Plans 1–4

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	$400	$500	$800	$800	$900	$1,600	$1,200	$1,300	$2,400	$1,600	$1,700	$3,200
Maximum deductible per family	$1,500	$1,500	$2,400	$2,700	$2,700	$4,800	$3,900	$3,900	$7,200	$5,100	$5,100	$9,600
Out-of-pocket (OOP) maximum per person[3]	$2,850	$3,250	$6,000	$3,850	$4,250	$8,000	$4,850	$5,250	$10,000	$6,700	$7,100	$13,700
Out-of-pocket (OOP) maximum per family[3]	$9,750	$9,750	$18,000	$12,750	$12,750	$24,000	$15,750	$15,750	$27,400	$15,800	$15,800	$27,400
Maximum cost share per person	$7,900	$7,900	NA	$7,900	$7,900	NA	$7,900	$7,900	NA	$7,900	$7,900	NA
Maximum cost share per family	$15,800	$15,800	NA	$15,800	$15,800	NA	$15,800	$15,800	NA	$15,800	$15,800	NA
Preventive Care Services												
Wellness visit	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%
Office Visits and Virtual Care												
Primary care office visits	$20[1,6]	20%	50%	$20[1,6]	20%	50%	$25[1,6]	25%	50%	$25[1,6]	25%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$40[1]	NA	50%	$40[1]	NA	50%	$50[1]	NA	50%	$50[1]	NA	50%
Incentive Care Office Visits for asthma, heart conditions, cholesterol, high blood pressure, diabetes (Moda Plans only)	$15[1,10]	20%	Not covered	$15[1,10]	20%	Not covered	$20[1,10]	25%	Not covered	$20[1,10]	25%	Not covered
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1,9]	$0[1,9]	Not covered	$0[1,9]	$0[1,9]	Not covered	$0[1,9]	$0[1,9]	Not covered	$0[1,9]	$0[1,9]	Not covered
Specialist office visits	$40[1]	20%	50%	$40[1]	20%	50%	$50[1]	25%	50%	$50[1]	25%	50%
Urgent care	$40[1]	20%	20%	$40[1]	20%	20%	$50[1]	25%	25%	$50[1]	25%	25%
Mental Health Services												
Mental health office visits	$20[1]	$20[1]	50%	$20[1]	$20[1]	50%	$25[1]	$25[1]	50%	$25[1]	$25[1]	50%
Mental health inpatient and residential services	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	$20[1]	$20[1]	50%	$20[1]	$20[1]	50%	$25[1]	$25[1]	50%	$25[1]	$25[1]	50%
Outpatient Services												
Outpatient surgery/facility care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Outpatient rehabilitation (physical, occupational & speech therapy) **Kaiser Plans:** Maximum 20 visits per therapy per Plan Year **Moda Plans:** 30 sessions per plan year / 60 for spinal or head injury	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Tests (outpatient)												
Preventive tests	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%
Laboratory	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
X-ray, imaging, and special diagnostic procedures	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
CT, MRI, PET scans	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%
Alternative Care Services[8]												
Acupuncture, chiropractic & naturopathic services[11]	$20[1]	20%	50%	$20[1]	20%	50%	$25[1]	25%	50%	$25[1]	25%	50%
Maternity Care												
Outpatient maternity care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%

Plans 1–4 – *continued*

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Hospital Services												
Inpatient care/surgery	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Skilled nursing facility care (**Kaiser Plans:** 100 days per plan year, **Moda Plans:** 60 days per plan year)	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Additional Cost Tier												
Moda Plans Only: $100 Additional Cost Tier (ACT): 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	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[4], knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 20%	$500 copay + 50%	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%
Emergency Services												
Emergency room (copay waived if admitted)	$100 copay + 20%			$100 copay + 20%			$100 copay + 25%			$100 copay + 25%		
Ambulance	20%			20%			25%			25%		
Other Covered Services												
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	10%	50%	10%	10%	50%	10%	10%	50%	10%	10%	50%
Durable medical equipment (DME)	20%	20%	50%	20%	20%	50%	25%	25%	50%	25%	25%	50%
Bariatric surgery	$500 + 20%	$500 + 20%	Not covered	$500 + 20%	$500 + 20%	Not covered	$500 + 25%	$500 + 25%	Not covered	$500 + 25%	$500 + 25%	Not covered
Pharmacy Services												
Out-of-pocket (OOP) maximum	Rx applies toward Max Cost Share			Rx applies toward Max Cost Share			Rx applies toward Max Cost Share			Rx applies toward Max Cost Share		
Retail												
Value	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply		
Preferred brand	25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply		
Non-preferred brand[5]	50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply		
Mail												
Value	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply		
Preferred brand	25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply		
Non-preferred brand[5]	50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply		
Specialty												
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$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 $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			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		
Non-preferred brand[5]	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.			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.		

