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Oregon Educators Benefit Board

2018-19 Plan Year

Benefits Open Enrollment Guide

Enrollment Required
Starting August 15
OEBBenroll.com

Important! **Sept. 15 deadline for MOST members**
Verify your enrollment deadline with your employer.

What's Inside

Action Required

Who

Everyone eligible for OEBB benefits must log in, even if you decline coverage.

What/Where

1. Log in to **OEBBenroll.com** to make your plan selections or to decline coverage for 2018-19.

2. Look for specific plan cost information from your employer.

When

During YOUR Open Enrollment Period – Start Date August 15

OEBB's Open Enrollment is August 15 to September 15, 2018. Some employers use different end dates. Confirm YOUR deadline with your employer.

Why

1. **If you don't, you probably won't have coverage for 2018-19.** Your current medical, dental and vision elections will NOT roll over into 2018-19. So unless your employer defaults you into a plan, you won't have coverage.

2. **Open Enrollment is the one time per year you can make changes without a major life event.** Mid-year changes are only allowed if you experience a Qualified Status Change (QSC) event (e.g., marriage, birth or adoption of a child, divorce). Let your employer know anytime you experience a QSC, even during Open Enrollment.

   More information about QSC events can be found on the OEBB website at: **www.oregon.gov/OHA/OEBB/Pages/QSC-Matrix.aspx**

3. **It's your health and your paycheck! You should control what coverage you have.** If your employer does enroll you in a default plan, you may not like what you get! Don't leave your choices to someone else.

How/Need Help?

Many people just log in and follow the onscreen instructions, but if you need more help, you can find detailed instructions at: **www.oregon.gov/OHA/OEBB/Guides/MyOEBB-Enrollment-Guide.pdf**

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Getting Started

Definitions

Out-of-Area Dependents

Early Retirees

Wellness Programs

Contact Information

Common Mistakes

Definitions for Benefit Terms

ACA Maximum Cost Share This is the maximum amount you will pay out-of-pocket for in-network medical and prescription services combined, including Additional Cost Tier (ACT) copayments.

Additional Cost Tier (ACT) Services in this tier require an additional copayment of $100 or $500. These copayments do not apply toward the deductible or the annual medical out-of-pocket maximum and are in addition to any other applicable copayment or coinsurance you must pay under your specific medical plan benefits. These copayments do apply toward the annual ACA Maximum Cost Share.

CCM Coordinated Care Model (Moda Synergy and Summit medical plans).

COBRA This acronym stands for the Consolidated Omnibus Budget Reconciliation Act, which is the federal law requiring employers to allow for continued coverage through a group health plan after losing eligibility in the group, on a self-pay basis.

Coinsurance The percentage of eligible health care expenses you pay after you meet any required annual deductible.

Constant Dental Plan In contrast to Incentive Dental Plans, benefits remain constant regardless of how often an individual visits the dentist.

Copayments (copay) The fixed dollar amount you pay for certain services.

Deductible The amount you must pay each year before your plan begins to pay for covered health care expenses you use.

Dependent An individual who qualifies for OEBB benefits based on their relationship to someone else as opposed to their own employment status (e.g., a spouse, domestic partner, child, step-child, etc.).

Early Retiree An individual who retires before the age of 65. In order to be eligible for OEBB benefits, an early retiree must not be eligible for Medicare and must be eligible to receive a service retirement allowance under PERS or a retirement benefit plan or system offered by an OEBB-participating employer.

Employer Contribution The amount your employer pays toward your benefits package or health insurance premium. This is sometimes referred to as your "cap."

Exclusive PPO Dental Plan This plan has no out-of-network benefit. Under this plan, services performed outside the Delta Dental PPO network are not covered except for a dental emergency.

Formulary A list showing which prescription drugs are covered by a health insurance plan and which coverage tier they fall under (e.g., generic, preferred, non-preferred).

HMO Health Maintenance Organization (Kaiser medical plans).

Definitions for Benefit Terms

Incentive Dental Plan (Delta Dental Premier Plans 1 & 5) Benefits start at 70 percent for your first plan year of coverage. Thereafter, benefit payments increase by 10 percent each plan year (up to a maximum of 100 percent) provided the individual has visited the dentist at least once during the previous plan year. Failure to do so will cause a 10 percent reduction in benefit payments the following plan year, although payment will never fall below 70 percent.

