OEBB Summary of Medical and Pharmacy Benefits 2019-20 Plan Year

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente		Medical Plan 3 Kaiser Permanente *HSA Optional*		Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 6 Connexus Network *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	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	None	NA	$1,600[2]	NA	$400	$500	$800	$800	$900	$1,600	$1,600[2]	$1,700[2]	$3,200[2]
Maximum deductible per family	None	NA	$3,200[2]	NA	$1,500	$1,500	$2,400	$2,700	$2,700	$4,800	$3,400[2]	$3,400[2]	$6,400[2]
Out-of-pocket (OOP) maximum per person [3]	$1,500	NA	$6,550[2]	NA	$2,850	$3,250	$6,000	$3,850	$4,250	$8,000	$6,400[2]	$6,750[2]	$13,100[2]
Out-of-pocket (OOP) maximum per family [3]	$3,000	NA	$13,100[2]	NA	$9,750	$9,750	$18,000	$12,750	$12,750	$24,000	$13,500[2]	$13,500[2]	$26,200[2]
Maximum cost share per person	NA	NA	NA	NA	$7,900	$7,900	NA	$7,900	$7,900	NA	NA	NA	NA
Maximum cost share per family	NA	NA	NA	NA	$15,800	$15,800	NA	$15,800	$15,800	NA	NA	NA	NA
Preventive Care Services													
Wellness visit (Moda plans: ages 21 and over, must use Medical Home)	$0	NA	$0[1]	NA	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered
Routine adult, well-child and women's exams; annual obesity screening & immunizations. See Plan Handbook for add'l Preventive Care Services.	$0	Not Covered	$0[1]	Not Covered	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%
Primary care office visits	$20	Not Covered	20%	Not Covered	$20[1,6]	20%	50%	$20[1,6]	20%	50%	15%	20%	50%
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	NA	NA	NA	NA	$40[1]	NA	50%	$40[1]	NA	50%	15%	NA	50%
Specialist office visits	$30	Not Covered	20%	Not Covered	$40[1]	20%	50%	$40[1]	20%	50%	15%	20%	50%
Urgent care	$35	See Plan Handbook	20%	See Plan Handbook	$40[1]	20%	20%	$40[1]	20%	20%	15%	20%	20%
Mental Health Services													
Mental health office visits	$20	Not Covered	20%	Not Covered	$20[1]	$20[1]	50%	$20[1]	$20[1]	50%	15%	20%	50%
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0	Not Covered	20%	Not Covered	$20[1]	$20[1]	50%	$20[1]	$20[1]	50%	15%	20%	50%
Outpatient Services													
Outpatient surgery/facility care	$75	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
Outpatient rehabilitation (physical, occupational & speech therapy) **Kaiser Plans:** Maximum 20 visits per therapy per Plan Year **Moda Plans:** 30 sessions per plan year / 60 for spinal or head injury	$30 per visit	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
Tests (outpatient)													
Preventive tests	$0	Not Covered	$0[1]	Not Covered	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%	$0[1]	$0[1]	50%
Laboratory	$20 per visit	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
X-ray, imaging, and special diagnostic procedures	$20 per visit	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
CT, MRI, PET scans	$20 per visit	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	20%	25%	50%
Alternative Care Services ($2,000 combined maximum)													
Acupuncture, chiropractic & naturopathic services, labs, diagnostics, etc. *Cost of supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum*	$20 per service	Not Covered	20%	Not Covered	$20[1]	20%	50%	$20[1]	20%	50%	20%	25%	50%
Maternity Care													
Outpatient maternity care	$0	Not Covered	$0[1]	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission max	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
Hospital Services													
Inpatient care/surgery	$100 per day, up to $500 per admission max	See Plan Handbook	20%	See Plan Handbook	20%	20%	50%	20%	20%	50%	20%	25%	50%
Skilled nursing facility care (**Kaiser Plans:** 100 days per plan year, **Moda Plans:** 60 days per plan year)	$0	NA	20%	NA	20%	20%	50%	20%	20%	50%	20%	25%	50%
Additional Cost Tier													
Moda Plans Only: $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	NA	NA	NA	NA	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	20%	25%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[4], knee & shoulder arthroscopy, uncomplicated hernia repair	NA	NA	NA	NA	$500 copay + 20%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 20%	$500 copay + 50%	20%	25%	50%
Emergency Services													
Emergency room (copay waived if admitted)	$100 per visit (waived if admitted)		20%		$100 copay + 20%	$100 copay + 20%		$100 copay + 20%	$100 copay + 20%		20%	25%	
Ambulance	$75		20%		20%	20%		20%	20%		20%	25%	
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	20%	Not Covered	10%	10%	50%	10%	10%	50%	20%	25%	50%
Durable medical equipment (DME)	20%	Not Covered	20%	Not Covered	20%	20%	50%	20%	20%	50%	20%	25%	50%
Bariatric surgery (Roux-en-Y and gastric sleeve)	$500 + Inpatient Care costs	Not Covered	$500 + 20%	Not Covered	$500 + 20%	$500 + 20%	Not covered	$500 + 20%	$500 + 20%	Not covered	$500 + 20%	$500 + 25%	Not covered

NA - 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 be met before benefits will be paid (except where 1 indicates deductible waived).

[3] For Moda plans, OOP max includes medical copayments and coinsurance. Pharmacy copays and coinsurance and ACT copayments will continue accruing towards Maximum Cost Share.

[4] Benefit is subject to a reference price limitation.

