



2026-2027 OEGB Benefits Comparison Medical and Pharmacy Plans

 This is a **high-level medical plan** comparison. Please see plan documents for details.

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 ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	\$950	\$1,050	\$1,350	\$1,350	\$1,450	\$2,150	\$1,750	\$1,850	\$2,950	\$2,150	\$2,250	\$3,750
Maximum deductible per family	\$2,100	\$2,100	\$2,700	\$2,900	\$2,900	\$4,300	\$3,700	\$3,700	\$5,900	\$4,500	\$4,500	\$7,500
Out-of-pocket (OOP) maximum per person ³	\$4,000	\$4,400	\$7,150	\$5,000	\$5,400	\$9,150	\$6,000	\$6,400	\$11,150	\$7,850	\$8,250	\$14,850
Out-of-pocket (OOP) maximum per family ³	\$8,800	\$8,800	\$14,300	\$10,800	\$10,800	\$18,300	\$12,800	\$12,800	\$22,300	\$16,500	\$16,500	\$29,700
Preventive care services												
Routine adult, well-child and women’s exams; annual obesity screening and immunizations 	\$0 ¹	\$0 ¹	50% after deductible	\$0 ¹	\$0 ¹	50% after deductible	\$0 ¹	\$0 ¹	50% after deductible	\$0 ¹	\$0 ¹	50% after deductible
Office visits and virtual care												
Primary care office visits	\$35 ^{1,5}	20% after deductible	50% after deductible	\$35 ^{1,5}	20% after deductible	50% after deductible	\$40 ^{1,5}	25% after deductible	50% after deductible	\$40 ^{1,5}	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	\$55 ¹	Not applicable	50% after deductible	\$55 ¹	Not applicable	50% after deductible	\$65 ¹	Not applicable	50% after deductible	\$65 ¹	Not applicable	50% after deductible
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered	\$0 ¹	\$0 ¹	Not covered
Specialist office visits	\$55 ¹	20% after deductible	50% after deductible	\$55 ¹	20% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible
Urgent care	\$55 ¹	20% after deductible	20% after deductible	\$55 ¹	20% after deductible	20% after deductible	\$65 ¹	25% after deductible	25% after deductible	\$65 ¹	25% after deductible	25% after deductible

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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 ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Mental health and chemical dependency services												
Mental health office visits	\$35 ¹	\$35 ¹	50% after deductible	\$35 ¹	\$35 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible
Mental health inpatient and residential services	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	\$35 ¹	\$35 ¹	50% after deductible	\$35 ¹	\$35 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible	\$40 ¹	\$40 ¹	50% after deductible
Chemical dependency services (inpatient)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient services												
Outpatient surgery / facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational and speech therapy) 	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Diagnostic testing												
Labs, x-ray, and imaging	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	\$100 copay + 20% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 20% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible
Alternative care services ⁷												
Acupuncture and Chiropractic ⁷ 	\$35 ¹	20% after deductible	50% after deductible	\$35 ¹	20% after deductible	50% after deductible	\$40 ¹	25% after deductible	50% after deductible	\$40 ¹	25% after deductible	50% after deductible
Naturopathic office visits	\$55 ¹	20% after deductible	50% after deductible	\$55 ¹	20% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible	\$65 ¹	25% after deductible	50% after deductible

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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 ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordinated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Maternity care												
Routine maternity care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Physician or midwife services and hospital stay, delivery and routine newborn nursery care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Hospital services												
Inpatient care / surgery	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care 	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Additional Cost Tier (ACT)												
Moda Plans Only: \$100 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% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 20% after deductible	\$100 copay + 20% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible	\$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible
Moda Plans Only: \$500 ACT: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 20% after deductible	\$500 copay + 20% after deductible	\$500 copay + 50% after deductible	\$500 copay + 20% after deductible	\$500 copay + 20% after deductible	\$500 copay + 50% after deductible	\$500 copay + 25% after deductible	\$500 copay + 25% after deductible	\$500 copay + 50% after deductible	\$500 copay + 25% after deductible	\$500 copay + 25% after deductible	\$500 copay + 50% after deductible
Emergency services												
Emergency room (copay waived if admitted)	\$100 copay + 20% after deductible			\$100 copay + 20% after deductible			\$100 copay + 25% after deductible			\$100 copay + 25% after deductible		
Ambulance	20% after deductible			20% after deductible			25% after deductible			25% after deductible		

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 ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Other covered services												
Hearing aids: \$4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible
Durable medical equipment (DME)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Pharmacy services												
Out-of-pocket (OOP) maximum	Rx applies toward OOP maximum			Rx applies toward OOP maximum			Rx applies toward OOP maximum			Rx applies toward OOP maximum		
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 ⁴	50% up to \$350 per 31-day supply			50% up to \$350 per 31-day supply			50% up to \$350 per 31-day supply			50% up to \$350 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 ⁴	50% up to \$900 per 90-day supply			50% up to \$900 per 90-day supply			50% up to \$900 per 90-day supply			50% up to \$900 per 90-day supply		

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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 ⁵	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	
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						
Non-preferred brand ⁴	50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed			50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed			50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed						

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 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.

