Part-Time Non-Represented & SEIU
Plan Comparison 2024-2025
Portland Public Schools

Moda 866-223-2375
Group # 10006726

Kaiser 866-923-0409
Group # 018050

Medical

	Kaiser Medical Plan 1 In-Network	Kaiser Medical Plan 1 Out-of-Network	Moda Medical Plan 1 In-Network Coordinated Care[5]	Moda Medical Plan 1 In-Network Non-Coordinated Care[6]	Moda Medical Plan 1 Any Out-of-Network Services
Medical Network					
Network	Kaiser Permanente Facilities	Kaiser Permanente Facilities	Connexus Network	Connexus Network	Connexus Network
Deductibles & Out-of-Pocket Maximums					
Deductible per person	None	N/A	$400	$500	$800
Maximum deductible per family	None	N/A	$1500	$1500	$2400
Out-of-pocket {OOP) maximum per person	$1,500	N/A	$2,850[3]	$3,250[3]	$6,000[3]
Out-of-pocket {OOP) maximum per family	$3,000	N/A	$9,750[3]	$9,750[3]	$18,000[3]
Preventive Care Services					
Routine adult, well-child and women's exams; annual obesity screening & immunizations	$0	Not covered	$0[1]	$0[1]	50% after deductible
Office Visits and Virtual Care					
Primary care office visits	$20	Not covered	$20[1,5]	20% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	N/A	N/A	$40[1]	N/A	50% after deductible
Incentive care office visits (Moda Plans only)	N/A	N/A	$151[1]	20% after deductible	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0	Not covered	$0[1]	$0[1]	Not covered
Specialist office visits	$30	Not covered	$40[1]	20% after deductible	50% after deductible
Urgent care	$35	See Plan Handbook	$40[1]	20% after deductible	20% after deductible
Mental Health and Chemical Dependency Services					
Mental health office visits	$20	Not covered	$20[1]	$20[1]	50% after deductible
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	Not covered	20% after deductible	20% after deductible	50% after deductible

	Kaiser Medical Plan 1 In-Network	Out-of-Network	Coordinated Care[5]	**Moda Medical Plan 1** In-Network Non-Coordinated Care[6]	**Moda Medical Plan 1** Any Out-of-Network Services
Chemical dependency services (outpatient or residential)	$0	Not covered	$20[1]	$20[1]	50% after deductible
Chemical dependency services (inpatient)	$0	Not covered	20% after deductible	20% after deductible	50% after deductible
Outpatient Services					
Outpatient surgery/facility care	$75	Not covered	20% after deductible	20% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational & speech therapy)	$30 per visit	Not covered	20% after deductible	20% after deductible	50% after deductible
Diagnostic Testing					
Labs, X-ray, and imaging	$20 per visit	Not covered	20% after deductible	20% after deductible	50% after deductible
CT MRI, PET	after	deductible	20% deductible	$100 copay + 20% after	$100 copay +
	$ copay + 20% deductible				
	$				