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

[6] If enrolled in a Moda medical plan, each covered individual must choose a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the far left column under that plan when using a provider in the Connexus network. If an individual has not chosen a PCP 360 with Moda, they will receive the "non-coordinated" benefit shown in the center column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level (far right column under that plan) regardless of whether or not the individual has chosen a PCP 360 with Moda.

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.

Kaiser Member Handbooks Available at:
https://my.kp.org/oebb/plan-details/oregon-washington-actives/

Kaiser Contact
866-223-2375

Group ID: 18050

Moda Member Handbooks Available at:
https://www.modahealth.com/oebb/members/handbooks.shtml

OEBB Moda Health Medical
Toll-free: 866-923-0409
Local: 503-265-2909
Group ID: 10006726

OEBB Moda Health Pharmacy
Toll-Free: 866-923-0411
Local: 503-265-2911

OEBB Summary of Medical and Pharmacy Benefits 2019-20 Plan Year

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente		Medical Plan 3 Kaiser Permanente *HSA Optional*		Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 6 Connexus Network *HSA optional*		
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Pharmacy Services*													
Out-of-pocket (OOP) maximum	$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 plan OOP max		
Retail													
Value (Moda Plans Only)	NA	NA	NA	NA	$4 per 31-day supply			$4 per 31-day supply			$4[1] per 31-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	$5 per 30-day-supply	See Plan Handbook	20%	See Plan Handbook	$12 per 31-day supply			$12 per 31-day supply			20%	25%	
Preferred brand	$25 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			20%	25%	
Non-preferred brand[5]	$45 per 30-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook	50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			20%	25%	
Mail													
Value (Moda Plans Only)	NA	NA	NA	NA	$8 per 90-day supply			$8 per 90-day supply			$8[1] per 90-day supply		
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook	20%	See Plan Handbook	$24 per 90-day supply			$24 per 90-day supply			20%	25%	
Preferred Brand	$50 per 90-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $150			25% up to $150			20%	25%	
Non-preferred brand[5]	$90 per 90-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook	50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			20%	25%	
Specialty													
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $200 per 31-day supply			25% up to $200 per 31-day supply			20%	25%	
Non-preferred brand[5]	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	50% up to $500 per 31-day supply			50% up to $500 per 31-day supply			20%	25%	

*** Please reference footnotes (1, 5, & 6) on Page 1 for Pharmacy Services**

OEBB Summary of Vision Benefits 2019-20 Plan Year

Vision	VSP Choice Plus Plan VSP Choice Network
Plan Year Maximum	N/A
Routine Eye Exam:	
Benefit:	Plan pays 100% after $10 copay
Frequency:	Every 12 months
Lenses:	
Basic lens benefit:	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. **Polycarbonate lenses, scratch resistant and UV coatings covered in full**
Lens enhancements:	**$0 copay for standard progressive lenses** **$15 copay for anti-reflective coating or progressive lenses**
Frequency:	Once every 12 months
Frames / Contacts:	
Benefit:	Covered in full up to retail allowance of **$300**; 20% off amount over retail allowance for frames Additional $50 or higher allowance for feature frame brands (i.e. Nike, Calvin Klein, Columbia Sportswear, Cole Haan, etc.) Available in-network at VSP doctor and participating retail chain locations (not applicable at Costco or Walmart) Not eligible to combine the Enhanced Featured Frame Allowance with Extra $20 or Extra $40 promotions.
Frequency:	Once every 12 months
Non-Prescription Benefit	
Benefit:	OEBB members can use their frame allowance to pay for non-prescription sunglasses, in lieu of prescription glasses or contacts. Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details

*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

OEBB Summary of Dental Benefits 2019-20 Plan Year

Dental	Premier Plan 5 ♦ Delta Dental Premier Network (INCENTIVE PLAN See footnote ♦ for details.)	Premier Plan 6 Delta Dental Premier Network	Kaiser Dental Plan† Kaiser Permanente Facilities (LIMITED NETWORK PLAN! MUST USE IN-NETWORK PROVIDERS! See footnote † for details.)
Dental Office Visit Copayment	NA	NA	$20 *
Benefit Maximum	$1,700	$1,200	$4,000 ***
Deductible	$50	$50	NA
Preventive & 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	100%	100% *
Restorative Services *			
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	80% [1]	100% *[2]
Simple Extraction *			
Simple tooth extractions	70% + 10% each Plan Year	80%	100% *
Oral Surgery *			
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	80%	$50 Copay *
Periodontics *			
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	80%	100% *
Endodontics *			
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	80%	$50 Copay *
Major Restorative Services *			
Gold or porcelain crowns and onlays	70%	50%	$250 Copay *
Implants	50%	50%	50% * (limit of 4 per lifetime)
Other Covered Services*			
Occlusal guards (night guards)	50% up to $250 max,once every 5 years	50% up to $250 max,once every 5 years	90%
Athletic mouth guards	50%	50%	90%
Nitrous Oxide	50%	50%	$25 Copay * (Ages 13 & Up)
Fixed and Removable Prosthetic Services *			
Full and partial dentures, relines, rebases	50%	50%	$100 Copay *
Bridge retainers and pontics	50%	50%	$250 Copay *
Orthodontics * (All plans except Delta Dental Plan 6)			
Orthodontic Treatment	80% to $1,800 lifetime max	**NO ORTHO COVERAGE on this plan**	$2,500 Copay + $20 per visit **

♦ Under Delta Dental Plan 5, 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 and other non-incentive plans will have an effect on benefit level.

† The Kaiser Dental Plan does NOT require 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.

* For Kaiser Permanente 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.

*** Preventive care and orthodontia do not accrue to this maximum.

[1] Posterior fillings paid to composite 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. Contact Kaiser Permanente directly for fees.

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