ESTACADA SCHOOL DISTRICT #108
2015-2016 MANAGEMENT AND CONFIDENTIAL BENEFIT OPTIONS

STEP 1.

PLEASE NOTE THAT THE FOLLOWING 4 PAGES CONTAIN MULTIPLE BENEFIT OPTIONS FOR YOUR REVIEW. PLEASE TAKE YOUR TIME AND USE THE BELOW WEBSITE FOR ADDITIONAL ASSISTANCE TO COMPARE THE HIGHLIGHTED PLANS TO CHOOSE WHICH IS BEST FOR YOU AND YOUR DEPENDENTS.

For Plan Comparisons please visit
http://www.oregon.gov/OHA/OEBB/pages/index.aspx

STEP 2.

CHOOSE THE APPROPRIATE PLAN AND USE THE COMPOSITE RATE (SEE PGS 5 – 6), ADD ALL BENEFITS COSTS (INCL THE BELOW LISTED LIFE, AD&D, LONG TERM DISABILITY)

Life & Disability ($50,000 coverage)	**$6.85**
LTD	**$.00235 times average monthly salary**

TOTAL COST OF YOUR LIFE, AD&D, LTD, VISION, DENTAL AND MEDICAL $___________

COMPUTE YOUR CAP: THE DISTRICT CONTRIBUTES $1458.00 PER MONTH FOR AN 8 HOUR EMPLOYEE OR PRO-RATED AT $182.25 PER HOUR WORKED.

Fill in the amount of district contribution: $___________

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Subtract the district contribution from the total Benefit line
ESTIMATED TOTAL PER PAYCHECK COST $___________
(Your per month paycheck deduction)

STEP 3.

REGISTER!

MANDATORY ENROLLMENT IS REQUIRED! **SIGN ON TO THE BELOW WEBSITE DURING THE ASSIGNED OPEN ENROLLMENT DATES FOR OUR DISTRICT. IF YOU DO NOT VISIT THIS SITE, YOU WILL "NOT" HAVE HEALTH BENEFITS**

To Register During Open Enrollment Visit

https://myoebb.org/oebb/!pb.main

All enrollments must be submitted by the employee on the OEBB web site between 8/15/2015 and 08/31/2015.

Forms submitted after 08/31/2015 will not be processed for Septembers payroll-Octobers payroll could have double deductions!

