ESTACADA SCHOOL DISTRICT #108
2016-2017 BENEFIT OPTIONS FOR THE OSEA EMPLOYEES

STEP 1.

PLEASE NOTE THAT THE FOLLOWING 10 PAGES CONTAIN MULTIPLE BENEFIT OPTIONS FOR YOUR REVIEW. PLEASE TAKE YOUR TIME AND USE THE BELOW WEBSITE FOR ADDITIONAL ASSISTANCE TO COMPARE THE 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 TIER, ADD ALL BENEFITS COSTS – (*See pgs 11-14 for rates*)
(Note: OSEA Members are at the Tiered rate structure)

(INCL THE BELOW LISTED LIFE, AD&D, LONG TERM DISABILITY)

Life & Disability ($10,000 coverage)	**$2.74**
LTD	**$.00235 times average monthly salary**

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

COMPUTE YOUR CAP: THE DISTRICT CONTRIBUTES $1190.00 PER MONTH FOR AN 8 HOUR EMPLOYEE OR PRO-RATED AT $148.75 PER HOUR WORKED.

Fill in the amount of district contribution: **$_____**
District contributions are pooled. If the pool is not sufficient to meet the premium amount, employees will have monthly deduction made from their paychecks beginning in September.

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 8/15/2016 and 08/31/2016.

Forms submitted after 08/31/2016 will not be processed for Septembers payroll-Octobers payroll could have double deductions!

Summary of Medical and Pharmacy Benefits
2016-17 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	KAISER PERMANENTE® **Med Plan 1 (HMO)**		KAISER PERMANENTE® **Med Plan 2 (HMO)**	
	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	$800	See Plan Handbook
Maximum deductible per family	None	See Plan Handbook	$2,400	See Plan Handbook
Out-of-pocket (OOP) maximum per person [3]	$1,500	See Plan Handbook	$4,000	See Plan Handbook
Out-of-pocket (OOP) maximum per family [3]	$3,000	See Plan Handbook	$12,000	See Plan Handbook
Maximum cost share per person	NA	NA	NA	NA
Maximum cost share per family	NA	NA	NA	NA
Preventive Care Services				
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0	NA	$0[1]	NA
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[1]	Not Covered
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)				
Moda Medical Home incentive care	NA	NA	NA	NA
Incentive office visits and home visits	NA	NA	NA	NA
Professional Services				
Moda Medical Home primary care services	NA	NA	NA	NA
Primary care office visits	$20	Not Covered	$25[1]	Not Covered
Specialist office visits	$30	Not Covered	$35[1]	Not Covered
Mental health office visits	$20	Not Covered	$25[1]	Not Covered
Mental health inpatient and residential services	$100 per day, up to $500 per admission maximum	Not Covered	20%	Not Covered
Chemical dependency services (inpatient, outpatient or residential)	$0	Not Covered	$0[1]	Not Covered
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
Maternity Care				
Outpatient Materntity Care	$0	Not Covered	$0[1]	Not Covered
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
Outpatient and Hospital Services				
Inpatient care/surgery	$100 per day, up to $500 per admission maximum	See Plan Handbook	20%	See Plan Handbook
Outpatient surgery/facility care	$75	Not Covered	20%	Not Covered
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	$0	NA	20%	NA
Viscosupplementation	$30[5]	Not Covered	$35[1,5]	Not Covered
Upper Endoscopies	$75	Not Covered	20%	Not Covered
Sleep Studies	$20 per visit	Not Covered	$25[1] per visit	Not Covered
MRI, CT, PET imaging	$20 per visit	Not Covered	$25[1] per visit	Not Covered
Lumbar Discographies	$75 per visit	Not Covered	20%	Not Covered
Moda Plans Only: $100 Additional Cost Tier (ACT): spinal injections, tonsillectomies	NA	NA	NA	NA
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, hernia repair	NA	NA	NA	NA
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
Outpatient diagnostic lab and X-ray	$20 per visit	Not Covered	$25[1] per visit	Not Covered
Emergency and Urgent Care				
Urgent care visit	$35	See Plan Handbook	$40[1]	See Plan Handbook
Emergency room (copay waived if admitted)	$100 per visit (waived if admitted)		20%	
Ambulance	$75		$100[1]	
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
Durable Medical Equipment	20%	Not Covered	20%[1]	Not Covered
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[1]	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$0		$0[1]	
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%	