In-Network Provider A provider or facility contracted with a health plan to provide services at a negotiated discount.

Maximum Benefit The total amount payable by a plan per plan year.

Maximum Plan Allowance (MPA) The maximum amount a plan will pay toward the cost of a service.

Medical Home A medical home is a team-based health care delivery model intended to provide comprehensive and continuous medical care to patients with the goal of achieving the best health outcomes.

Medicare Eligible A person who currently meets the requirements to receive Medicare benefits, either due to disability or age (65 or older).

Out-of-Network Provider A provider who does not have a contract with the health plan. Note: Some plans will not cover services performed by out-of-network providers. Choose plans and providers carefully.

Out-of-Pocket Maximum The most you will pay for services in a year before your plan begins paying 100% of eligible expenses. Note: Monthly insurance premiums are not included in this and must continue to be paid even after the Out-of-Pocket Maximum has been met.

PPO Preferred Provider Organization (Moda Connexus medical plans).

Pre-authorization (or Prior Authorization) An insurance plan requirement that covered services be approved by the plan prior to the date of service.

Preventive Care Measures taken for disease prevention, as compared to disease treatment.

Primary Care Provider Also referred to as General Practitioner, provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions not limited by cause, organ system, or diagnosis.

Qualified Status Change (QSC) A life event that allows a member to change their plan elections outside the annual Open Enrollment period. For a full listing of all the Qualified Status Changes, please visit our website for our full matrix:
https://www.oregon.gov/oha/OEBB/Policies/QSCMatrix.pdf

Self-Pay Early Retiree (SPER) An Early Retiree who does not receive any contribution from their previous employer and pays their full premium directly to OEBB.

Out-of-Area Dependents

Information on covering dependents who do not live with you, by carrier:

Kaiser Permanente

Kaiser HMO Medical/Rx, Vision and Dental Plans (Kaiser Permanente Facilities)

Kaiser Permanente provides access to urgent and emergency care outside of the Kaiser Permanente network. Your out-of-area benefit also covers routine, continuing and follow-up care for dependent children residing outside of the KPNW service area. With this benefit, you pay 20 percent coinsurance of the actual fee charged for the service the provider, facility or vendor provided. Limited to ten office visits, ten lab and X-ray (excluding specialty scans) and ten prescription drug fills per year. You can find more information at: **my.kp.org/oebb**

Moda Health/Delta Dental

Moda PPO Medical Plans (Connexus Network)

If a dependent lives outside the Connexus network area, the OEBB employee must update the dependent's address in the MyOEBB system prior to the dependent seeking services. The dependent will be enrolled in an out-of-area status beginning the 1st day of the month following notification.

Members are encouraged to utilize providers in the Moda Health Travel Network to avoid balance billing for amounts above the maximum plan allowance. Moda Health will extend plan benefits for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by in-network physicians or providers. Fees charged by non-Travel Network, out-of-area providers of care will be reimbursed at the maximum plan allowance for those services. Members may be balance billed for any additional charges.

Moda CCM Medical Plans (Synergy and Summit Networks)

For the Synergy and Summit networks, benefits for out-of-area dependents will be paid at the in-network benefit level. The dependent's out-of-area address must be updated in the MyOEBB system and that dependent must elect a Moda Medical Home to use for primary care when they are in the service area. When seeking services outside of the area, members are encouraged to use the Moda Travel Network to avoid balance billing.

To locate a medical/dental Travel Network provider, call the Moda Health Medical Customer Service Team at 866-923-0409.

Moda Vision Plans

Vision members can see any licensed provider, but benefit dollars will go further if you utilize an in-network provider.

Moda/Delta Dental Premier Plans (Delta Dental Premier Network)

Members enrolled in a Delta Dental Plan 1, 5 or 6 should see a Premier network dentist, to avoid balance billing for amounts above the maximum plan allowance.

Moda/Delta Dental Exclusive PPO Plan (Delta Dental PPO Network)

Members enrolled in the Delta Dental Exclusive PPO plan must use a Delta Dental PPO provider (providers available nationwide) or they will receive no benefit. To locate a Delta Dental provider, call the Delta Dental Customer Service Team at 866-923-0410.

