Portland Community College Moda Medical/Pharmacy Plans - Oct. 1, 2024 - Sept. 30, 2025

No lifetime maximum on any medical plans.	Moda 2			Moda 3			Moda 6 *HSA Optional*		
Plan Year Costs[5]	**In-Network Coordinated Care**[5] **Member Pays**	**In-Network Non-Coordinated Care**[6] **Member Pays**	**Out-of-Network Member Pays**	**In-Network Coordinated Care**[5] **Member Pays**	**In-Network Non-Coordinated Care**[6] **Member Pays**	**Out-of-Network Member Pays**	**In-Network Coordinated Care**[5] **Member Pays**	**In-Network Non-Coordinated Care**[6] **Member Pays**	**Out-of-Network Member Pays**
Deductible per person	$800	$900	$1,600	$1,200	$1,300	$2,400	$1,600[2]	$1,700[2]	$3,200[2]
Maximum deductible per family	$2,700	$2,700	$4,800	$3,900	$3,900	$7,200	$3,400[2]	$3,400[2]	$6,400[2]
Out-of-pocket (OOP) maximum per person[3]	$3,850 [3]	$4,250 [3]	$8,000 [3]	$4,850	$5,250	$10,000	$6,400[2,3]	$6,750[2,3]	$13,100[2,3]
Out-of-pocket (OOP) maximum per family[3]	$12,750 [3]	$12,750 [3]	$24,000 [3]	$15,750	$15,750	$27,400	$13,500[2,3]	$13,500[2,3]	$26,200[2,3]
Preventive Care Services									
Routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for details.	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office Services									
Primary care office visits	$20[1,5]	20% after deductible	50% after deductible	$25[1,5]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360	$40[1]	N/A	50% after deductible	$50[1]	N/A	50% after deductible	15% after deductible	N/A	50% after deductible
Incentive Care office visits	$15[1]	20% after deductible	N/A	$20[1]	25% after deductible	N/A	15% after deductible	20% after deductible	N/A
Virtual Care - CirrusMD telehealth	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0 after deductible	$0 after deductible	Not covered
Specialist office visits	$40[1]	20% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Urgent Care	$40[1]	20% after deductible	20% after deductible	$50[1]	25% after deductible	25% after deductible	15% after deductible	20% after deductible	See Plan Handbook
Mental Health Services									
Mental health office visits	$20[1]	$20[1]	50% after deductible	$25[1]	$25[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Mental health inpatient and residential services	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	$20[1]	$20[1]	50% after deductible	$25[1]	$25[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Chemical dependency services (inpatient)	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient Services									
Outpatient surgery/facility care	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient Rehabilitation (physical, occupational & speech therapy) See Plan Handbook for details.	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Tests (outpatient)									
Labs, x-ray and imaging	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% 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 + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative Care Services[7]									
Acupuncture and Chiropractic[7] See Plan Handbook for details.	$20[1]	20% after deductible	50% after deductible	$25[1]	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Naturopathic office visits	$40[1]	20% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible
Maternity Care									
Routine Maternity Care	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Hospital Services									
Inpatient care/surgery	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Additional Cost Tier									
$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% 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	20% after deductible	25% after deductible	50% after deductible
$500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[4], knee & shoulder arthroscopy, uncomplicated hernia repair	$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	20% after deductible	25% after deductible	50% after deductible
Emergency Services									
Emergency room (copay waived if admitted)	$100 copay + 20% after deductible			$100 copay + 25% after deductible			20% after deductible	25% after deductible	See Plan Handbook
Ambulance	20% after deductible			25% after deductible			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	10% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable Medical Equipment (DME)	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

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Pharmacy Services									
Out of pocket maximum	Rx applies toward plan OOP max			Rx applies toward plan OOP max			Rx applies toward plan OOP max		
Retail									
Value	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook	$4[1] per 31-day supply		See Plan Handbook
Select generic	$12 per 31-day supply			$12 per 31-day supply			20% after deductible	25% after deductible	
Preferred Brand	25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			20% after deductible	25% after deductible	
Mail									
Value	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook	$8[1] per 90-day supply		See Plan Handbook
Select generic	$24 per 90-day supply			$24 per 90-day supply			20% after deductible	25% after deductible	
Preferred Brand	25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			20% after deductible	25% after deductible	
Specialty									
Generic	~~$12 per 31-day supply or $30 per 90-day supply when allowed~~		See Plan Handbook	~~$12 per 31-day supply or $30 per 90-day supply when allowed~~		See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Preferred brand	~~25% up to $200 per 31-day supply or $400 per 90-day supply when allowed~~			~~25% up to $200 per 31-day supply or $400 per 90-day supply when allowed~~			20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $500 per 31-day supply or $1,000 per 90-day supply when allowed			50% up to $500 per 31-day supply or $1,000 per 90-day supply when allowed			20% after deductible	25% after deductible	

