# Part-Time Non-Represented & SEIU
# Plan Comparison 2025-2026
# 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 | **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 |
|---|---|---|---|---|---|
| **Medical Network** | | | | | |
| Network | Kaiser Permanente Facilities | Kaiser Permanente Facilities | Connexus Network | Connexus Network | Connexus Network |
| **Deductibles & Out-of-Pocket Maximums** | | | | | |
| Deductible per person | $400 | N/A | $700 | $800 | $1,100 |
| Maximum deductible per family | $800 | N/A | $1,600 | $1,600 | $2,200 |
| Out-of-pocket (OOP) maximum per person | $1,700 | N/A | $3,750 | $4,150 | $6,900 |
| Out-of-pocket (OOP) maximum per family | $3,400 | N/A | $8,300 | $8,300 | $13,800 |
| **Preventive Care Services** | | | | | |
| Routine adult, well-child and women's exams; annual obesity screening & immunizations | $0[1] | Not covered | $0[1] | $0[1] | 50% after deductible |
| **Office Visits and Virtual Care** | | | | | |
| Primary care office visits | $25[1] | Not covered | $25[1,5] | 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 | $45[1] | N/A | 50% after deductible |
| Incentive care office visits (Moda Plans only) | N/A | N/A | $20[1] | 20% after deductible | N/A |
| Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans) | $0[1] | Not covered | $0[1] | $0[1] | Not covered |
| Specialist office visits | $35[1] | Not covered | $45[1] | 20% after deductible | 50% after deductible |
| Urgent care | $40[1] | See Plan Handbook | $45[1] | 20% after deductible | 20% after deductible |
| **Mental Health and Chemical Dependency Services** | | | | | |
| Mental health office visits | $25[1] | Not covered | $25[1] | $25[1] | 50% after deductible |
| Mental health inpatient and residential services | 20% after deductible | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |

| | **Kaiser Medical Plan 1** In-Network | **Kaiser Medical Plan 1** 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 |
|---|---|---|---|---|---|
| Chemical dependency services (outpatient or residential) | $0[1] | Not covered | $25[1] | $25[1] | 50% after deductible |
| Chemical dependency services (inpatient) | $0[1] | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |
| **Outpatient Services** | | | | | |
| Outpatient surgery/facility care | 20% after deductible | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |
| Outpatient rehabilitation (physical, occupational & speech therapy) | $35[1] per visit | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |
| **Diagnostic Testing** | | | | | |
| Labs, X-ray, and imaging | $35[1] per visit | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |
| CT, MRI, PET scans | $100[1] per visit | Not covered | $100 copay + 20% after deductible | $100 copay + 20% after deductible | $100 copay + 50% after deductible |
| **Alternative Care Services** | | | | | |
| Acupuncture and Chiropractic[7] | $25[1] per visit | Not covered | $25[1] | 20% after deductible | 50% after deductible |
| Naturopathic office visits | $25[1] per visit | Not covered | $45[1] | 20% after deductible | 50% after deductible |
| **Maternity Care** | | | | | |
| Routine maternity care | $0[1] | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |
| Physician or midwife services & hospital stay, delivery & routine newborn nursery care | 20% after deductible | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |
| **Hospital Services** | | | | | |
| Inpatient care/surgery | 20% after deductible | See Plan Handbook | 20% after deductible | 20% after deductible | 50% after deductible |
| Skilled nursing facility care | 20% after deductible | N/A | 20% after deductible | 20% after deductible | 50% after deductible |
| **Additional Cost Tier** | | | | | |

| | **Kaiser Medical Plan 1** In-Network | **Kaiser Medical Plan 1** 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 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 | $100 copay + 20% after deductible | $100 copay + 20% after deductible | $100 copay + 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 | $500 copay + 20% after deductible | $500 copay + 20% after deductible | $500 copay + 50% after deductible |
| **Emergency Services** | | | | | |
| Emergency room | 20% after deductible | 20% after deductible | $100 copay + 20% after deductible | $100 copay + 20% after deductible | $100 copay + 20% after deductible |
| Ambulance | $75[1] | $75[1] | 20% after deductible | 20% after deductible | 20% after deductible |
| **Other Covered Services** | | | | | |
| Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for state-mandated benefit for children | 10%[1] | Not covered | 10% after deductible | 10% after deductible | 50% after deductible |
| Durable medical equipment (DME) | 20%[1] | Not covered | 20% after deductible | 20% after deductible | 50% after deductible |
| **Pharmacy Services** | | | | | |
| 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 |
| **Retail** | | | | | |
| Value | N/A | N/A | $4 per 31-day supply | $4 per 31-day supply | See Plan Handbook |
| Generic (Kaiser Plans) / Select generic (Moda Plans) | $10 per 30-day supply | See Plan Handbook | $12 per 31-day supply | $12 per 31-day supply | See Plan Handbook |
| Preferred brand | $30 per 30-day supply | See Plan Handbook | 25% up to $75 per 31-day supply | 25% up to $75 per 31-day supply | See Plan Handbook |
| Non-preferred brand[4] | $50 per 30-day supply if criteria met | See Plan Handbook | 50% up to $175 per 31-day supply | 50% up to $175 per 31-day supply | See Plan Handbook |
| **Mail** | | | | | |

| | **Kaiser Medical Plan 1** In-Network | **Kaiser Medical Plan 1** 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 |
|---|---|---|---|---|---|
| Value | N/A | N/A | $8 per 90-day supply | $8 per 90-day supply | See Plan Handbook |
| Generic (Kaiser Plans) / Select generic (Moda Plans) | $20 per 90-day supply | See Plan Handbook | $24 per 90-day supply | $24 per 90-day supply | See Plan Handbook |
| Preferred brand | $60 per 90-day supply | See Plan Handbook | 25% up to $150 per 90-day supply | 25% up to $150 per 90-day supply | See Plan Handbook |
| Non-preferred brand[4] | $100 per 90-day supply if criteria met | See Plan Handbook | 50% up to $450 per 90-day supply | 50% up to $450 per 90-day supply | See Plan Handbook |
| **Specialty** | | | | | |
| Generic (Moda Plans only) | 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 |
| Select generic (Kaiser Plans) / Preferred brand (Moda Plans) | 25% up to $150 per 30-day supply | 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 |
| Non-preferred brand[4] | 25% up to $150 per 30-day supply | 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 |

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

| | | |
|---|---|---|
| Full and partial dentures, relines, rebases | 50% | $100 copay[3] |
| Bridge retainers and pontics | 50% | $250 copay[3] |
| **Orthodontics** | | |
| Orthodontic treatment | 80% to $1,800 lifetime max | $2,500 copay + $20 per visit |

[1] Under Delta Dental Plan 5- 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 plan.

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

# Vision

| | **VSP Choice 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. Scratch resistant and UV coatings covered in full. Polycarbonate lenses covered in full for dependent children |
| Lens enhancements | $0 copay for standard progressive lenses; discounts for polycarbonate for adults, anti-reflective coating or premium/custom progressive lenses |
| Frequency | Once per plan year |
| **Frames** | |
| Benefit | Covered in full after $20 copay up to retail allowance of **$150**; 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 **$150**; up to $60 copay for contact lens fitting and evaluation exam |
| 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 |