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Summary of Medical and Pharmacy Benefits
2016-17 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	KAISER PERMANENTE® **Med Plan 1 (HMO)**		KAISER PERMANENTE® **Med Plan 2 (HMO)**	
	In-Network Member Pays	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Tobacco Cessation Program (Available to ages 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.	
Pharmacy Services				
Out of pocket maximum	$1100 Rx max also applies to Medical OOP Max		$1100 Rx max also applies to Medical OOP Max	
Retail				
Value (Moda Plans Only)	NA	NA	NA	NA
Generic (Kaiser plans) / Select generic (Moda Plans)	$5 per 30-day-supply	See Plan Handbook	$5 per 30-day supply	See Plan Handbook
Preferred Brand	$25 per 30-day supply	See Plan Handbook	$25 per 30-day supply	See Plan Handbook
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
Mail				
Value (Moda Plans Only)	NA	NA	NA	NA
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook	$10 per 90-day supply	See Plan Handbook
Preferred Brand	$50 per 90-day supply	See Plan Handbook	$50 per 90-day supply	See Plan Handbook
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
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
Preferred	25% up to $100 per 30 day supply	See Plan Handbook	25% up to $100 per 30 day supply	See Plan Handbook
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

N/A - Not applicable

* Available as PPO plan for Coos and Curry counties. For all other areas, this plan is available as Synergy/Summit only.

** If enrolled in a Synergy/Summit Plan, you must select a Medical Home (primary care clinic) for each individual on the plan. Preventive, incentive, and primary care must be performed at designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the OON benefit level.

[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 now 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] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For Synergy/Summit plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

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

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

[6] Entities in Coos and Curry counties receive Synergy/Summit pharmacy benefit design, with the exception that pharmacy expenses will continue to accrue toward Maximum Cost Share limit.

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.

Summary of Medical and Pharmacy Benefits
2016-17 Plan Year

No lifetime maximum on any medical plans.

	moda HEALTH Alder Plan Synergy/Summit Only*		moda HEALTH Birch Plan PPO and Synergy/Summit	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network** Member Pays**	**Out-of-Network Member Pays**	**In-Network** Member Pays**	**Out-of-Network Member Pays**
Deductible per person	$400	$800	$800	$1,600
Maximum deductible per family	$1,200	$2,400	$2,400	$4,800
Out-of-pocket (OOP) maximum per person [3]	$3,000	$6,000	$4,000	$8,000
Out-of-pocket (OOP) maximum per family [3]	$9,000	$18,000	$12,000	$24,000
Maximum cost share per person	$6,850	N/A	$6,850	N/A
Maximum cost share per family	$13,700	N/A	$13,700	N/A
Preventive Care Services				
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	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[1]	50%	$0[1]	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)				
Moda Medical Home incentive care	$10 copay[1]	50%	$15 copay[1]	50%
Incentive office visits and home visits	20%[1]	50%	20%[1]	50%
Professional Services				
Moda Medical Home primary care services	$20 copay[1]	50%	$30 copay[1]	50%
Primary care office visits	20%	50%	20%	50%
Specialist office visits	20%	50%	20%	50%
Mental health office visits	$20 copay[1]	50%	$30 copay[1]	50%
Mental health inpatient and residential services	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	50%	$0[1]	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%	50%	20%	50%
Maternity Care				
Outpatient Materntity Care	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%
Outpatient and Hospital Services				
Inpatient care/surgery	20%	50%	20%	50%
Outpatient surgery/facility care	20%	50%	20%	50%
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	20%	50%	20%	50%
Viscosupplementation	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Upper Endoscopies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Sleep Studies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
MRI, CT, PET imaging	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Lumbar Discographies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Moda Plans Only: $100 Additional Cost Tier (ACT): spinal injections, tonsillectomies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, hernia repair	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 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	20%	50%	20%	50%
Outpatient diagnostic lab and X-ray	20%	50%	20%	50%
Emergency and Urgent Care				
Urgent care visit	$50[1]		$50[1]	
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%	
Ambulance	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%	50%	10%	50%
Durable Medical Equipment	20%	50%	20%	50%
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[1]		$0[1]	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$0[1]		$0[1]	
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 copay + 20%	Not covered	$500 copay + 20%	Not covered

