2018-2019 INSURANCE PLAN OFFERINGS

****HEALTH, DENTAL AND VISION PLANS ARE OFFERED AT COMPOSITE PRICING ONLY****

FOR QUESTIONS/INFORMATION REGARDING ALL PLANS, PLEASE CONTACT THE FOLLOWING:

MODA MEDICAL & VISION PLANS: **1-866-923-0409** **Website**: www.modahealth.com/oebb **Email**: OEBBquestions@modahealth.com

VSP VISION PLANS: **1-800-877-7195** **Website**: www.vsp.com

MODA DENTAL PLANS: **1-866-923-0410** **Website**: www.modahealth.com/oebb **Email**: OEBBquestions@modahealth.com

WILLAMETTE DENTAL PLANS: **1-855-433-6825** **Website**: https://www.willamettedental.com/oebb/

Email: info@willamettedental.com

MODA PHARMACY PLANS: **1-866-923-0411** **Website**: www.modahealth.com/oebb **Email**: OEBBquestions@modahealth.com

UNUM LONG-TERM CARE PLANS: **1-800-227-4165** **Website**:unuminfo.com/OEBB002/index.aspx

THE STANDARD LIFE, ACCIDENTAL DEATH AND DISMEMBERMENT, SHORT-TERM DISABILITY & LONG-TERM DISABILITY PLANS:

Phone: **1-866-756-8115** **Website**: www.standard.com/mybenefits/oebb

OEBB Summary of Medical and Pharmacy Benefits 2018-19 Plan Year

Moda Health CCM Synergy/Summit Plans

No lifetime maximum on any medical plans.	Alder CCM** Synergy or Summit Network		Birch CCM** Synergy or Summit Network		Cedar CCM** Synergy or Summit Network		Dogwood CCM** Synergy or Summit Network		Evergreen CCM** Synergy or Summit Network *Optional HSA Allowed*		Fir CCM** Synergy or Summit Network *Optional HSA Allowed*	
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 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	$400	$800	$800	$1,600	$1,200	$2,400	$1,600	$3,200	$1,600[2]	$3,200[2]	$2,000[2]	$4,000[2]
Maximum deductible per family	$1,200	$2,400	$2,400	$4,800	$3,600	$7,200	$4,800	$9,600	$3,200[2]	$6400[2]	$4,000[2]	$8000[2]
Out-of-pocket (OOP) maximum per person [3]	$3,000	$6,000	$4,000	$8,000	$5,000	$10,000	$6,850	$13,700	$6,550[2]	$13,100[2]	$6,650[2]	$13,300[2]
Out-of-pocket (OOP) maximum per family [3]	$9,000	$18,000	$12,000	$24,000	$13,700	$27,400	$13,700	$27,400	$13,100[2]	$26,200[2]	$13,300[2]	$26,600[2]
Maximum cost share per person	$7,350	N/A	$7,350	N/A	$7,350	N/A	$7,350	N/A	NA	NA	NA	NA
Maximum cost share per family	$14,700	N/A	$14,700	N/A	$14,700	N/A	$14,700	N/A	NA	NA	NA	NA
Preventive Care Services												
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$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[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	$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%	$15 copay[1]	50%	$15 copay[1]	50%	20%	50%	20%	50%
Incentive office visits and home visits	see above	50%	see above	50%	see above	50%	see above	50%	see above	50%	see above	50%
Office Services												
Moda Medical Home primary care services	$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%	20%	50%
Primary care office visits	see above	50%	see above	50%	see above	50%	see above	50%	see above	50%	see above	50%
Specialist office visits	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Urgent Care	$50[1]		$50[1]		$50[1]		$50[1]		20%		20%	
Mental Health Services												
Mental health office visits	$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%	20%	50%
Mental health inpatient and residential services	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	20%	50%	20%	50%
Outpatient Services												
Outpatient surgery/facility care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	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	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Tests (outpatient)												
Preventive tests	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%
Laboratory	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
X-ray, imaging, and special diagnostic procedures	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
CT, MRI, PET scans	$100 + 20%	$100 + 50%	$100 + 20%	$100 + 50%	$100 + 20%	$100 + 50%	$100 + 20%	$100 + 50%	20%	50%	20%	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%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Maternity Care												
Outpatient Materntity Care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Hospital Services												
Inpatient care/surgery	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)	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	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	$100 + 20%	$100 + 50%	$100 + 20%	$100 + 50%	$100 + 20%	$100 + 50%	$100 + 20%	$100 + 50%	20%	50%	20%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	$500 + 20%	$500 + 50%	$500 + 20%	$500 + 50%	$500 + 20%	$500 + 50%	$500 + 20%	$500 + 50%	20%	50%	20%	50%
Emergency Services												
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		20%		20%	
Ambulance	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%	50%	10%	50%	10%	50%	10%	50%	20%	50%	20%	50%
Durable Medical Equipment (DME)	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered
Pharmacy Services												
Out-of-pocket Maximum	Rx applies toward plan OOP Max		Rx applies toward plan OOP Max		Rx applies toward plan OOP Max		Rx applies toward plan OOP Max		Rx applies toward plan OOP Max		Rx applies toward plan OOP Max	
Retail												
Value (Moda Plans Only)	$0		$0		$0		$0		$0[1]		$0[1]	
Generic (Kaiser plans) / Select generic (Moda Plans)	$8 per 31-day supply		$8 per 31-day supply		$8 per 31-day supply		$8 per 31-day supply		20%		20%	
Preferred Brand	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%		20%	
Non-preferred brand[5]	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%		20%	
Mail												
Value (Moda Plans Only)	$0		$0		$0		$0		$0[1]		$0[1]	
Generic (Kaiser plans) / Select generic (Moda Plans)	$16 per 90-day supply		$16 per 90-day supply		$16 per 90-day supply		$16 per 90-day supply		20%		20%	
Preferred Brand	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%		20%	
Non-preferred brand[5]	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%		20%	
Specialty												
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	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%		20%	
Non-preferred brand[5]	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%		20%	