This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.

 This is a **high-level medical plan** comparison. Please see plan documents for details.

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 ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Deductible per person		\$2,550	\$2,650	\$4,550	\$2,150 ²	\$2,250 ²	\$3,750 ²	\$2,550 ²	\$2,650 ²	\$4,550 ²
Maximum deductible per family		\$5,300	\$5,300	\$9,100	\$4,500 ²	\$4,500 ²	\$7,500 ²	\$5,300 ²	\$5,300 ²	\$9,100 ²
Out-of-pocket (OOP) maximum per person ³		\$7,950	\$8,350	\$14,850	\$7,550 ²	\$7,900 ²	\$14,250 ²	\$7,650 ²	\$7,900 ²	\$14,450 ²
Out-of-pocket (OOP) maximum per family ³		\$16,700	\$16,700	\$29,700	\$15,800 ²	\$15,800 ²	\$28,500 ²	\$15,800 ²	\$15,800 ²	\$28,900 ²
Preventive care services										
Routine adult, well-child and women’s exams; annual obesity screening and immunizations		\$0 ¹	\$0 ¹	50% after deductible	\$0 ¹	\$0 ¹	50% after deductible	\$0 ¹	\$0 ¹	50% after deductible
Office visits and virtual care										
Primary care office visits		\$45 ^{1,5}	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)		\$65 ¹	Not applicable	50% after deductible	15% after deductible	Not applicable	50% after deductible	20% after deductible	Not applicable	50% after deductible
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)		\$0 ¹	\$0 ¹	Not covered	\$0 after deductible	\$0 after deductible	Not covered	\$0 after deductible	\$0 after deductible	Not covered
Specialist office visits		\$65 ¹	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Urgent care		\$65 ¹	25% after deductible	25% after deductible	15% after deductible	20% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Mental health services										
Mental health office visits		\$45 ¹	\$45 ¹	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Mental health inpatient and residential services		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)		\$45 ¹	\$45 ¹	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (inpatient)		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

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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 ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Outpatient services										
Outpatient surgery / facility care		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational and speech therapy)		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Diagnostic testing										
Labs, x-ray, and imaging		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans		 \$100 copay + 25% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative care services										
Acupuncture and Chiropractic ⁷		\$45 ¹	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Naturopathic services		\$65 ¹	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Maternity care										
Routine maternity care		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Physician or midwife services and hospital stay, delivery and routine newborn nursery care		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Hospital services										
Inpatient care / surgery		25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care		 25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

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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 ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Additional cost tier (ACT)									
Moda Plans only: \$100 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% after deductible	\$100 copay + 25% after deductible	\$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Moda Plans only: \$500 ACT: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 25% after deductible	\$500 copay + 25% after deductible	\$500 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Emergency services									
Emergency room (copay waived if admitted)	\$100 copay + 25% after deductible			20% after deductible	25% after deductible	See plan handbook	20% after deductible	25% after deductible	See plan handbook
Ambulance	25% after deductible			20% after deductible	25% after deductible	See plan handbook	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% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Pharmacy services									
Out-of-pocket (OOP) maximum	Rx applies toward OOP maximum			Rx applies toward plan OOP maximum			Rx applies toward plan OOP maximum		
Retail									
Value	\$4 per 31-day supply		See plan handbook	\$4 ¹ per 31-day supply		See plan handbook	\$4 ¹ per 31-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$12 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to \$75 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand ⁵	50% up to \$350 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

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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 ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care ⁵ Member Pays	In-Network Non-Coordi-nated Care ⁶ Member Pays	Any Out-of-Network Services Member Pays
Mail									
Value	\$8 per 90-day supply		See plan handbook	\$8 ¹ per 90-day supply		See plan handbook	\$8 ¹ per 90-day supply		See plan handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	\$24 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Preferred brand	25% up to \$150 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand ⁴	50% up to \$900 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Specialty									
Generic (Moda Plans only)	\$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	20% after deductible	25% after deductible	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			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand ⁴	50% up to \$1,000 per 31-day supply or \$2,000 for 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

- 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 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.

This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.



2026–27 Benefits Comparison

Dental Plans

 This is a **high-level dental plan** comparison. Please see plan documents for details.