OREGON EDUCATORS BENEFIT BOARD 2015-16 PLAN YEAR
SUMMARY OF MEDICAL AND PHARMACY BENEFITS

Medical Plans no lifetime maximum on any medical plans	Med Plan 1 Kaiser (HMO)		Med Plan 2 Kaiser (HMO)		Med Plan 3 Kaiser (HMO)		Med Plan A Moda Health (PPO)		Med Plan B Moda Health (PPO)		Med Plan C Moda Health (PPO)		Med Plan D Moda Health (PPO)		Med Plan E Moda Health (PPO)		Med Plan F Moda Health (PPO)		Med Plan G Moda Health (PPO) Not HSA-Compliant		Med Plan H Moda Health (PPO) HSA Required	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum effective October 1, 2014.	**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**	**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**	**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**	**In-Network*, Member Pays**	**Out-of-Network, Member Pays**	**In-Network*, Member Pays**	**Out-of-Network, Member Pays**
Deductible per person	None	See Plan Handbook	$200	See Plan Handbook	$1,500[2]	See Plan Handbook	$200		$350		$500		$750		$1,000		$1,250		$1,500		$1,500[2]	
Maximum deductible per family	None	See Plan Handbook	$600	See Plan Handbook	$3,000[2]	See Plan Handbook	$600		$1,050		$1,500		$2,250		$3,000		$3,750		$4,500		$3,000[2]	
Out-of-pocket (OOP) maximum per person	$1,500	See Plan Handbook	$3,400	See Plan Handbook	$5,000[2]	See Plan Handbook	$2,400	$4,800	$2,950	$5,900	$3,300	$6,600	$3,800	$7,600	$4,250	$8,500	$5,500	$11,000	$6,350	$12,700	$5,000[2]	
Out-of-pocket (OOP) maximum per family	$3,000	See Plan Handbook	$6,800	See Plan Handbook	$10,000[2]	See Plan Handbook	$7,200	$14,400	$8,850	$17,700	$9,900	$19,800	$11,400	$22,800	$12,700	$25,400	$12,700	$25,400	$12,700	$25,400	$10,000[2]	
Maximum cost share per person (Includes OOP, ACT, and Pharmacy)	NA	NA	NA	NA	NA	NA	$6,600	n/a	$6,600	n/a	$6,600	n/a	$6,600	n/a	$6,600	n/a	$6,600	n/a	$6,600	n/a	n/a	
Maximum cost share per family (Includes OOP, ACT, and Pharmacy)	NA	NA	NA	NA	NA	NA	$13,200	n/a	$13,200	n/a	$13,200	n/a	$13,200	n/a	$13,200	n/a	$13,200	n/a	$13,200	n/a	n/a	
Preventive Care Services																						
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0	NA	$0	NA	$0	NA	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered
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	$0	Not Covered	$0	Not Covered	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)																						
Moda Medical Home incentive care	NA	NA	NA	NA	NA	NA	$10 copay[1]	50%	$10 copay[1]	50%	$10 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	20%	50%
Incentive office visits and home visits	NA	NA	NA	NA	NA	NA	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%	50%
Professional Services																						
Moda Medical Home primary care services	NA	NA	NA	NA	NA	NA	$20 copay[1]	50%	$20 copay[1]	50%	$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
Primary care office visits	$20	Not Covered	$25[1]	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Specialist office visits	$30	Not Covered	$35[1]	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Mental health office visits	$20	Not Covered	$25[1]	Not Covered	20%	Not Covered	$20 copay[1]	50%	$20 copay[1]	50%	$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
Mental health inpatient and residential services	$100 per day, up to $500 per admission maximum	Not Covered	20%	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0	Not Covered	$0	Not Covered	20%	Not Covered	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	20%	50%
Alternative Care Services ($2,000 combined maximum)																						
Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. *Cost of lab, x-rays, supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum*	$20 per service	Not Covered	$25[1] per service	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Maternity Care																						
Outpatient Materntity Care	$0	Not Covered	$0	Not Covered	$0	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission maximum	Not Covered	20%	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Outpatient and Hospital Services																						
Inpatient care/surgery	$100 per day, up to $500 per admission maximum	See Plan Handbook	20%	See Plan Handbook	20%	See Plan Handbook	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Outpatient surgery/facility care	$75	Not Covered	20%	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	$0	NA	20%	NA	20%	NA	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Viscosupplementation	$30[5]	Not Covered	$35[1,5]	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Upper Endoscopies	$75	Not Covered	20%	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Sleep Studies	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
MRI, CT, PET imaging	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Lumbar Discographies	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Moda Plans Only: $100 Additional Cost Tier (ACT): spinal injections, tonsillectomies	NA	NA	NA	NA	NA	NA	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[3], knee & shoulder arthroscopy, hernia repair	NA	NA	NA	NA	NA	NA	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	20%	50%
Outpatient Rehabilitation (physical, occupational & speech therapy) Kaiser Plans: Maximum 20 visits per therapy per Plan Year Moda Plans: 30 days per plan year / 60 for spinal or head injury	$30 per visit	Not Covered	$35[1] per visit	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Outpatient diagnostic lab and X-ray	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Emergency and Urgent Care																						
Urgent care visit	$35	See Plan Handbook	$40[1]	See Plan Handbook	20%	See Plan Handbook	$50[1]		$50[1]		$50[1]		$50[1]		$50[1]		$50[1]		$50[1]		20%	
Emergency room (copay waived if admitted)	$100 per visit (waived if admitted)		20%		20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		20%	
Ambulance	$75		$100[1]		20%		20%		20%		20%		20%		20%		20%		20%		20%	
Other Covered Services																						
Hearing Aids $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	Not Covered	10%[1]	Not Covered	20%	Not Covered	10%	50%	10%	50%	10%	50%	10%	50%	10%	50%	10%	50%	10%	50%	20%	50%
Durable Medical Equipment	20%	Not Covered	20%[1]	Not Covered	20%	Not Covered	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%