NA - Not applicable

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the 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 "Out-of-Network" 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 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 CCM 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 CCM Plans.

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

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.

OEBB Summary of Medical and Pharmacy Benefits 2018-19 Plan Year

Moda Health PPO Connexus Plans

No lifetime maximum on any medical plans.	Birch PPO Connexus Network		Cedar PPO Connexus Network		Dogwood PPO Connexus Network		Evergreen PPO Connexus Network *Optional HSA Allowed*		Fir PPO Connexus Network *Optional HSA Allowed*	
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 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	$800	$1,600	$1,200	$2,400	$1,600	$3,200	$1,600[2]	$3,200[2]	$2,000[2]	$4,000[2]
Maximum deductible per family	$2,400	$4,800	$3,600	$7,200	$4,800	$9,600	$3,200[2]	$6400[2]	$4,000[2]	$8000[2]
Out-of-pocket (OOP) maximum per person [3]	$4,000	$8,000	$5,000	$10,000	$6,850	$13,700	$6,550[2]	$13,100[2]	$6,650[2]	$13,300[2]
Out-of-pocket (OOP) maximum per family [3]	$12,000	$24,000	$13,700	$27,400	$13,700	$27,400	$13,100[2]	$26,200[2]	$13,300[2]	$26,600[2]
Maximum cost share per person	$7,350	N/A	$7,350	N/A	$7,350	N/A	NA	NA	NA	NA
Maximum cost share per family	$14,700	N/A	$14,700	N/A	$14,700	N/A	NA	NA	NA	NA
Preventive Care Services										
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered	$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[1]	50%	$0[1]	50%	$0[1]	50%	$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%	$15 copay[1]	50%	20%	50%	20%	50%
Incentive office visits and home visits	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%	50%	20%	50%
Office Services										
Moda Medical Home primary care services	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%	20%	50%
Primary care office visits	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Specialist office visits	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Urgent Care	$50[1]		$50[1]		$50[1]		20%		20%	
Mental Health Services										
Mental health office visits	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%	20%	50%
Mental health inpatient and residential services	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0[1]	50%	$0[1]	50%	$0[1]	50%	20%	50%	20%	50%
Outpatient Services										
Outpatient surgery/facility care	20%	50%	20%	50%	20%	50%	20%	50%	20%	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	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Tests (outpatient)										
Preventive tests	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%	$0[1]	50%
Laboratory	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
X-ray, imaging, and special diagnostic procedures	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
CT, MRI, PET scans	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%	20%	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%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Maternity Care										
Outpatient Materntity Care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Hospital Services										
Inpatient care/surgery	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)	20%	50%	20%	50%	20%	50%	20%	50%	20%	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	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%	20%	50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement [4], knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	20%	50%	20%	50%
Emergency Services										
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		20%		20%	
Ambulance	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%	50%	10%	50%	10%	50%	20%	50%	20%	50%
Durable Medical Equipment (DME)	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
Bariatric Surgery (Roux-en-Y and gastric sleeve)	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered	$500 + 20%	Not covered
Pharmacy Services										
Out-of-pocket Maximum	Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward plan OOP max		Rx applies toward plan OOP max	
Retail										
Value (Moda Plans Only)	$4 per 31-day supply		$4 per 31-day supply		$4 per 31-day supply		$4 per 31-day supply		$4 per 31-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	$12 per 31-day supply		$12 per 31-day supply		$12 per 31-day supply		20%		20%	
Preferred Brand	25% up to $75 per 31-day supply		25% up to $75 per 31-day supply		25% up to $75 per 31-day supply		20%		20%	
Non-preferred brand[5]	50% up to $175 per 31-day supply		50% up to $175 per 31-day supply		50% up to $175 per 31-day supply		20%		20%	
Mail										
Value (Moda Plans Only)	$8 per 90-day supply		$8 per 90-day supply		$8 per 90-day supply		$8[1] per 90-day supply		$8[1] per 90-day supply	
Generic (Kaiser plans) / Select generic (Moda Plans)	$24 per 90-day supply		$24 per 90-day supply		$24 per 90-day supply		20%		20%	
Preferred Brand	25% up to $150 per 90-day supply		25% up to $150 per 90-day supply		25% up to $150 per 90-day supply		20%		20%	
Non-preferred brand[5]	50% up to $450 per 90-day supply		50% up to $450 per 90-day supply		50% up to $450 per 90-day supply		20%		20%	
Specialty										
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply		25% up to $200 per 31-day supply		25% up to $200 per 31-day supply		20%		20%	
Non-preferred brand[5]	50% up to $500 per 31-day supply		50% up to $500 per 31-day supply		50% up to $500 per 31-day supply		20%		20%	

