

## 2014-15 Plan Year Monthly Premium by Coverage Tier

	Statewide Med Plan E Moda Health (PPO) (Not HSA Compliant)	Synergy/Summit Med Plan E Moda Health (PPO) (Not HSA Compliant)	Statewide Med Plan G Moda Health (PPO) (Not HSA Compliant)	Synergy/Summit Med Plan G Moda Health (PPO) (Not HSA Compliant)	Statewide Med Plan H Moda Health (PPO) (HSA Compliant Plan - Must be contributing to an HSA)	Synergy/Summit Med Plan H Moda Health (PPO) (HSA Compliant Plan - Must be contributing to an HSA)	Med Plan 3 Kaiser Permanente (HMO) (HSA Compliant Plan - Contributing to an HSA is optional)
Employee Only	\$ 470.91	\$ 436.36	\$ 392.97	\$ 363.85	\$ 353.36	\$ 327.44	\$ 350.10
Employee + Spouse or Domestic Partner	\$ 1,036.01	\$ 960.00	\$ 864.53	\$ 800.48	\$ 777.39	\$ 720.37	\$ 770.23
Employee + Child(ren)	\$ 894.75	\$ 829.11	\$ 746.66	\$ 691.35	\$ 671.40	\$ 622.14	\$ 665.20
Employee & Spouse or Domestic Partner & Child(ren)	\$ 1,459.86	\$ 1,352.77	\$ 1,218.24	\$ 1,127.97	\$ 1,095.43	\$ 1,015.07	\$ 1,085.33

No lifetime maximum on any medical plans

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum effective October 1, 2014.