NA = 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 preventive, 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 Connexus Network are considered "In-

[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 Deductible must be met before benefits will be paid (except where [1] indicates Deductible Waived).**

[3] **Benefit is subject to a reference price limitation. This is not applicable to Summit or Synergy Plans.**

[4] **To remain HSA-compliant, medications for certain conditions are not included in the Plan H value tier. See Plan Handbook for details.**

[5] **On Kaiser Plans 1 & 2, viscosupplementation and other "Clinically Administered Medications" are subject to the office visit copayment plus 20 % coinsurance**

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.

OREGON EDUCATORS BENEFIT BOARD 2015-16 PLAN YEAR
SUMMARY OF MEDICAL AND PHARMACY BENEFITS

Medical Plans **no lifetime maximum on any medical plans**	**Med Plan 1** **Kaiser (HMO)**		**Med Plan 2** **Kaiser (HMO)**		**Med Plan 3** **Kaiser (HMO)**		**Med Plan A** **Moda Health (PPO)**		**Med Plan B** **Moda Health (PPO)**		**Med Plan C** **Moda Health (PPO)**		**Med Plan D** **Moda Health (PPO)**		**Med Plan E** **Moda Health (PPO)**		**Med Plan F** **Moda Health (PPO)**		**Med Plan G** **Moda Health (PPO)** Not HSA-Compliant		**Med Plan H** **Moda Health (PPO)** HSA Required	
Weight Management (subscriber and covered dependents unless noted otherwise)																						
Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply)	$0		$0		$0		$0		$0		$0		$0		$0		$0		$0		$0	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$0		$0		$0		$0		$0		$0		$0		$0		$0		$0		$0	
Bariatric Surgery (a.k.a., Gastric bypass, Roux-en-Y)[3] *Subscribers only, not covered for dependents. Approved providers only - See Plan Handbook for specific criteria.*	$500 + Inpatient Care costs		$500 + 20%		$500 + 20%		$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 + 20%	Not covered
Tobacco Cessation Program **(available to age 10 and over)**																						
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.		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.		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.		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.		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.		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.	
Pharmacy Services																						
Out of pocket maximum	$1100 Rx max also applies to Medical OOP Max		$1100 Rx max also applies to Medical OOP Max		Rx applies toward plan OOP max		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward plan OOP max	
Retail																						
Value (Moda Plans Only)	NA	NA	NA	NA	NA	NA	$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0[4]	
Generic (Kaiser plans) / Select generic (Moda Plans)	$5 per 30-day-supply	See Plan Handbook	$5 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		20%	
Preferred Brand	$25 per 30-day supply	See Plan Handbook	$25 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		20%	
Non-preferred brand	$45 per 30-day supply if criteria met	See Plan Handbook	$45 per 30-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook	50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		20%	
Mail																						
Value (Moda Plans Only)	NA	NA	NA	NA	NA	NA	$0		$0		$0		$0		$0		$0		$0		$0[4]	
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook	$10 per 90-day supply	See Plan Handbook	20%	See Plan Handbook	$16		$16		$16		$16		$16		$16		$16		20%	
Preferred Brand	$50 per 90-day supply	See Plan Handbook	$50 per 90-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		20%	
Non-preferred brand	$90 per 90-day, supply if criteria met	See Plan Handbook	$90 per 90-day, supply if criteria met	See Plan Handbook	20%	See Plan Handbook	50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		20%	
Specialty																						
Select generic	25% up to $100 per 30 day supply	See Plan Handbook	25% up to $100 per 30 day supply	See Plan Handbook	20%	See Plan Handbook	$16		$16		$16		$16		$16		$16		$16		20%	
Preferred	25% up to $100 per 30 day supply	See Plan Handbook	25% up to $100 per 30 day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		20%	
Non-preferred brand	25% up to $100 per 30 day supply	See Plan Handbook	25% up to $100 per 30 day supply	See Plan Handbook	20%	See Plan Handbook	50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		20%	

NA = 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 preventive, 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 Connexus Network are considered "In-Network".