Summary of Medical and Pharmacy Benefits
2016-17 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	moda HEALTH **Alder Plan Synergy/Summit Only***		moda HEALTH **Birch Plan PPO and Synergy/Summit**	
	In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network** Member Pays**	**Out-of-Network Member Pays**
Tobacco Cessation Program (Available to ages 10 and over)				
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications	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	**PPO[6]**	**Synergy/Summit**	**PPO[6]**	**Synergy/Summit**
Out of pocket maximum	Rx applies toward Max Cost Share	Rx applied toward plan OOP Max	Rx applies toward Max Cost Share	Rx applies toward plan OOP max
Retail				
Value (Moda Plans Only)	$4 (up to 90-day supply)	$0 (up to 90-day supply)	$4 (up to 90-day supply)	$0 (up to 90-day supply)
Generic (Kaiser plans) / Select generic (Moda Plans)	$12 per 31-day supply	$8 per 31-day supply	$12 per 31-day supply	$8 per 31-day supply
Preferred Brand	25% up to $75 per 31-day supply	25% up to $50 per 31-day supply	25% up to $75 per 31-day supply	25% up to $50 per 31-day supply
Non-preferred brand	50% up to $175 per 31-day supply	50% up to $150 per 31-day supply	50% up to $175 per 31-day supply	50% up to $150 per 31-day supply
Mail				
Value (Moda Plans Only)	$8	$0	$8	$0
Generic (Kaiser plans) / Select generic (Moda Plans)	$24	$16	$24	$16
Preferred Brand	25% up to $150 per 90-day supply	25% up to $100 per 90-day supply	25% up to $150 per 90-day supply	25% up to $100 per 90-day supply
Non-preferred brand	50% up to $450 per 90-day supply	50% up to $300 per 90-day supply	50% up to $450 per 90-day supply	50% up to $300 per 90-day supply
Specialty				
Select generic	N/A		N/A	
Preferred	25% up to $200 per 31-day supply	25% up to $100 per 31-day supply	25% up to $200 per 31-day supply	25% up to $100 per 31-day supply
Non-preferred brand	50% up to $500 per 31-day supply	50% up to $300 per 31-day supply	50% up to $500 per 31-day supply	50% up to $300 per 31-day supply

N/A - Not applicable

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[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 now 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).

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	In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network** Member Pays**	**Out-of-Network Member Pays**
Deductible per person	$1,200	$2,400	$1,600	$3,200
Maximum deductible per family	$3,600	$7,200	$4,800	$9,600
Out-of-pocket (OOP) maximum per person [3]	$5,000	$10,000	$6,850	$13,700
Out-of-pocket (OOP) maximum per family [3]	$13,700	$27,400	$13,700	$27,400
Maximum cost share per person	$6,850	N/A	$6,850	N/A
Maximum cost share per family	$13,700	N/A	$13,700	N/A
Preventive Care Services				
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	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[1]	50%	$0[1]	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)				
Moda Medical Home incentive care	$15 copay[1]	50%	$15 copay[1]	50%
Incentive office visits and home visits	20%[1]	50%	20%[1]	50%
Professional Services				
Moda Medical Home primary care services	$30 copay[1]	50%	$30 copay[1]	50%
Primary care office visits	20%	50%	20%	50%
Specialist office visits	20%	50%	20%	50%
Mental health office visits	$30 copay[1]	50%	$30 copay[1]	50%
Mental health inpatient and residential services	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	50%	$0[1]	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%	50%	20%	50%
Maternity Care				
Outpatient Materntity Care	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%
Outpatient and Hospital Services				
Inpatient care/surgery	20%	50%	20%	50%
Outpatient surgery/facility care	20%	50%	20%	50%
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	20%	50%	20%	50%
Viscosupplementation	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Upper Endoscopies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Sleep Studies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
MRI, CT, PET imaging	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Lumbar Discographies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Moda Plans Only: $100 Additional Cost Tier (ACT): spinal injections, tonsillectomies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, hernia repair	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 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	20%	50%	20%	50%
Outpatient diagnostic lab and X-ray	20%	50%	20%	50%
Emergency and Urgent Care				
Urgent care visit	$50[1]		$50[1]	
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%	
Ambulance	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%	50%	10%	50%
Durable Medical Equipment	20%	50%	20%	50%
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[1]		$0[1]	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$0[1]		$0[1]	
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 copay + 20%	Not covered	$500 copay + 20%	Not covered