## 2014-15 Plan Year "HB2557 Health Plan Comparison"

Moda Description of Services	Med Plan E Moda Health (PPO) Not HSA-Compliant		Med Plan G Moda Health (PPO) Not HSA-Compliant		Med Plan H Moda Health (PPO) HSA Required		Med Plan 3 Kaiser Permanente (HMO) (HSA-Compliant/Optional)		
	In-Network*, Member Pays	Out-of-Network, Member Pays	In-Network*, Member Pays	Out-of-Network, Member Pays	In-Network*, Member Pays	Out-of-Network, Member Pays	Kaiser Description of Services	In-Network, Member Pays	Out-of-Network, Member Pays
Deductible per person	\$1,000		\$1,500		\$1,500 <sup>4</sup>		Deductible per person	\$1,500 <sup>4</sup>	See Plan Handbook
Maximum deductible per family	\$3,000		\$4,500		\$3,000 <sup>4</sup>		Maximum deductible per family	\$3,000 <sup>4</sup>	See Plan Handbook
Out-of-pocket maximum per person	\$4,250	\$8,500	\$6,350	\$12,700	\$5,000 <sup>4</sup>		Out-of-pocket maximum per person	\$5,000 <sup>4</sup>	See Plan Handbook
Out-of-pocket maximum per family	\$12,700	\$25,400	\$12,700	\$25,400	\$10,000 <sup>4</sup>		Out-of-pocket maximum per family	\$10,000 <sup>4</sup>	See Plan Handbook
<b>Preventive Care Services</b>									
Moda Medical Home wellness visit (ages 21 and over)	\$0	Not covered	\$0	Not covered	\$0	Not covered	N/A	N/A	N/A
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	\$0	50%	\$0	50%	\$0	50%	Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	\$0	Not Covered
<b>Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)</b>									
Moda Medical Home incentive care	\$15 copay <sup>1</sup>	50%	\$15 copay <sup>1</sup>	50%	20%	50%	N/A	N/A	N/A
Incentive office visits and home visits	20% <sup>1</sup>	50%	20% <sup>1</sup>	50%	20%	50%	N/A	N/A	N/A
<b>Professional Services</b>							<b>Provider Services</b>		
Moda Medical Home primary care services	\$30 copay <sup>1</sup>	50%	\$30 copay <sup>1</sup>	50%	20%	50%	Primary Care Services as described in Plan Handbook	20%	Not Covered
Primary care and specialist office visits	20%	50%	20%	50%	20%	50%	Specialist office visits	20%	Not Covered
Mental health office visits	\$30 copay <sup>1</sup>	50%	\$30 copay <sup>1</sup>	50%	20%	50%	Mental health office visits	20%	Not Covered
Mental health inpatient and residential services	20%	50%	20%	50%	20%	50%	Mental health inpatient and residential services	20%	Not Covered
Chemical dependency services (inpatient, outpatient or residential)	\$0	50%	\$0	50%	20%	50%	Chemical dependency services (inpatient, outpatient or residential)	20%	Not Covered
<b>Alternative Care Services (\$2,000 combined maximum)</b>									
Acupuncture, Chiropractic & Naturopathic Services	20%	50%	20%	50%	20%	50%	Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc.	20%	Not Covered
All other services (e.g., labs, diagnostics, etc.) <i>Cost of lab, x-rays, supplies &amp; procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum</i>	20%	50%	20%	50%	20%	50%	See Plan Handbook	See Plan Handbook	See Plan Handbook
<b>Maternity Care</b>									
Physician or midwife services & hospital stay, delivery & routine newborn nursery care, and outpatient maternity care	20%	50%	20%	50%	20%	50%	Outpatient Maternity Care	\$0	Not Covered
							Delivery & Routine Newborn Nursery Care	20%	Not Covered
<b>Outpatient and Hospital Services</b>									
Inpatient care and outpatient hospital/facility care	20%	50%	20%	50%	20%	50%	Inpatient Care	20%	See Plan Handbook
Skilled nursing facility care (60 days per plan year)	20%	50%	20%	50%	20%	50%	N/A	N/A	N/A
Surgery	20%	50%	20%	50%	20%	50%	Outpatient Surgery, Upper Endoscopies	20%	Not Covered
Outpatient diagnostic lab and X-ray	20%	50%	20%	50%	20%	50%	Laboratory / X-Ray, Imaging (MRI, CT, PET), Lumbar Discographies, and Sleep Studies	20%	Not Covered
\$100 Additional Cost Tier: Sleep studies, specified imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupplementation, tonsillectomies, lumbar discographies	\$100 copay + 20%	\$100 copay + 50%	\$100 copay + 20%	\$100 copay + 50%	20%	50%	Viscosupplementation	20%	Not Covered
\$500 Additional Cost Tier: Spine surgery, knee and hip replacement <sup>3</sup> , knee and shoulder arthroscopy, hernia repair	\$500 copay + 20%	\$500 copay + 50%	\$500 copay + 20%	\$500 copay + 50%	20%	50%	N/A	N/A	N/A
Outpatient Rehabilitation (physical, occupational & speech therapy) 30 days per plan year / 60 for spinal or head injury	20%	50%	20%	50%	20%	50%	Outpatient Rehabilitation (physical, occupational & speech therapy) <i>Maximum 20 visits per therapy per Plan Year</i>	20%	Not Covered