[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 Deductible must be met before benefits will be paid (except where [1] indicates Deductible Waived).

[3] Benefit is subject to a reference price limitation. This is not applicable to Summit or Synergy Plans.

[4] To remain HSA-compliant, medications for certain conditions are not included in the Plan H value tier. See Plan Handbook for details.

[5] On Kaiser Plans 1 & 2, viscosupplementation and other "Clinically Administered Medications" are subject to the office visit copayment plus 20 % coinsurance

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OREGON EDUCATORS BENEFIT BOARD 2015-16 PLAN YEAR
SUMMARY OF DENTAL BENEFITS

Plan Option	Dental Plan 1 ♦	Dental Plan 2 ♦	Dental Plan 3 ♦	Dental Plan 4	Dental Plan 6	Dental Plan 8 †	Dental Plan 8 ‡
Dental	**Moda Health/ODS**	**Moda Health/ODS**	**Moda Health/ODS**	**Moda Health/ODS**	**Moda Health/ODS**	**Kaiser**	**Willamette Dental Group**
Dental Office Visit Copayment	NA	NA	NA	NA	NA	$20*	$20 [3]*
Benefit Maximum	$2,200	$1,500	$1,500	$1,500	$1,200	NA	NA
Deductible	$50	$50	$50	$50	$50	NA	NA
Plan Year Maximum	$2,200	$1,500	$1,500	$1,500	$1,200	NA	NA
Preventive and Diagnostic Services*	**Deductible Waived for Preventive & Diagnostic Services on ODS Plans**						
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	70% + 10% each Plan Year	70% + 10% each Plan Year	100%	100%	100%*	100%*
Restorative Services*							
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	70% + 10% [1] each Plan Year	70% + 10% [1] each Plan Year	80% [1]	80% [1]	100% [2]*	100% [2]*
Simple Extraction*							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	80%	100%*	100%*
Oral Surgery*							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	80%	100%*	100%*
Periodontics*							
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	80%	100%*	100%*
Endodontics*							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	80%	100%*	100%*
Major Restorative Services*							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	50%	100%*	100%*
Implants	70% + 10% each Plan Year	70% + 10% each Plan Year	50%	50%	50%	50%* (limit of 4 per lifetime)	See Certificate of Coverage for copays
Fixed and Removable Prosthetic Services*							
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	70% + 10% each Plan Year	50%	50%	50%	100%*	100%*
Bridge retainers and pontics	70% + 10% each Plan Year	70% + 10% each Plan Year	50%	50%	50%	100%*	100%*
Orthodontics * (All plans except ODS Dental Plan 6)							
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NA	$1,500 copay + $20 per visit	$1,500 copay + $20 per visit**

♦ Under Moda Health/ODS Plans 1 - 3, 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. Switching between incentive plans (1 - 3) and non-incentive plans (4, 6 and 8) will have an effect on benefit level.

† Kaiser Dental Plan 8 no longer requires enrollment in a Kaiser medical plan. Services must be provided by a contracted Kaiser provider in order for benefits to be payable. See handbook for details.

‡ Under Willamette Dental Group Plan 8, services must be provided by a Willamette Dental Group provider in order for benefits to be payable. See handbook for details.
*** For Kaiser Permanente and Willamette Dental Group plans: Office visit copayment applies at each visit, in addition to any plan copayments for services.**
**** Pre-Orthodontic Service fee of $150 is credited toward the orthodontic benefit if patient accepts treatment plan.**
[1] Posterior fillings paid to amalgam fee.

