OEBB 2015-16 PLAN YEAR

SUMMARY OF KAISER PERMANENTE MEDICAL BENEFITS

Plan Options	Med Plan 1		Med Plan 3	
No lifetime maximum on any medical plans	Kaiser (HMO)		Kaiser (HMO) HSA-Compliant Plan (HSA Optional)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	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	$1,500[1]	See Plan Handbook
Maximum deductible per family	None	See Plan Handbook	$3,000[1]	See Plan Handbook
Out-of-pocket (OOP) maximum per person	$1,500	See Plan Handbook	$5,000[1]	See Plan Handbook
Out-of-pocket (OOP) maximum per family	$3,000	See Plan Handbook	$10,000[1]	See Plan Handbook
Preventive Care Services				
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
Professional Services				
Primary Care office visits	$20	Not Covered	20%	Not Covered
Specialist office visits	$30	Not Covered	20%	Not Covered
Mental health office visits	$20	Not Covered	20%	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	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 per service	Not Covered	20%	Not Covered
Maternity				
Outpatient Maternity Care	$0	Not Covered	$0	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
Emergency and Urgent Care				
Urgent care visit	$35	See Plan Handbook	20%	See Plan Handbook
Emergency Room	$100 per visit (waived if admitted)		20%	
Ambulance	$75		20%	

Plan Options	Med Plan 1		Med Plan 3	
	In-Network,Member Pays	Out-of-Network,Member Pays	In-Network,Member Pays	Out-of-Network,Member Pays
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: 100 days per plan year	$0	NA	20%	NA
Viscosupplementation[2]	$30	Not Covered	20%	Not Covered
Upper Endoscopies	$75	Not Covered	20%	Not Covered
Sleep Studies	$20 per visit	Not Covered	20%	Not Covered
MRI, CT, PET imaging	$20 per visit	Not Covered	20%	Not Covered
Lumbar Discographies	$20 per visit	Not Covered	20%	Not Covered
Outpatient Rehabilitation (physical, occupational & speech therapy) Maximum 20 visits per therapy per Plan Year	$30 per visit	Not Covered	20%	Not Covered
Outpatient diagnostic lab and x-ray	$20 per visit	Not Covered	20%	Not Covered
Other Covered Services				
Hearing Aids $4,000 maximum benefit every 48 months for adults, see handbook for State mandatd benefit for children	10%	Not Covered	20%	Not Covered
Durable Medical Equipment	20%	Not Covered	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		$0	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$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%	
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.	

SUMMARY OF KAISER PERMANENTE PHARMACY BENEFITS

Plan Options	Med Plan 1		Med Plan 3	
	In-Network,Member Pays	Out-of-Network,Member Pays	In-Network,Member Pays	Out-of-Network,Member Pays
Pharmacy Services				
Out-of-Pocket Maximum	$1100 Rx max also applies to Medical OOP max		Rx applies toward plan OOP max	
Retail				
Generic	$5 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Preferred Brand	$25 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred Brand	$45 per 30-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook
Mail				
Generic	$10 per 90-day supply	See Plan Handbook	20%	See Plan Handbook
Preferred Brand	$50 per 90-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred Brand	$90 per 90-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook
Specialty				
Select Generic	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Preferred	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook
Non-preferred Brand	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook

[1] Plan 3 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.

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

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

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SUMMARY OF MODA HEALTH MEDICAL BENEFITS