NA - Not applicable

** If enrolled in a Moda CCM plan using the Synergy or Summit Network, you must select a Medical Home (primary care clinic) for each individual on the plan. Primary care must be performed at the 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 "Out-of-Network" 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 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 CCM 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 CCM Plans.

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

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.

OEBB Summary of Dental Benefits 2018-19 Plan Year

LIMITED NETWORK PLANS! MUST USE IN-NETWORK PROVIDERS!
See footnotes Ω, †, and ‡ for details.

Dental	Premier Plan 1 ♦ Delta Dental Premier Network	Premier Plan 5♦ Delta Dental Premier Network	Premier Plan 6 Delta Dental Premier Network	Exclusive PPO Plan[Ω] Delta Dental PPO Network		Willamette Dental Plan[‡] Willamette Dental Group Facilities
Dental Office Visit Copayment	NA	NA	NA	NA		$20 [3]*
Benefit Maximum	$2,200	$1,700	$1,200	$1,500		NA
Deductible	$50	$50	$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	70% + 10% each Plan Year	100%	100%		100% *
Restorative Services *						
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	70% + 10% [1] each Plan Year	80% [1]	90% [1]		100% *
Simple Extraction *						
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%		100% *
Oral Surgery *						
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%		$50 Copay *
Periodontics *						
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%		100% *
Endodontics *						
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%		$50 Copay*
Major Restorative Services *						
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	80%		$250 Copay *
Implants	70% + 10% each Plan Year	50%	50%	80%		See Certificate of Coverage for copays
Other covered services*						
Occlusal guards (night guards)	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years		100% [4]
Athletic mouth guards	50%	50%	50%	50%		$100 Copay *
Nitrous Oxide	50%	50%	50%	50%		$15 Copay *
Fixed and Removable Prosthetic Services *						
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%	80%		$100 Copay *
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	80%		$250 Copay *
Orthodontics * (All plans except Delta Dental Plan 6)						
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NA	80% to $1,800 lifetime max		$2,500 Copay + $20 per visit **

♦ Under Delta Dental Plans 1 and 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 (1 or 5) and other non-incentive plans will have an effect on benefit level.