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No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	moda HEALTH **Cedar Plan PPO and Synergy/Summit**		moda HEALTH **Dogwood Plan PPO and Synergy/Summit**	
	In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network** Member Pays**	**Out-of-Network Member Pays**
Tobacco Cessation Program (Available to ages 10 and over)				
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications	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	**PPO[6]**	**Synergy/Summit**	**PPO[6]**	**Synergy/Summit**
Out of pocket maximum	Rx applies toward Max Cost Share	Rx applies toward plan OOP max	Rx applies toward Max Cost Share	Rx applies toward plan OOP max
Retail				
Value (Moda Plans Only)	$4 (up to 90-day supply)	$0 (up to 90-day supply)	$4 (up to 90-day supply)	$0 (up to 90-day supply)
Generic (Kaiser plans) / Select generic (Moda Plans)	$12 per 31-day supply	$8 per 31-day supply	$12 per 31-day supply	$8 per 31-day supply
Preferred Brand	25% up to $75 per 31-day supply	25% up to $50 per 31-day supply	25% up to $75 per 31-day supply	25% up to $50 per 31-day supply
Non-preferred brand	50% up to $175 per 31-day supply	50% up to $150 per 31-day supply	50% up to $175 per 31-day supply	50% up to $150 per 31-day supply
Mail				
Value (Moda Plans Only)	$8	$0	$8	$0
Generic (Kaiser plans) / Select generic (Moda Plans)	$24	$16	$24	$16
Preferred Brand	25% up to $150 per 90-day supply	25% up to $100 per 90-day supply	25% up to $150 per 90-day supply	25% up to $100 per 90-day supply
Non-preferred brand	50% up to $450 per 90-day supply	50% up to $300 per 90-day supply	50% up to $450 per 90-day supply	50% up to $300 per 90-day supply
Specialty				
Select generic	N/A		$16	
Preferred	25% up to $200 per 31-day supply	25% up to $100 per 31-day supply	25% up to $200 per 31-day supply	25% up to $100 per 31-day supply
Non-preferred brand	50% up to $500 per 31-day supply	50% up to $300 per 31-day supply	50% up to $500 per 31-day supply	50% up to $300 per 31-day supply

N/A - Not applicable

* Available as PPO plan for Coos and Curry counties. For all other areas, this plan is available as Synergy/Summit only.

** If enrolled in a Synergy/Summit Plan, you must select a Medical Home (primary care clinic) for each individual on the plan. Preventive, incentive, and primary care must be performed at designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the OON benefit level.

[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 now 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] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For Synergy/Summit plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

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

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

[6] Entities in Coos and Curry counties receive Synergy/Summit pharmacy benefit design, with the exception that pharmacy expenses will continue to accrue toward Maximum Cost Share limit.

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.

Summary of Medical and Pharmacy Benefits
2016-17 Plan Year

No lifetime maximum on any medical plans.

	moda HEALTH **Evergreen Plan (HSA Required) PPO and Synergy/Summit**		KAISER PERMANENTE® **Med Plan 3 (HMO) (HSA Optional)**	
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	**In-Network** **Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Deductible per person	$1,600[2]	$3,200[2]	$1,600[2]	See Plan Handbook
Maximum deductible per family	$3,200[2]	$6400[2]	$3,200[2]	See Plan Handbook
Out-of-pocket (OOP) maximum per person [3]	$6,550[2]	$13,100[2]	$6,550[2]	See Plan Handbook
Out-of-pocket (OOP) maximum per family [3]	$13,100[2]	$26,200[2]	$13,100[2]	See Plan Handbook
Maximum cost share per person	N/A		NA	NA
Maximum cost share per family	N/A		NA	NA
Preventive Care Services				
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	NA
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	$0[1]	50%	$0[1]	Not Covered
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)				
Moda Medical Home incentive care	20%	50%	NA	NA
Incentive office visits and home visits	20%	50%	NA	NA
Professional Services				
Moda Medical Home primary care services	20%	50%	NA	NA
Primary care office visits	20%	50%	20%	Not Covered
Specialist office visits	20%	50%	20%	Not Covered
Mental health office visits	20%	50%	20%	Not Covered
Mental health inpatient and residential services	20%	50%	20%	Not Covered
Chemical dependency services (inpatient, outpatient or residential)	20%	50%	20%	Not Covered
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%	50%	20%	Not Covered
Maternity Care				
Outpatient Materntity Care	20%	50%	$0[1]	Not Covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	Not Covered
Outpatient and Hospital Services				
Inpatient care/surgery	20%	50%	20%	See Plan Handbook
Outpatient surgery/facility care	20%	50%	20%	Not Covered
Skilled nursing facility care Kaiser Plans: 100 days per plan year Moda Plans: 60 days per plan year	20%	50%	20%	NA
Viscosupplementation	20%	50%	20%	Not Covered
Upper Endoscopies	20%	50%	20%	Not Covered
Sleep Studies	20%	50%	20%	Not Covered
MRI, CT, PET imaging	20%	50%	20%	Not Covered
Lumbar Discographies	20%	50%	20%	Not Covered
Moda Plans Only: $100 Additional Cost Tier (ACT): spinal injections, tonsillectomies	20%	50%	NA	NA
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, hernia repair	20%	50%	NA	NA
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	20%	50%	20%	Not Covered
Outpatient diagnostic lab and X-ray	20%	50%	20%	Not Covered
Emergency and Urgent Care				
Urgent care visit	20%		20%	See Plan Handbook
Emergency room (copay waived if admitted)	20%		20%	
Ambulance	20%		20%	
Other Covered Services				
Hearing Aids $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	20%	50%	20%	Not Covered
Durable Medical Equipment	20%	50%	20%	Not Covered
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[1]		$0[1]	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$0[1]		$0[1]	
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 copay + 20%	Not covered	$500 + 20%	