Plan Options	Med Plan A		Med Plan B		Med Plan C		Moda Plan F	
No lifetime maximum on any medical plans	Moda Health (PPO)		Moda Health (PPO)		Moda Health (PPO)		Moda Health (PPO)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	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	$200		$350		$500		$1,250	
Maximum deductible per family	$600		$1,050		$1,500		$3,750	
Out-of-pocket (OOP) maximum per person	$2,400	$4,800	$2,950	$5,900	$3,300	$6,600	$5,500	$11,000
Out-of-pocket (OOP) maximum per family	$7,200	$14,400	$8,850	$17,700	$9,900	$19,800	$12,700	$25,400
Maximum cost share per person (includes OOP, ACT and Pharmacy)	$6,600	NA	$6,600	NA	$6,600	NA	$6,600	NA
Maximum cost share per family (includes OOP, ACT and Pharmacy)	$13,200	NA	$13,200	NA	$13,200	NA	$13,200	NA
Preventive Care Services								
Moda Medical Home wellness visit (ages 21 and over)	$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	50%	$0	50%	$0	50%	0%	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)								
Medical Home incentive care	$10 copay[1]	50%	$10 copay[1]	50%	$10 copay[1]	50%	**$15 copay[1]**	50%
Incentive office visits and home visits	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%[1]	50%
Professional Services								
Medical Home primary care services	$20 copay[1]	50%	$20 copay[1]	50%	$20 copay[1]	50%	**$30 copay[1]**	50%
Primary care and specialist office visits	20%	50%	20%	50%	20%	50%	20%	50%
Mental health office visits	$20 copay[1]	50%	$20 copay[1]	50%	$20 copay[1]	50%	$30 copay[1]	50%
Mental health inpatient and residential services	20%	50%	20%	50%	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0	50%	$0	50%	$0	50%	0%	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%	20%	50%	20%	50%
Maternity Care								
Outpatient Maternity Care	20%	50%	20%	50%	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care, and outpatient maternity care	20%	50%	20%	50%	20%	50%	20%	50%
Emergency and Urgent Care								
Urgent care visit	$50[1]		$50[1]		50[1]		$50[1]	
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%	
Ambulance	20%		20%		20%		20%	

SUMMARY OF MODA HEALTH MEDICAL BENEFITS - continued

Continued from previous page	Med Plan A		Med Plan B		Med Plan C		Moda Plan F	
	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
Outpatient and Hospital Services								
Inpatient care and outpatient surgery/facility care	20%	50%	20%	50%	20%	50%	20%	50%
Skilled nursing facility care (60 days per plan year)	20%	50%	20%	50%	20%	50%	20%	50%
Viscosupplementation	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$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%	$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%	$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%	$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%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
$100 Additional Cost Tier (ACT): spinal injections, tonsillectomies	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
$500 Additional Cost Tier (ACT): Spine surgery, knee and hip replacement[2], knee and shoulder arthroscopy, hernia repair	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%
Outpatient Rehabilitation (physical, occupational & speech therapy) 30 days per plan year / 60 for spinal or head injury	20%	50%	20%	50%	20%	50%	20%	50%
Outpatient diagnostic lab and X-ray	20%	50%	20%	50%	20%	50%	20%	50%
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%
Durable Medical Equipment	20%	50%	20%	50%	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		$0		$0		$0	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$0		$0		$0		$0	
Bariatric Surgery (a.k.a., Gastric bypass, Roux-en-Y).[2] 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	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered
Tobacco Cessation Program (available to age 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.		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.	

SUMMARY OF MODA HEALTH PHARMACY BENEFITS INCLUDED IN MEDICAL PLANS

Plan Options	Med Plan A	Med Plan B	Med Plan C	Moda Plan F
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 Max Cost Share
Retail Pharmacy Services				
Value	$0 (up to 90-day supply)	$0 (up to 90-day supply)	$0 (up to 90-day supply)	$0 (up to 90-day supply)
Select generic	$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
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
Non-preferred brand	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
Mail				
Value	0	0	0	0
Select generic	$16	$16	$16	$16
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
Non-preferred brand	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
Specialty				
Select generic	$16	$16	$16	$16
Preferred	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
Non-preferred brand	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

* 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 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 Synergy) plan, all providers within the ODS Plus Network are considered "In-Network".

[1] Deductible Waived

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

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SUMMARY OF DENTAL BENEFITS

Plan Option	Dental Plan 1 ǂ	Dental Plan 2 ǂ	Dental Plan 3 ǂ	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 and Diagnostic Services on Moda/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							
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**

ǂ 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.

† 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.

* 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.

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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	Child 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 o 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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