Plans 5–7

No lifetime maximum on any medical plans.	**Medical Plan 5 Connexus Network**			**Medical Plan 6 Connexus Network *HDHP HSA Compliant***			**Medical Plan 7 Connexus Network *HDHP HSA Compliant***		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	$2,000	$2,100	$4,000	$1,600[2]	$1,700[2]	$3,200[2]	$2,000[2]	$2,100[2]	$4,000[2]
Maximum deductible per family	$6,300	$6,300	$12,600	$3,400[2]	$3,400[2]	$6,400[2]	$4,200[2]	$4,200[2]	$8,000[2]
Out-of-pocket (OOP) maximum per person[3]	$6,800	$7,200	$13,700	$6,400[2]	$6,750[2]	$13,100[2]	$6,500[2]	$6,750[2]	$13,300[2]
Out-of-pocket (OOP) maximum per family[3]	$15,800	$15,800	$27,400	$13,500[2]	$13,500[2]	$26,200[2]	$13,500[2]	$13,500[2]	$26,600[2]
Maximum cost share per person	$7,900	$7,900	NA	NA	NA	NA	NA	NA	NA
Maximum cost share per family	$15,800	$15,800	NA	NA	NA	NA	NA	NA	NA
Preventive Care Services									
Wellness visit	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%
Office Visits and Virtual Care									
Primary care office visits	$30[1,6]	25%	50%	15%	20%	50%	20%	25%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$50[1]	NA	50%	15%	NA	50%	20%	NA	50%
Incentive Care Office Visits for asthma, heart conditions, cholesterol, high blood pressure, diabetes (Moda Plans only)	$25[1,10]	25%	Not covered	15%[10]	20%	Not covered	20%[10]	25%	Not covered
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1,9]	$0[1,9]	Not covered	$0[1,9]	$0[1,9]	Not covered	$0[1,9]	$0[1,9]	Not covered
Specialist office visits	$50[1]	25%	50%	15%	20%	50%	20%	25%	50%
Urgent care	$50[1]	25%	25%	15%	20%	See Plan Handbook	20%	25%	See Plan Handbook
Mental Health Services									
Mental health office visits	$30[1]	$30[1]	50%	15%	20%	50%	20%	25%	50%
Mental health inpatient and residential services	25%	25%	50%	20%	25%	50%	20%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	$30[1]	$30[1]	50%	15%	20%	50%	20%	25%	50%
Outpatient Services									
Outpatient surgery/facility care	25%	25%	50%	20%	25%	50%	20%	25%	50%
Outpatient rehabilitation (physical, occupational & speech therapy) **Kaiser Plans:** Maximum 20 visits per therapy per Plan Year **Moda Plans:** 30 sessions per plan year / 60 for spinal or head injury	25%	25%	50%	20%	25%	50%	20%	25%	50%
Tests (outpatient)									
Preventive tests	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%
Laboratory	25%	25%	50%	20%	25%	50%	20%	25%	50%
X-ray, imaging, and special diagnostic procedures	25%	25%	50%	20%	25%	50%	20%	25%	50%
CT, MRI, PET scans	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	20%	25%	50%	20%	25%	50%
Alternative Care Services[8]									
Acupuncture, chiropractic & naturopathic services[11]	$30[1]	25%	50%	20%	25%	50%	20%	25%	50%
Maternity Care									
Outpatient maternity care	25%	25%	50%	20%	25%	50%	20%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	25%	25%	50%	20%	25%	50%	20%	25%	50%
Hospital Services									
Inpatient care/surgery	25%	25%	50%	20%	25%	50%	20%	25%	50%
Skilled nursing facility care (**Kaiser Plans:** 100 days per plan year, **Moda Plans:** 60 days per plan year)	25%	25%	50%	20%	25%	50%	20%	25%	50%