[2] Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and one-surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Kaiser Permanente or Willamette Dental Group directly for actual fees.

[3] The office visit copayment is waived for participants in the Chronic Condition Dental Management program for specific preventive services.

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.

OREGON EDUCATORS BENEFIT BOARD 2015-16 PLAN YEAR
SUMMARY OF VISION BENEFITS

Plan Option	Vision Plan 1	Vision Plan 2	Vision Plan 3	Vision Plan 4	Vision Plan 5**
Vision	**Moda Health**	**Moda Health**	**Moda Health**	**Moda Health**	**Kaiser**
Plan Year Maximum	$250*	$350*	$450*	$600*	See allowances
Routine Eye Exam	100%	100%	100%	100%	$5 office visit copay
Exam Frequency	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months
Lenses	Either one pair of lenses or contacts	Either one pair of lenses or contacts	Either one pair of lenses or contacts	Either one pair of lenses or contacts	Either one pair of lenses or contacts
Single Vision	100%	100%	100%	100%	100% up to $58.50 per Plan Year
Bifocal	100%	100%	100%	100%	100% up to $86.00 per Plan Year
Lenticular	100%	100%	100%	100%	100% up to $86.00 per Plan Year
Trifocal	100%	100%	100%	100%	100% up to $109.00 per Plan Year
Contact Lenses	100%	100%	100%	100%	100% up to $192.50 per Plan Year
Lens Frequency	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months
Frames	100%	100%	100%	100%	100% up to $75.00
Frame Frequency	Under age 17: once per Plan Year	Under age 17: once per Plan Year	Under age 17: once per Plan Year	Under age 17: once per Plan Year	Under age 19: No charge for one pair of standard frames and lenses every 12 months
	Age 17 and older: once every two Plan Years	Age 17 and older: once every two Plan Years	Age 17 and older: once every two Plan Years	Age 17 and older: once every two Plan Years	Age 19 and older: once every 24 months

*** Exam and hardware charges all apply to the Plan Year maximum on Moda Health Plans 1 - 4.**

**** Must be simultaneously enrolled in a Kaiser medical plan to be enrolled in Kaiser Vision Plan 5.**

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2015-2016 Medical and Pharmacy
Carriers offered : MODA HEALTH & KAISER PERMANENTE

	Composite
MODA Plan B Statewide	**$1,672.39**
MODA Plan C Statewide	**$1,395.75**
MODA Plan D Statewide	**$1,295.49**
Plan H Statewide *	**$909.60**
MODA Plan B Synergy**	**$1,549.70**
MODA Plan C Synergy**	**$1,293.36**
MODA Plan D Synergy**	**$1,200.46**
MODA Plan H Synergy ***	**$842.86**
Kaiser Plan 1	**$1,395.21**
Kaiser 3 Plan 3	**$855.58**

MODA HEALTH: Pharmacy is included in this plan as any other covered medical expense. Rx's are applied to the deductible and then once the deductible is met they are paid at the same level as other medical expenses

** Health Savings Account (HSA) required. District HSA approved and provided through American Fidelity*

***Synergy plans – must choose medical home through MODA*

2015-2016 Dental
Carriers offered : MODA HEALTH/ODS, KAISER PERMANENTE, WILLAMETTE DENTAL

	Composite
MODA/ODS Plan 1 w/ortho	$153.59
MODA/ODS Plan 2 w/ortho	$137.89
MODA/ODS Plan 3 w/ortho	$135.10
MODA/ODS Plan 4 w/ortho	$127.68
MODA/ODS Plan 6 (excl. ortho)	
KAISER Plan 8 w/ortho	$159.05
WILLAMETTE Dental Plan 8 w/ortho	$18.24

2015-2016 Vision
Carriers offered : MODA HEALTH & KAISER PERMANENTE

	Composite
MODA Plan 1	$27.88
MODA Plan 2	$36.62
MODA Plan 3	$41.31
MODA Plan 4	$48.32
KAISER Vision Plan 5	$18.24