

# 2025-2026 Kaiser 3 ACA Plan Comparison

## Medical

	<b>Kaiser Medical Plan 3</b> <i>HSA Optional In-Network</i>	<b>Kaiser Medical Plan 3</b> <i>HSA Optional Out-of-Network</i>
<b>Medical Network</b>		
Network	Kaiser Permanente Facilities	Kaiser Permanente Facilities
<b>Deductibles &amp; Out-of-Pocket Maximums</b>		
Deductible per person	\$1,800 <sup>2</sup>	N/A
Maximum deductible per family	\$3,600 <sup>2</sup>	N/A
Out-of-pocket (OOP) maximum per person	\$6,750 <sup>2</sup>	N/A
Out-of-pocket (OOP) maximum per family	\$13,500 <sup>2</sup>	N/A
<b>Preventive Care Services</b>		
Routine adult, well-child and women's exams; annual obesity screening & immunizations	\$0 <sup>1</sup>	Not covered
<b>Office Visits and Virtual Care</b>		
Primary care office visits	20% after deductible	Not covered
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	N/A	N/A
Incentive care office visits (Moda Plans only)	N/A	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	\$0 after deductible	Not covered
Specialist office visits	20% after deductible	Not covered
Urgent care	20% after deductible	See Plan Handbook
<b>Mental Health and Chemical Dependency Services</b>		
Mental health office visits	20% after deductible	Not covered
Mental health inpatient and residential services	20% after deductible	Not covered
Chemical dependency services (outpatient or residential)	20% after deductible	Not covered
Chemical dependency services (inpatient)	20% after deductible	Not covered
<b>Outpatient Services</b>		
Outpatient surgery/facility care	20% after deductible	Not covered
Outpatient rehabilitation (physical, occupational & speech therapy)	20% after deductible	Not covered
<b>Diagnostic Testing</b>		
Labs, X-ray, and imaging	20% after deductible	Not covered
CT, MRI, PET scans	20% after deductible	Not covered

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<b>Alternative Care Services</b>		
Acupuncture and Chiropractic <sup>7</sup>	20% after deductible	Not covered
Naturopathic office visits	20% after deductible	Not covered
<b>Maternity Care</b>		
Routine maternity care	\$0 <sup>1</sup>	Not covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20% after deductible	Not covered
<b>Hospital Services</b>		
Inpatient care/surgery	20% after deductible	See Plan Handbook
Skilled nursing facility care	20% after deductible	N/A
<b>Additional Cost Tier</b>		
<b>Moda Plans Only:</b> \$100 Additional Cost Tier (ACT) <sup>3</sup> : 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
<b>Moda Plans Only:</b> \$500 Additional Cost Tier (ACT) <sup>3</sup> : Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	N/A	N/A
<b>Emergency Services</b>		
Emergency room	20% after deductible	20% after deductible
Ambulance	20% after deductible	20% after deductible
<b>Other Covered Services</b>		
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for state-mandated benefit for children	20% after deductible	Not covered
Durable medical equipment (DME)	20% after deductible	Not covered
<b>Pharmacy Services</b>		
Out-of-pocket (OOP) maximum	Rx applies toward plan OOP max	Rx applies toward plan OOP max
<b>Retail</b>		
Value	\$0 <sup>7</sup>	N/A
Generic (Kaiser Plans) / Select generic (Moda Plans)	20% after deductible	See Plan Handbook
Preferred brand	20% after deductible	See Plan Handbook
Non-preferred brand <sup>4</sup>	20% after deductible	See Plan Handbook
<b>Mail</b>		
Value	N/A	N/A
Generic (Kaiser Plans) / Select generic (Moda Plans)	20% after deductible	See Plan Handbook
Preferred brand	20% after deductible	See Plan Handbook

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Non-preferred brand <sup>4</sup>	20% after deductible	See Plan Handbook
<b>Specialty</b>		
Generic (Moda Plans only)	N/A	N/A
Select generic (Kaiser Plans) / Preferred brand (Moda Plans)	20% after deductible	See Plan Handbook
Non-preferred brand <sup>4</sup>	20% after deductible	See Plan Handbook

N/A = Not applicable

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

<sup>1</sup> Deductible waived.

<sup>2</sup> 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).

<sup>3</sup> For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

<sup>4</sup> A formulary exception must be approved for non-preferred brand prescription medication.

<sup>5</sup> To receive in-network coordinated care benefits, you must choose and use a PCP 360.

<sup>6</sup> To receive in-network non-coordinated benefits, you must use Connexus providers.

<sup>7</sup> 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.