Clackamas Community College OEBB 2025-2026 Plan Year – Summary of Moda Medical Plans and Pharmacy Benefits

Medical Plans - No lifetime maximum on any medical plans	**Moda Medical Plan 1**			**Moda Medical Plan 2**			**Moda Medical Plan 6 -** HSA Optional		
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	$700	$800	$1,100	$1,100	$1,200	$1,900	$1,900[2]	$2,000[2]	$3,500[2]
Maximum deductible per family	$1,600	$1,600	$2,200	$2,400	$2,400	$3,800	$4,000[2]	$4,400[2]	$7,000[2]
Out-of-pocket (OOP) maximum per person[3]	$3,750	$4,150	$6,900	$4,750	$5,150	$8,900	$7,300[2]	$7,650[2]	$14,000[2]
Out-of-pocket (OOP) maximum per family[3]	$8,300	$8,300	$13,800	$10,300	$10,300	$17,800	$15,300[2]	$15,300[2]	$28,000[2]
Preventative Care Services									
Wellness Visit	$0[1]	$0[1]	50% after ded	$0[1]	$0[1]	50% after ded	$0[1]	$0[1]	50% after ded
Routine adult, well-child and women's exams; annual obesity screening and immunizations*. See Plan Handbook for additional Preventive Care Services	$0[1]	$0[1]	50% after ded	$0[1]	$0[1]	50% after ded	$0[1]	$0[1]	50% after ded
Office Visits and Virtual Care									
Primary care office visits	$25[1,5]	20% after ded	50% after ded	$25[1,6]	20% after ded	50% after ded	15% after ded	20% after ded	50% after ded
Primary care office visits with a provider other than your chosen PCP 360	$45[1]	NA	50% after ded	$45[1]	NA	50% after ded	15% after ded	NA	50% after ded
Incentive care office visits	$20*[1]	20% after ded	N/A	$20*[1]	20% after ded	N/A	15% after ded	20% after ded	N/A
CirrusMD telehealth* (virtual visits)	$0[1]	$0[1]	Not covered	$0[1,9]	$0[1]	Not covered	$0[1] after ded	$0[1] after ded	Not covered
Specialist office visits	$45[1]	20% after ded	50% after ded	$45[1]	20% after ded	50% after ded	15% after ded	20% after ded	50% after ded
Urgent care	$45[1]	20% after ded	20% after ded	$45[1]	20% after ded	20% after ded	15% after ded	20% after ded	See Plan Handbook
Mental Health Services									
Mental health office visits	$25[1]	$25[1]	50% after ded	$25[1]	$25[1]	50% after ded	15% after ded	20% after ded	50% after ded
Mental health inpatient and residential services	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Chemical dependency services (outpatient or residential)	$25[1]	$25[1]	50% after ded	$25[1]	$25[1]	50% after ded	15% after ded	20% after ded	50% after ded
Chemical dependency services (inpatient)	20% after ded	20% after ded	20% after ded	20%	20%	50%	20% after ded	25% after ded	50% after ded
Outpatient Services									
Outpatient surgery/facility care	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Outpatient rehabilitation (physical, occupational & speech therapy) 30 sessions per plan year / 60 for spinal or head injury	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Diagnostic Testing									
Labs, x-rays, and imaging	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
CT, MRI, PET scans*	$100 copay + 20% after ded	$100 copay + 20% after ded	$100 copay + 50% after ded	$100 copay + 20% after ded	$100 copay + 20% after ded	$100 copay + 50% after ded	20% after ded	25% after ded	50% after ded
Alternative Care Services[8]									
Acupuncture and chiropractic[7]	$25[1]	20% after ded	50% after ded	$25[1]	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Naturopathic office visits	$45[1]	20% after ded	50% after ded	$45[1]	20% after ded	50% after ded	15% after ded	20% after ded	50% after ded
Maternity Care									
Routine maternity care	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Hospital Services									
Inpatient care/surgery	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Skilled nursing facility care*	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Additional Cost Tier									

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Specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea,	$100 copay + 20% after ded	$100 copay + 20% after ded	$100 copay + 50% after ded	$100 copay + 20% after ded	$100 copay + 20% after ded	$100 copay + 50% after ded	20% after ded	25% after ded	50% after ded
viscosupplementation, upper endoscopies, sleep studies, lumbar discographies									
Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20% after ded	$500 copay + 20% after ded	$500 copay + 50% after ded	$500 copay + 20% after ded	$500 copay + 20% after ded	$500 copay + 50% after ded	20% after ded	25% after ded	50% after ded
Emergency Services									
Emergency room (copay waived if admitted)	$100 copay + 20% after ded			$100 copay + 20% after ded			20% after ded	25% after ded	See Plan Handbook
Ambulance	20% after ded			20% after ded			20% after ded	25% after ded	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 ded	10% after ded	50% after ded	10% after ded	10% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Durable medical equipment (DME)	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	20% after ded	25% after ded	50% after ded
Pharmacy Services									
Out-of-pocket (OOP) maximum	Rx applies toward OOP Max			Rx applies toward OOP Max			Rx applies toward 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 ded	25% after ded	
Preferred brand	25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			20% after ded	25% after ded	
Non-preferred brand[4]	50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			20% after ded	25% after ded	
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 ded	25% after ded	
Preferred brand	25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			20% after ded	25% after ded	
Non-preferred brand[4]	50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			20% after ded	25% after ded	
Specialty									
Generic	$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	20% after ded	25% after ded	See Plan Handbook
Preferred brand	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			20% after ded	25% after ded	
Non-preferred brand[4]	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			20% after ded	25% after ded	

Plan Premium	Moda Medical Plan 1	Moda Medical Plan 2	Moda Medical Plan 6
Employee Only	$821.57	$762.14	$636.16
Employee + Spouse/Partner	$1,807.46	$1,676.70	$1,399.56
Employee + Child(ren)	$1,561.02	$1,448.09	$1,208.74
Employee + Family	$2,546.95	$2,362.67	$1,972.14
The premiums listed above are not the amounts that you pay each month. Utilize the Monthly Benefits Calculator on the **HR Webpage** to calculate your monthly out-of-pocket cost.			

NA – Not applicable
After ded – 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).
3 OOP max includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.
4 A formulary exception must be approved for non-preferred brand prescription medication.

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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 Acupuncture and spinal manipulation services are subject to 12 combined visits per plan 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 document and your member handbook, the member handbook will prevail.**