Summary of Medical and Pharmacy Benefits
2016-17 Plan Year

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	moda HEALTH **Evergreen Plan (HSA Required) PPO and Synergy/Summit**		KAISER PERMANENTE® **Med Plan 3 (HMO) (HSA Optional)**	
	In-Network Member Pays**	**Out-of-Network Member Pays**	**In-Network Member Pays**	**Out-of-Network Member Pays**
Tobacco Cessation Program (Available to ages 10 and over)				
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications	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.		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.	
Pharmacy Services	**PPO[6]**	**Synergy/Summit**		
Out of pocket maximum	Rx applies toward plan OOP max		Rx applies toward plan OOP max	
Retail				
Value (Moda Plans Only)	$4[1] (up to 90-day supply)	$0[1] (up to 90-day supply)	NA	NA
Generic (Kaiser plans) / Select generic (Moda Plans)	20%		20%	See Plan Handbook
Preferred Brand	20%		20%	See Plan Handbook
Non-preferred brand	20%		20%	See Plan Handbook
Mail				
Value (Moda Plans Only)	$8[1]	$0[1]	NA	NA
Generic (Kaiser plans) / Select generic (Moda Plans)	20%		20%	See Plan Handbook
Preferred Brand	20%		20%	See Plan Handbook
Non-preferred brand	20%		20%	See Plan Handbook
Specialty				
Select generic	N/A		20%	See Plan Handbook
Preferred	20%		20%	See Plan Handbook
Non-preferred brand	20%		20%	See Plan Handbook

N/A - Not applicable

* Available as PPO plan for Coos and Curry counties. For all other areas, this plan is available as Synergy/Summit only.

** If enrolled in a Synergy/Summit Plan, you must select a Medical Home (primary care clinic) for each individual on the plan. Preventive, incentive, and primary care must be performed at designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the OON benefit level.

[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 now 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] For PPO plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share. For Synergy/Summit plans, OOP max includes medical copayments, coinsurance, as well as pharmacy copays and coinsurance. ACT copayments will continue accruing towards Maximum Cost Share limit.)

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

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

[6] Entities in Coos and Curry counties receive Synergy/Summit pharmacy benefit design, with the exception that pharmacy expenses will continue to accrue toward Maximum Cost Share limit.

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Summary of Dental Benefits
2016-17 Plan Year

Dental	Dental Plan 1 ♦	Dental Plan 2 ♦	Dental Plan 3 ♦	Dental Plan 4	Dental Plan 6	Dental Plan 8 †	Dental Plan 8 ‡
Dental Office Visit Copayment	NA	NA	NA	NA	NA	$20 *	$20 [3]*
Benefit Maximum	$2,200	$1,500	$1,500	$1,500	$1,200	$4,000 ***	NA
Deductible	$50	$50	$50	$50	$50	NA	NA
Preventive and Diagnostic Services * - Deductible Waived for Preventive & Diagnostic Services on Delta Dental 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
Occlusal guards (night guards)	50% up to $150 maximum, once every 5 years	50% up to $150 maximum, once every 5 years	50% up to $150 maximum, once every 5 years	50% up to $150 maximum, once every 5 years	50% up to $150 maximum, once every 5 years	50% up to $150 maximum, once every 5 years	100% [4]
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 Delta 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 Delta Dental 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.

*** Preventative care and orthodontia do not accrue to this maximum

[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.

[4] Replacement of lost or stolen appliance once every 2 years, replacement or repair of broken appliance as needed.