	Kaiser Medical Plan 1 Dn(HZy } pvh¤	Kaiser Medical Plan 1 Out-of-Network	Moda Medical Plan 1 In-Network Coordinated Care[5]	Moda Medical Plan 1 Dn(HZy } pvh¤ Hpn(?ppvYenTyZY¤?TvZ[6]	Moda Medical Plan 1 =n¢¤I {y(p\(HZy } pvh¤ MZv|eWZx¤
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Moda Plans Only: 7--¤=YYeyepnTj¤?pxy¤OeZv¤!=?O#[3]<¤MrenZ¤x{v`Zv£'¤ hnZZ¤ ¤aer¤vZrjTWZ l Zny'¤hnZZ¤ ¤xap{jYZv¤TvyavpxWpr£'¤ {nWp l rjeWTyZY¤aZvneT¤vZrTev¤	N/A	N/A	7--¤WprT¢$¤1- ¤T_Zv¤ YZY{WyeUjZ¤	7--¤WprT¢$¤1- ¤T\yZv¤ YZY{WyeUjZ¤	7--¤WprT¢$¤ 7- ¤T\yZv¤ YZY{WyeUjZ¤
Emergency Services					
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=l U{jTnWZ¤	97¤	97¤	1- ¤T\yZv¤YZY{WyeUjZ¤	1- ¤T_Zv¤YZY{WyeUjZ¤	1- ¤T\yZv¤ YZY{WyeUjZ¤
Other Covered Services					
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@{vTUjZ¤ l ZYeWTj¤Zt{er l Zny¤!@GA#¤	1- ¤	Hpy¤Wp|ZvZY¤	1- ¤T\yZv¤YZY{WyeUjZ¤	1- ¤T_Zv¤YZY{WyeUjZ¤	7- ¤T\yZv¤ YZY{WyeUjZ¤
Pharmacy Services					
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Retail					
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BZnZveW¤!ETexZv¤KjTnx#+¤MZjZWy¤`ZnZveW¤!GpYT¤KjTnx#¤	/-¤rZv¤3-(YT¢¤ x{rrj¢¤	MZZ¤KjTn¤ CTnYUpph¤	/1¤rZv¤3/(YT¢¤x{rrj¢¤	/1¤rZv¤3/(YT¢¤x{rrj¢¤	MZZ¤KjTn¤ CTnYUpph¤
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Mail					

	#'-&,0 &%'$#(0 !(#)0 0 In-Network				
Value	N/A				
Generic (Kaiser Plans) / Select generic (Moda Plans)	$20 per 90-day supply				
Preferred brand	$60 per 90-day supply				
Non-preferred brand[4]	$100 per 90-day supply if criteria met				
"+&$'#(./0					
Generic (Moda Plans only)	N/A				
Select generic (Kaiser Plans) / Preferred brand (Moda Plans)	25% up to $150 per 30-day supply				
Non-preferred brand[4]	25% up to $150 per 30-day supply				

N/A = 30-day to per

Dental

	Delta Dental Premier Plan 5[1]	Kaiser Dental Plan
"1;@-9G&1@C<>8G		
Network	Delta Dental Premier	Limited Network Plan - Kaiser Permanente Facilities[2]
"1;@-9G'36/1G+6?6@G!<=-EG		
Copay	N/A	$20[3]
"10A/@6.91?G G 1;126@G%-D6:A:?G		
Benefit maximum	$1,700[4]	$4,000[4]
Deductible	$50	N/A
(>1B1;@6B1G G"6-4;<?@6/G*1>B6/1?G "10A/@6.91G,-6B10G2<>G(>1B1;@6B1G G"6-4;<?@6/G*1>B6/1?G<;G"19@-G"1;@-9G(9-;?[6]		
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each plan year[6]	100%[6]
)1?@<>-@6B1G*1>B6/1?G		
Routine fillings, inlays and stainless steel crowns	70% + 10%[1] each plan year	100%[3]
*6:=91G#D@>-/@6<;G		
Simple tooth extractions	70% + 10% each plan year	100%[3]
'>-9G*A>41>FG		
Surgical tooth extractions, including diagnosis and evaluationr		

Full and partial dentures, relines, rebases	50%	$100 copay[3]
Bridge retainers and pontics	50%	$250 copay[3]
Orthodontics		
Orthodontic treatment	80% to $1,800 lifetime max	$2,500 copay + $20 per visit

[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.

[2] Services performed by providers outside the limited network are not covered unless for a dental emergency. Emergency services consist of limited exam and palliative treatment only.

[3] O f ce visit copay applies at each visit, in addition to any plan copays for services.

[4] Preventive care and orthodontia do not accrue to this maximum.

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

[6] Preventive services will not accrue towards the plan benefit maximum.

Vision

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Network	VSP Choice Network
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Plan year maximum	."&
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Benefit	Plan pays 100% after $10 copay
Frequency	Once per plan year
+7>B7B	
Basic lens benefit	$20 copay (applied towards lenses & frame): Glass or plastic [illegible]
Lens enhancements	
Frequency	
*A4=7B	
Benefit	
Frequency	
(?>C45CB :><:7D?8 8A4=7B4>6<7>B7B	
Benefit	
Frequency	
-?>!/A7B5A:@C:?> '7>78:C	
Benefit	