N/A - 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 b
met before benefits will be paid (except where [1] indicates deductible waived).
[3] For Moda plans, OOP max includes medical copayments, coinsurance, ACT copayments and pharmacy expenses.
[4] A fromulary exception must be approved for non-preferred brand prescription medication.
[5] To receive in-network coordinated care benefits, you must chose and use a PDP 360.
[6] To receive in-network non-coordinated care benefits, you must see 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.

No lifetime maximum on any medical plans.	Kaiser Med Plan 1 (HMO)	Kaiser Med Plan 2B	Kaiser Med Plan 3 (HMO) *HSA Optional*
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network, Member Pays**	**In-Network, Member Pays**	**In-Network, Member Pays**
Deductible per person	None	$1,200	$1,600[2]
Maximum deductible per family	None	$3,600	$3,200[2]
Out-of-pocket (OOP) maximum per person	$1,500	$4,500	$6,550[2]
Out-of-pocket (OOP) maximum per family	$3,000	$13,500	$13,100[2]
Preventive Care Services			
Routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for details.	$0	$0[1]	$0[1]
Office Services			
Primary care office visits	$20	$30[1]	20% after deductible
Virtual Care	$0	$0[1]	$0 after deductible
Specialist office visits	$30	$40[1]	20% after deductible
Urgent Care	$35	$45[1]	20% after deductible
Mental Health Services			
Mental health office visits	$20	$30[1]	20% after deductible
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	20% after deductible	20% after deductible
Chemical dependency services (inpatient, outpatient or residential)	$0	$0[1]	20% after deductible
Outpatient Services			
Outpatient surgery/facility care	$75	20% after deductible	20% after deductible
Outpatient Rehabilitation (physical, occupational & speech therapy) See Plan Handbook for details.	$30 per visit	$40[1] per visit	20% after deductible
Tests (outpatient)			
Labs, X-ray, and imaging	$20 per visit	$30[1] per visit	20% after deductible
CT, MRI, PET scans	$70 per visit	$80[1] per visit	20% after deductible
Alternative Care Services			
Acupuncture and Chiropractic [7] See Plan Handbook for details.	$20 per service	$30[1] per service	20% after deductible
Naturopathic Office Visits	$20 per service	$30[1] per service	20% after deductible
Maternity Care			
Routine Maternity Care	$0	$0[1]	$0[1]
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission maximum	20% after deductible	20% after deductible
Hospital Services			
Inpatient care/surgery	$100 per day, up to $500 per admission maximum	20% after deductible	20% after deductible
Skilled nursing facility care, See Plan Handbook for details.	$0	20% after deductible	20% after deductible
Emergency Services			
Emergency room (copay waived if admitted)	$150 per visit (waived if admitted)	20% after deductible	20% after deductible
Ambulance	$75	$100[1]	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%	10%[1]	20% after deductible
Durable Medical Equipment (DME)	20%	20%[1]	20% after deductible

Pharmacy Services			
Out of pocket maximum	Rx applies to plan OOP max noted above	Rx applies to plan OOP max noted above	Rx applies to plan OOP max noted above
Retail			
Value	N/A	N/A	$0[7]
Generic	$10 per 30-day-supply	$10 per 30-day-supply	20% after deductible
Preferred Brand	$30 per 30-day supply	$30 per 30-day supply	20% after deductible
Non-preferred brand [4]	$50 per 30-day supply if criteria met	$50 per 30-day supply if criteria met	20% after deductible
Mail			
Value			
Generic	$20 per 90-day supply	$20 per 90-day supply	20% after deductible
Preferred Brand	$60 per 90-day supply	$60 per 90-day supply	20% after deductible
Non-preferred brand [4]	$100 per 90-day supply if criteria met	$100 per 90-day supply if criteria met	20% after deductible
Specialty			
Select generic	25% up to $150 per 30-day supply	25% up to $150 per 30-day supply	20% after deductible
Non-preferred brand [4]	25% up to $150 per 30-day supply	25% up to $150 per 30-day supply	20% after deductible

[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).
[4] A formulary exception must be approved for non-preferred brand prescription medication.
[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.

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.