5]	20% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	N/A	N/A	N/A	N/A	$40[1]	N/A	50% after deductible	15% after deductible	N/A	50% after deductible
Incentive care office visits (Moda Plans only)	N/A	N/A	N/A	N/A	$15[1]	20% after deductible	N/A	15% after deductible	20% after deductible	N/A

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Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0	Not covered	$0 after deductible	Not covered	$0[1]	$0[1]	Not covered	$0 after deductible	$0 after deductible	Not covered
Specialist office visits	$30	Not covered	20% after deductible	Not covered	$40[1]	20% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Urgent care	$35	See Plan Handbook	20% after deductible	See Plan Handbook	$40[1]	20% after deductible	20% after deductible	15% after deductible	20% after deductible	See Plan Handbook
Mental Health and Chemical Dependency Services										
Mental health office visits	$20	Not covered	20% after deductible	Not covered	$20[1]	$20[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	Not covered	20% after deductible	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	$0	Not covered	20% after deductible	Not covered	$20[1]	$20[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Chemical dependency services (inpatient)	$0	Not covered	20% after deductible	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient Services										
Outpatient surgery/facility care	$75	Not covered	20% after deductible	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational & speech therapy)	$30 per visit	Not covered	20% after deductible	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Diagnostic Testing										
Labs, X-ray, and imaging	$20 per visit	Not covered	20% after deductible	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

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CT, MRI, PET scans	$70 per visit	Not covered	20% after deductible	Not covered	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative Care Services										
Acupuncture and Chiropractic[7]	$20 per service	Not covered	20% after deductible	Not covered	$20[1]	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Naturopathic office visits	$20 per service	Not covered	20% after deductible	Not covered	$40[1]	20% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Maternity Care										
Routine maternity care	$0	Not covered	$0[1]	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission max	Not covered	20% after deductible	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Hospital Services										
Inpatient care/surgery	$100 per day, up to $500 per admission max	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	$0	N/A	20% after deductible	N/A	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Additional Cost Tier										

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Moda Plans Only: $100 Additional Cost Tier (ACT)[3]: 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	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
Moda Plans Only: $500 Additional Cost Tier (ACT)[3]: Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	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
Emergency Services										
Emergency room (copay waived if admitted)	$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
Ambulance	$75	$75	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	20% after deductible	25% after deductible	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%	Not covered	20% after deductible	Not covered	10% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable medical equipment (DME)	20%	Not covered	20% after deductible	Not covered	20% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

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Out-of-pocket (OOP) maximum	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max	Rx applies toward plan OOP max
Retail										
Value	N/A	N/A	$0[7]	N/A	$4 per 31-day supply	$4 per 31-day supply	See Plan Handbook	$4[1] per 31-day supply	$4[1] per 31-day supply	See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$10 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook	$12 per 31-day supply	$12 per 31-day supply	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Preferred brand	$30 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook	25% up to $75 per 31-day supply	25% up to $75 per 31-day supply	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Non-preferred brand[4]	$50 per 30-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook	50% up to $175 per 31-day supply	50% up to $175 per 31-day supply	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Mail										
Value	N/A	N/A	N/A	N/A	$8 per 90-day supply	$8 per 90-day supply	See Plan Handbook	$8[1] per 90-day supply	$8[1] per 90-day supply	See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$20 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook	$24 per 90-day supply	$24 per 90-day supply	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Preferred brand	$60 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook	25% up to $150 per 90-day supply	25% up to $150 per 90-day supply	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Non-preferred brand[4]	$100 per 90-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook	50% up to $450 per 90-day supply	50% up to $450 per 90-day supply	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Specialty										
Generic (Moda Plans only)	N/A	N/A	N/A	N/A	$12 per 31-day supply or $36 per 90-day supply when allowed	$12 per 31-day supply or $36 per 90-day supply when allowed	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook

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Select generic (Kaiser Plans) / Preferred brand (Moda Plans)	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Non-preferred brand[4]	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook

N/A = Not applicable

Plan year costs: Deductibles and copayments apply to the annual out-of-pocket maximum.

[1] Deductible waived.

[2] Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family 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 maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

[4] A formulary exception must be approved for non-preferred brand prescription medication.

[5] To receive in-network coordinated care benefits, you must choose and use a PCP 360.

[6] To receive in-network non-coordinated benefits, you must use Connexus providers.

[7] For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

Dental

	Delta Dental Premier Plan 5[1]	Delta Dental Premier Plan 6	Kaiser Dental Plan
Dental Network			
Network	Delta Dental Premier	Delta Dental Premier	Limited Network Plan – Kaiser Permanente Facilities[2]
Dental Office Visit Copay			
Copay	N/A	N/A	$20[3]
Deductibles & Benefit Maximums			
Benefit maximum	$1,700[4]	$1,200	$4,000[4]
Deductible	$50	$50	N/A
Preventive & Diagnostic Services – Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans[6]			
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each plan year[6]	100%[6]	100%[6]
Restorative Services			
Routine fillings, inlays and stainless steel crowns	70% + 10%[1] each plan year	80%[1]	100%[3]
Simple Extraction			
Simple tooth extractions	70% + 10% each plan year	80%	100%[3]
Oral Surgery			
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each plan year	80%	$50 copay[3]
Periodontics			
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each plan year	80%	100%[3]
Endodontics			
Root canal and related therapy including diagnosis and evaluation	70% + 10% each plan year	80%	$50 copay[3]
Major Restorative Services			
Gold or porcelain crowns and onlays	70%	50%	$250 copay[3]
Implants	50%	50%	50%[3]
Other Covered Services			
Occlusal guards (night guards)	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	65%, once every 5 years
Athletic mouth guards	50%	50%	65%, once every 12 months
Nitrous Oxide	50%	50%	$0 copay (age 12 & under); $25 copay (age 13 & up)

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

[1] Under Delta Dental Plans 1 and 5, and Exclusive PPO - Incentive Plan benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

[2] Services performed by providers outside the limited network are not covered unless for a dental emergency. Emergency services consist of limited exam and palliative treatment only.

[3] Office visit copay applies at each visit, in addition to any plan copays for services.

[4] Preventive care and orthodontia do not accrue to this maximum.

[5] Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit under the Willamette Dental Group plan.

[6] Preventive services will not accrue towards the plan benefit maximum.

Vision

	VSP Choice Plus Plan
Vision Network	
Network	VSP Choice Network
Plan Year Maximum	
Plan year maximum	N/A
Routine Eye Exam	
Benefit	Plan pays 100% after $10 copay
Frequency	Once per plan year
Lenses	
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-reflective coating or premium/custom progressive lenses
Frequency	Once per plan year
Frames	
Benefit	Covered in full up to retail allowance of **$300**; 20% off amount over retail allowance for frames
Frequency	Once per plan year
Contacts (in lieu of frames and lenses)	
Benefit	Covered in full up to retail allowance of **$300**
Frequency	Once per plan year
Non-Prescription Benefit	
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