Ω The Delta Dental Exclusive PPO plan has no out-of-network benefit. Services performed by providers outside the Delta Dental PPO network are not covered unless for a dental emergency. Covered emergencies consist of problem focused exam, palliative treatment and x-rays. All other services are considered non-covered.

† 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.

‡ Under the Willamette Dental Plan, services must be provided by a Willamette Dental Group provider in order for benefits to be payable. See handbook for details.

*

** 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. Please contact Kaiser

[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.

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.

OEBB Summary of Vision Benefits 2018-19 Plan Year

Vision		Opal Plan May use any licensed provider	Pearl Plan May use any licensed provider	Quartz Plan May use any licensed provider	VSP Choice Plus Plan VSP Choice Network	VSP Choice Plan VSP Choice Network
Plan Year Maximum		$600*	$400*	$250*	N/A	N/A
Routine Eye Exam:						
Benefit:		Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	Plan pays 100% after $10 copay
Frequency:		Once per Plan Year	Once per Plan Year	Once per Plan Year	Every 12 months	Every 12 months
Lenses:						
Basic lens benefit:		Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	$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**	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. **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**	**$0 copay for standard progressive lenses** Discounts for polycarbonate, anti-reflective coating or progressive lenses
Frequency:		Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Frames / Contacts:						
Benefit:		Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	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.	Covered in full up to retail allowance of **$150**; 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:		**Frames:** *Age 0-16*: Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	**Frames:** *Age 0-16*: Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	**Frames:** *Age 0-16*: Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	Once every 12 months	Once every 12 months
Non-Prescription Benefit						
Benefit:		Not Covered	Not Covered	Not Covered	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	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

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Unum Long Term Care Plan
2018-19 Plan Year
(no change from 2017-18 Plan Year)

Feature	Benefit
Elimination Period	90 Days (cumulative within 730 days)
Monthly Benefit Amount	Base Plan 1: Employee-paid $2,000 Base Plan 2: Employer-paid $2,000 Additional employee-paid increments of $1,000 up to $9,000
Benefit Duration Options	3 years, 6 years or unlimited
Contract Basis	Indemnity
Covered Facilities	Nursing Home, Assisted Living, Hospice, Rehabilitation, Alzheimer's and Residential Care
Guarantee Issue	Employees up to $6,000 monthly benefit for 6 years
Pre-existing Conditions	No pre-existing condition exclusions will apply, but chronic illness* must occur on or after the coverage effective date.
Optional Benefits	• 5% simple inflation, uncapped • Total home care benefit
Premium Waiver	Included in plan.
Bed Reservation	• 90 days for stay in acute care facility • 30 days for other temporary absence • Total of 90 days per calendar year
International Benefit	Coverage at 75% of the home care benefit for care received outside of the U.S. or Canada.
Assisted Living	100% of monthly benefit
Professional Home Care	50% of monthly benefit
Issue Ages	• 18+ for employees and retirees • 18 to 80 for family members
Limitations and Exclusions	• War or act of war, whether declared or undeclared • Chronic illness caused by intentionally self-inflicted injuries or attempted suicide, while sane. • Chronic illness caused by the commission of a crime for which the insured has been convicted under law, or caused by the insured's attempt to commit a crime under law • Chronic illness caused by alcoholism, alcohol abuse, drug addiction or drug abuse • Any period of time while the insured is chronically ill and confined in a hospital, other than if the insured is confined to a long term care facility that is a distinctly separate part of a hospital – does not apply to bed reservation benefit • Any period of time while the insured is chronically ill and outside of the U.S., its territories or possessions or Canada for 30 consecutive days or longer if home care benefits are not selected
Refund of Premium	Premium payments made for coverage beyond the termination date (or date of death) will be refunded
Respite Care Benefit	21 days per calendar year Respite care benefits can be paid while a person is satisfying the elimination period – the days that a respite care benefit is paid apply towards the elimination period.
Additional Care Benefit	A separate pool of $5,000 to cover services such as equipment and caregiver training to assist the insured living at home or in other residential housing. Pool will not reduce the insured's lifetime maximum benefit and is payable during the elimination period.
Home Care by Relative	Available through Total Home Care provision.

"Chronic Illness" and "Chronically Ill" mean:

- Members are unable to perform, without Substantial Assistance from another individual, two or more Activities of Daily Living; or
- Members require Substantial Supervision by another individual to protect Members from threats to Member's health and safety due to Severe Cognitive Impairment.