Dental	 Delta Dental of Oregon & Alaska	 Delta Dental of Oregon & Alaska	 Delta Dental of Oregon & Alaska	 Delta Dental of Oregon & Alaska	 Delta Dental of Oregon & Alaska	
	Premier Plan 1 ¹	Premier Plan 5 ¹	Premier Plan 6	Exclusive PPO – Incentive Plan ¹	Exclusive PPO Plan	Willamette Dental Plan
Network	Delta Dental Premier	Delta Dental Premier	Delta Dental Premier	Limited Network Plan Delta Dental PPO ²	Limited Network Plan Delta Dental PPO ²	Limited Network Plan Willamette Dental Facilities ²
Dental office visit copay	Not applicable	Not applicable	Not applicable	Not applicable	Not applicable	\$20 ³
Benefit maximum	\$2,200 ⁴	\$1,700 ⁴	\$1,200	\$2,300 ⁴	\$1,500 ⁴	Not applicable
Deductible	\$50	\$50	\$50	\$50	\$50	Not applicable
Preventive and diagnostic services – deductible waived for preventive and diagnostic services on Delta Dental Plans ⁶						
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each plan year ⁶	70% + 10% each plan year ⁶	100% ⁶	100% ⁶	100% ⁶	100%
Restorative services						
Routine fillings, inlays and stainless steel crowns	70% + 10% ¹ each plan year	70% + 10% ¹ each plan year	80% ¹	70% + 10% ¹ each plan year	90% ¹	100% ³
Simple extraction						
Simple tooth extractions	70% + 10% each plan year	70% + 10% each plan year	80%	70% + 10% each plan year	90%	100% ³
Oral surgery						
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each plan year	70% + 10% each plan year	80%	70% + 10% each plan year	90%	\$50 copay ³
Periodontics						
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each plan year	70% + 10% each plan year	80%	70% + 10% each plan year	90%	100% ³
Endodontics						
Root canal and related therapy including diagnosis and evaluation	70% + 10% each plan year	70% + 10% each plan year	80%	70% + 10% each plan year	90%	\$50 copay ³

Dental Plans — continued

 This is a **high-level dental plan** comparison. Please see plan documents for details.

 Delta Dental of Oregon & Alaska		 Delta Dental of Oregon & Alaska		 Delta Dental of Oregon & Alaska		 Delta Dental of Oregon & Alaska		 Delta Dental of Oregon & Alaska			
Dental		Premier Plan 1 ¹	Premier Plan 5 ¹	Premier Plan 6	Exclusive PPO – Incentive Plan ¹	Exclusive PPO Plan	Willamette Dental Plan				
Major restorative services											
Gold or porcelain crowns and onlays		70% + 10% each plan year	70%	50%	70% + 10% each plan year	80%	\$250 copay ^{3, 5}				
Implants		70% + 10% each plan year	50%	50%	70% + 10% each plan year	80%	Implant surgery up to \$1,500 calendar year maximum ⁵				
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	50% up to \$250 max, once every 5 years	50% up to \$250 max, once every 5 years	100% once every 2 years				
Athletic mouth guards		50%	50%	50%	50%	50%	\$100 copay ³				
Nitrous Oxide		50%	50%	50%	50%	50%	\$15 copay ³				
Fixed and removable prosthetic services											
Full and partial dentures, relines, rebases		70% + 10% each plan year	50%	50%	70% + 10% each plan year	80%	\$100 copay ^{3, 5}				
Bridge retainers and pontics		70% + 10% each plan year	50%	50%	70% + 10% each plan year	80%	\$250 copay ^{3, 5}				
Orthodontics											
Orthodontic treatment		80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	No ortho coverage on this plan	80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	\$2,500 copay + \$20 per visit				

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| <p>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.</p> <p>2 Services performed by providers outside the limited network are not covered unless for a dental emergency. If you have a dental emergency outside our service area, you may go to the nearest dental office. Member pays the cost share that normally applies for non-emergency dental care services, plus amounts that exceed Usual and Customary Charges for qualifying claims.</p> <p>3 Office visit copayment applies at each visit, in addition to any plan copayments for services.</p> <p>4 Preventive care and orthodontia do not accrue to this maximum.</p> | <p>5 Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit under the Willamette Dental plan.</p> <p>6 Preventive services will not accrue towards the plan benefit maximum.</p> <p>This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.</p> |
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 This is a **high-level vision plan** comparison. Please see plan documents for details.

					
Vision	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	Not applicable	Not applicable
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 per plan year	Once per plan year
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 and 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 and 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 \$15 copay for anti-reflective coating or premium/custom progressive lenses	\$0 copay for standard progressive lenses Discounts for polycarbonate for adults, anti-reflective coating or premium/custom progressive lenses
Frequency	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year
Frames					
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 after \$20 copay up to retail allowance of \$300; 20% off amount over retail allowance for frames	Covered in full after \$20 copay up to retail allowance of \$150; 20% off amount over retail allowance for frames

Vision Plans — continued

 This is a **high-level vision plan** comparison. Please see plan documents for details.

    					
Vision	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
Frames					
Frequency	Age 0–16: Once per plan year Age 17+: Once every two plan years	Age 0–16: Once per plan year Age 17+: Once every two plan years	Age 0–16: Once per plan year Age 17+: Once every two plan years	Once per plan year	Once per plan year
Contacts (in lieu of frames and lenses)					
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; up to \$60 copay for contact lens fitting and evaluation exam	Covered in full up to retail allowance of \$150; up to \$60 copay for contact lens fitting and evaluation exam
Frequency	Up to the plan maximum	Up to the plan maximum	Up to the plan maximum	Once per plan year	Once per plan year
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	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

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