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	In-Network*, Member Pays	Out-of-Network, Member Pays	In-Network*, Member Pays	Out-of-Network, Member Pays	In-Network*, Member Pays	Out-of-Network, Member Pays	Kaiser Description of Services	In-Network, Member Pays	Out-of-Network, Member Pays
<b>Emergency and Urgent Care</b>									
Urgent care visit	\$50 <sup>1</sup>		\$50 <sup>1</sup>		20%		Urgent care visit	20%	See Plan Handbook
Emergency room (copay waived if admitted)	\$100 copay + 20%		\$100 copay + 20%		20%		Emergency Room	20%	
Ambulance	20%		20%		20%		Ambulance	20%	
<b>Other Covered Services</b>									
Hearing Aids (\$4,000 maximum benefit every 48 months) as described in Plan Handbook	10%	50%	10%	50%	20%	50%	Hearing Aids (children up to age 19 and students to age 26, replacement every 48 months) as described in Plan Handbook	20%	Not Covered
Durable Medical Equipment	20%	50%	20%	50%	20%	50%	Durable Medical Equipment	20%	Not Covered
<b>Weight Management (subscriber and covered dependents unless noted otherwise)</b>									
Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply for children)	\$0		\$0		\$0		Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply for children)	\$0	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	\$0		\$0		\$0		12 Health Coaching Sessions per Plan Year & Online Educational Resources	\$0	
Bariatric Surgery (a.k.a., Gastric bypass, Roux-en-Y) <sup>3</sup> <i>Subscribers only, not covered for dependents. Approved providers only - See Plan Handbook for specific criteria.</i>	\$500 copay + 20%	Not covered	\$500 copay + 20%	Not covered	\$500 + 20%	Not covered	Bariatric Surgery (subscribers only, not covered for dependents) See Plan Handbook for specific criteria.	\$500 + 20%	
<b>Tobacco Cessation Program</b>									
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications (available to age 10 and over)	Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications	Four 30-minute phone calls (more if needed) to Kaiser Health Coaching at no charge. Prescription required for patches, gum & medications, all subject to Rx copays. See Plan Handbook for details.	
<b>Pharmacy Services</b>									
How Rx applies to Out-of-Pocket Maximum (OOP Max)	Rx payments do not accrue to the medical OOP Max. No Rx OOP Max.		Rx payments do not accrue to the medical OOP Max. No Rx OOP Max.		Rx payments accrue to the medical plan OOP max.		How Rx applies to Out-of-Pocket Maximum (OOP Max)	Rx payments accrue to the medical plan OOP max.	
<b>Retail</b>									
Value	\$0 (up to 90-day supply)		\$0 (up to 90-day supply)		\$0		N/A	N/A	N/A
Select generic	\$8 per 31-day supply \$24 per 90-day supply		\$8 per 31-day supply \$24 per 90-day supply		20%		Select Generic	20%	See Plan Handbook
Preferred	25% up to \$50 per 31-day supply		25% up to \$50 per 31-day supply		20%		Preferred	20%	See Plan Handbook
Non-preferred brand	50% up to \$150 per 31-day supply		50% up to \$150 per 31-day supply		20%		Non-preferred	20%	See Plan Handbook
<b>Mail</b>									
Value	\$0		\$0		\$0		N/A	N/A	N/A
Select generic	\$16		\$16		20%		Select Generic	20%	See Plan Handbook
Preferred	25% up to \$100 per 90-day supply		25% up to \$100 per 90-day supply		20%		Preferred	20%	See Plan Handbook
Non-preferred brand	50% up to \$300 per 90-day supply		50% up to \$300 per 90-day supply		20%		Non-preferred	20%	See Plan Handbook
<b>Specialty</b>									
Select generic	\$16		\$16		20%		N/A	N/A	N/A
Preferred	25% up to \$100 per 31-day supply		25% up to \$100 per 31-day supply		20%		N/A	N/A	N/A
Non-preferred brand	50% up to \$300 per 31-day supply		50% up to \$300 per 31-day supply		20%		N/A	N/A	N/A

N/A = not applicable

\* If enrolled in a Summit or Synergy plan, you must select a medical home for each individual on the plan and each individual must access services and coordinate care through their medical home in order to receive the "In-Network" benefit; all primary and incentive care office visits not accessed through the individual's medical home will be paid at the "Out-of-Network" benefit. If enrolled in a traditional Statewide (i.e., not Summit or Synergy) plan, all providers within the ODS Plus Network are considered "In-Network".

<sup>1</sup> Deductible Waived

<sup>2</sup> Moda Health Plan H 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 Deductible must be met before benefits will be paid (except where <sup>1</sup> indicates Deductible Waived).

<sup>3</sup> Benefit is subject to a reference price limitation.

<sup>4</sup> Moda Plan H & Kaiser Plan 3 - 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 Deductible must be met before benefits will be paid (except where <sup>1</sup> indicates Deductible Waived).

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.