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Summary of Vision Benefits
2016-17 Plan Year

Vision	Opal Plan	Pearl Plan	Quartz Plan	Vision Plan**
Plan Year Maximum	$600*	$400*	$250*	$250
Routine Eye Exam	100% - Once per Plan Year	100% - Once per Plan Year	100% - Once per Plan Year	See medical plan benefits**
Lenses (Either one pair of lenses or contacts)				
Plan pays 100% (up to plan maximum)	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months
Frames				
Plan pays 100% (up to plan maximum)	**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 19 and older** Once every 12 months

* Exam and hardware charges all apply to the Plan Year maximum on Moda Plans

** Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

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Member Services
1-888-469-6322
OEBB.Benefits@Oregon.Gov

Moda Health 2016-17 Plan Year

Plans and Rates

2016 Plan Year (Effective October 1, 2016)

Medical & Pharmacy - PPO					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
PPO	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Alder*	$692.73	$1,523.99	$1,316.21	$2,147.49	$1,648.67
Birch	$613.03	$1,348.64	$1,164.75	$1,900.39	$1,458.98
Cedar	$552.51	$1,215.51	$1,049.77	$1,712.81	$1,314.96
Dogwood	$481.34	$1,058.98	$914.60	$1,492.24	$1,145.63
Evergreen**	$425.65	$936.43	$808.75	$1,319.53	$1,013.04

Medical & Pharmacy - Synergy/Summit					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
Synergy/Summit	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Alder	$623.45	$1,371.60	$1,184.59	$1,932.74	$1,483.81
Birch	$551.71	$1,213.78	$1,048.26	$1,710.35	$1,313.08
Cedar	$497.25	$1,093.97	$944.80	$1,541.54	$1,183.47
Dogwood	$433.22	$953.10	$823.14	$1,343.03	$1,031.07
Evergreen**	$383.09	$842.80	$727.88	$1,187.59	$911.73

* Alder PPO only available in Coos and Curry counties.

** Pharmacy is included in this plan as any other covered medical expense. Rx's are applied to the deductible. Once the deductible is met they are paid at the same level as other covered medical expenses.

Member Services
1-888-469-6322
OEBB.Benefits@Oregon.Gov

Moda Health/Delta Dental 2016-17 Plan Year

Plans and Rates

2016 Plan Year (Effective October 1, 2016)

Dental and Orthodontia					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
	Employee Only	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Plan 1 w/ Ortho	$63.46	$125.71	$139.80	$207.02	$154.35
Plan 2 w/ Ortho	$56.62	$112.09	$125.99	$185.94	$138.57
Plan 3 w/ Ortho	$55.40	$109.70	$123.56	$182.22	$135.77
Plan 4 w/ Ortho	$52.14	$103.27	$117.03	$172.24	$128.32
Plan 6 (excl. Ortho)	$41.90	$82.95	$84.19	$128.61	$96.31

Moda Health 2016-17 Plan Year

Plans and Rates

2016 Plan Year (Effective October 1, 2016)

Vision					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
	Employee Only	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Opal	$21.92	$48.20	$41.62	$67.92	$50.04
Pearl	$17.89	$39.41	$34.03	$55.53	$40.89
Quartz	$12.64	$27.83	$24.01	$39.19	$28.87

Member Services
1-888-469-6322
OEBB.Benefits@Oregon.Gov

Kaiser Permanente 2016-17 Plan Year

Plans and Rates

2016 Plan Year (Effective October 1, 2016)

Medical and Pharmacy					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
HMO	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Plan 1	$588.98	$1,295.78	$1,119.08	$1,825.86	$1,402.12
Plan 2	$485.88	$1,069.61	$923.13	$1,506.97	$1,157.84
Plan 3	$354.78	$780.98	$673.83	$1,100.06	$842.68

Dental and Orthodontia					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
DHMO	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Plan 8 w/ Ortho	$71.91	$158.23	$136.65	$222.94	$171.20

Vision					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
	Employee Only	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Kaiser Vision Plan	$8.27	$18.20	$15.72	$25.65	$19.69

Revised 6-30-2016 to indicate Synergy plans available in Douglas County

Member Services
1-888-469-6322
OEBB.Benefits@Oregon.Gov

Willamette Dental Group 2016-17 Plan Year

Plans and Rates

2016 Plan Year (Effective October 1, 2016)

Dental and Orthodontia					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
DHMO	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Plan 8 w/ Ortho	$41.93	$83.03	$88.35	$132.77	$106.67

Revised 6-30-2016 to indicate Synergy plans available in Douglas County