Plans 5–7 – *continued*

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network *HDHP HSA Compliant*			Medical Plan 7 Connexus Network *HDHP HSA Compliant*		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[6] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Additional Cost Tier									
Moda Plans Only: $100 Additional Cost Tier (ACT): 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	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	20%	25%	50%	20%	25%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[4], knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%	20%	25%	50%	20%	25%	50%
Emergency Services									
Emergency room (copay waived if admitted)	$100 copay + 25%			20%	25%	See Plan Handbook	20%	25%	See Plan Handbook
Ambulance	25%			20%	25%	See Plan Handbook	20%	25%	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%	10%	50%	20%	25%	50%	20%	25%	50%
Durable medical equipment (DME)	25%	25%	50%	20%	25%	50%	20%	25%	50%
Bariatric surgery	$500 + 25%	$500 + 25%	Not covered	$500 + 20%	$500 + 25%	Not covered	$500 + 20%	$500 + 25%	Not covered
Pharmacy Services									
Out-of-pocket (OOP) maximum	Rx applies toward Max Cost Share			Rx applies toward plan OOP max			Rx applies toward plan OOP max		
Retail									
Value	$4 per 31-day supply			$4[1] per 31-day supply			$4[1] per 31-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply		See Plan Handbook	20%	25%	See Plan Handbook	20%	25%	See Plan Handbook
Preferred brand	25% up to $75 per 31-day supply			20%	25%		20%	25%	
Non-preferred brand[5]	50% up to $175 per 31-day supply			20%	25%		20%	25%	
Mail									
Value	$8 per 90-day supply			$8[1] per 90-day supply			$8[1] per 90-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply		See Plan Handbook	20%	25%	See Plan Handbook	20%	25%	See Plan Handbook
Preferred brand	25% up to $150 per 90-day supply			20%	25%		20%	25%	
Non-preferred brand[5]	50% up to $450 per 90-day supply			20%	25%		20%	25%	
Specialty									
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed			20%	25%		20%	25%	
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		See Plan Handbook	20%	25%	See Plan Handbook	20%	25%	See Plan Handbook
Non-preferred brand[5]	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			20%	25%		20%	25%	

NA – Not applicable

1 Deductible waived.

2 Individual deductible and out-of-pocket maximum apply to single coverage only. Family deductible and 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 max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share.

4 Benefit is subject to a reference price limitation.

5 A formulary exception must be approved for non-preferred brand prescription medication.

6 If enrolled in a Moda medical plan, each covered individual must choose and use a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the far left column under that plan when using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit shown in the center column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level (far right column under that plan) regardless of whether or not the individual has chosen a PCP 360 with Moda.

7 For value teir list please visit https://my.kp.org/oebb/plans/ at bottom of page.

8 For Kaiser plans, acupuncture care, spinal manipulation and naturopathic substance only accrue towards your $2000 benefit maximum. For Moda Plans, acupuncture and spinal manipulation services are subject to 12 visits per plan year.

9 For Moda plans, CirrusMD app is covered at no member cost sharing. All other virtual care for primary and urgent care services (defined as 2-way video conferencing visits) is covered at a $10 copay with deductible waived for plans 1-5. Plans 6 and 7 is a $10 copay after the deductible has been met.

10 For Moda plans, member must see their chosen PCP 360 or any in-network specialist to recieve the copay benefit.

11 For Moda plans, the copay listed is for acupuncture and spinal manipulation services only. Naturopathic substances are covered. See Plan Handbook for details.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

Summary of Dental Benefits 2021-22 Plan Year

	INCENTIVE PLANS See footnote ♦ for details.		DELTA DENTAL Delta Dental of Oregon & Alaska moda HEALTH	LIMITED NETWORK PLANS! MUST USE IN-NETWORK PROVIDERS! See footnotes Ω, †, and ‡ for details.			Willamette Dental Group
Dental	**Premier Plan 1 ♦ Delta Dental Premier Network**	**Premier Plan 5 ♦ Delta Dental Premier Network**	**Premier Plan 6 Delta Dental Premier Network**				**Willamette Dental Plan‡ Willamette Dental Group Facilities**
Dental Office Visit Copayment	NA	NA	NA				$20*[3]
Benefit Maximum	$2,200	$1,700	$1,200				NA
Deductible	$50	$50	$50				NA
Preventive & Diagnostic Services * – Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans							
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	70% + 10% each Plan Year	100%				100% *
Restorative Services *							
Routine fillings, inlays and stainless steel crowns	70% + 10%[1] each Plan Year	70% + 10%[1] each Plan Year	80%[1]				100% *
Simple Extraction *							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%				100% *
Oral Surgery *							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%				$50 Copay *
Periodontics *							
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%				100% *
Endodontics *							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%				$50 Copay *
Major Restorative Services *							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%				$250 Copay*[5]
Implants	70% + 10% each Plan Year	50%	50%				Implant surgery up to $1,500 calendar year maximum
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	50% up to $250 max, once every 5 years				100%[4]
Athletic mouth guards	50%	50%	50%				$100 Copay *
Nitrous Oxide	50%	50%	50%				$15 Copay *
Fixed and Removable Prosthetic Services *							
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%				$100 Copay*[5]
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%				$250 Copay*[5]
Orthodontics * (All plans except Delta Dental Plan 6)							
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NO ORTHO COVERAGE on this plan				$2,500 Copay + $20 per visit **

♦ 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. Switching between incentive plans (1,5, or Exclusive PPO - Incentive Plan) and other non-incentive plans will have an effect on benefit level.

‡ Under the Willamette Dental Plan, services must be provided by a Willamette Dental Group provider in order for benefits to be payable. See handbook for details.

*

** Pre-Orthodontic Service fee of $150 is credited toward the orthodontic benefit if patient accepts treatment plan.

*** Preventive care and orthodontia do not accrue to this maximum.

1 Amalgam and composite filling are covered.

2 Fillings are covered at 100% for all amalgam on posterior teeth, composite on anterior (smile line). Patients can request composite fillings, which are considered a buy-up and additional fees apply. Contact Kaiser Permanente directly for fees

3 The office visit copayment is waived for participants in the Chronic Condition Dental Management program for specific preventive services.

4 Replacement of lost or stolen appliance once every 2 years; replacement or repair of broken appliance as needed.

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

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Summary of Vision Benefits 2021-22 Plan Year

Dental		Moda Opal Plan May use any licensed provider	Moda Pearl Plan May use any licensed provider	Moda Quartz Plan May use any licensed provider	VSP Choice Plus Plan VSP Choice Network	VSP Choice Plan VSP Choice Network
Plan Year Maximum		$600*	$400*	$250*	N/A	N/A
Routine Eye Exam:						
Benefit:		Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	Plan pays 100% after $10 copay
Frequency:		Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Lenses:						
Basic lens benefit:		Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	$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**	$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**
Lens enhancements:					$0 copay for standard progressive lenses **$15 copay for anti-reflective coating or premium/custom progressive lenses**	$0 copay for standard progressive lenses **Discounts for polycarbonate, anti-reflective coating or premium/custom progressive lenses**
Frequency:		Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Frames / Contacts:						
Benefit:		Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Covered in full up to retail allowance of **$300;** 20% off amount over retail allowance for frames Additional $50 or higher allowance for feature frame brands (i.e. Nike, Calvin Klein, Columbia Sportswear, Cole Haan, etc.) Available in-network at VSP doctor and participating retail chain locations (not applicable at Costco or Walmart) Not eligible to combine the Enhanced Featured Frame Allowance with Extra $20 or Extra $40 promotions.	Covered in full up to retail allowance of **$150;** 20% off amount over retail allowance for frames Additional $50 or higher allowance for feature frame brands (i.e. Nike, Calvin Klein, Columbia Sportswear, Cole Haan, etc.) Available in-network at VSP doctor and participating retail chain locations (not applicable at Costco or Walmart) Not eligible to combine the Enhanced Featured Frame Allowance with Extra $20 or Extra $40 promotions.
Frequency:		**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts:** Up to the plan maximum	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts:** Up to the plan maximum	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts:** Up to the plan maximum	Once every 12 months	Once every 12 months
Non-Prescription Benefit						
Benefit:		Not Covered	Not Covered	Not Covered	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. Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.	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. Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details.

* Exam and hardware charges all apply to the plan year maximum on Moda Plans

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You can get this document in other languages, large print, braille or a format you prefer. Contact OEBB Member Services at 888-4My-OEBB (888-469-6322) or email oebb.benefits@state.or.us. We accept all relay calls or you can dial 711.

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