VSP

VSP Vision Plans (VSP Choice Network)

Members can find VSP Choice providers nationwide. Search for a provider at: **www.vsp.com**

Willamette Dental Group

Willamette Dental Plan (Willamette Dental Group Facilities)

Members can access care at any one of the over 50 Willamette Dental Group offices located throughout Oregon, Washington and Idaho. Dependents residing outside of the Willamette Dental Group service area will not have coverage for any dental care with a non-Willamette Dental Group provider, unless they have a dental emergency. Non-emergent services will only be covered when performed by a Willamette Dental Group provider.

Early Retiree Information

Enrollment Changes Allowable during Open Enrollment

As an Early Retiree during Open Enrollment you can:

- Continue or Change (as allowed per the QSC Matrix) your medical, dental and/or vision enrollment
- Continue or Decrease any optional coverages enrolled in such as life or AD&D
- Drop eligible dependents from any or all coverages
- Waive, Decline or Cancel any coverages

As a Reminder:

- Any coverage waived, declined or canceled cannot be added back unless you are doing so because of gaining other OEBB coverage
- Any eligible dependent removed from coverage cannot be added back unless the dependent experiences a Qualified Status Change (QSC) event that would allow the enrollment in coverage. Contact your benefits administrator within 31 days of the qualifying event.

Becoming Eligible for Medicare during the Plan Year

If you or an eligible enrolled dependent becomes eligible for Medicare, OEBB coverage will end the last day of the month prior to the Medicare eligibility effective date.

- If the Early Retiree gains Medicare eligibility, any eligible dependents currently enrolled may continue OEBB coverage until they no longer meet eligibility or become eligible for Medicare.
- The only exception to this rule is: if the Early Retiree or eligible dependent gains Medicare eligibility due to End Stage Renal Disease (ESRD), OEBB coverage can be continued for up to 30 months beyond Medicare eligibility.

The OEBB system will end coverage for eligibility gained due to turning 65. You will need to notify your benefits administrator when gaining eligibility prior to turning 65.

Medicare Enrollment Resources

You can enroll in Medicare up to three months in advance. The Senior Health Insurance Benefits Assistance (SHIBA) Program was created to assist with Medicare and Medicare plan selection questions. The SHIBA website (healthcare.oregon.gov/shiba) is full of helpful Medicare information and certified counselors are available by phone at **1.800.722.4134**.

Additional Resources for Early Retirees can be found online at:
www.oregon.gov/oha/OEBB/Pages/Retiree-Guide.aspx

Wellness Programs

Whatever your wellness goals or lifestyle, we have options to support you. With resources for mental and physical health, both online and in-person, you can select the programs that work best for you to achieve your personal wellness goals.
Please note: OEBB's Healthy Futures incentive program has been discontinued, but the carriers' online health assessments are still available anytime.

Feel Better Your Way.

OEBBwellness.com

- Chronic Disease Management
- Depression & Stress Management
- Diet & Exercise
- Weight Management
- Health Assessment
- Diabetes Prevention & Management
- Tobacco Cessation
- Sleep Management

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888.469.6322

Who You Gonna Call?

A quick guide to "Who Does What" with your benefits

moda HEALTH
866.923.0409
modahealth.com/oebb

KAISER PERMANENTE
866.223.2375
my.kp.org/oebb

Willamette Dental Group
855.433.6825
willamettedental.com/oebb

vsp Vision Care
800.877.7195
vsp.com

TheStandard
866-756-8115
standard.com/mybenefits/oebb

RBH the road to better health
866.750.1327
myrbh.com

unum
800.227.4165
w3.unum.com/enroll/oebb

OEBB stands for the Oregon Educators Benefit Board, but we also serve cities, counties and local governments along with educators, so we just go by "OEBB" (pronounced OH-ebb). The OEBB Board decides which insurance plans and benefits are offered to participating employers. OEBB holds the legal contracts with the carriers, collects premiums from employers and passes them along to the carriers.

Contact OEBB if you need help: logging into or navigating the MyOEBB enrollment system (OEBBenroll.com), clarifying rules, verifying enrollments, understanding your benefits or wellness program options.

The Carriers are the insurance companies that pay your providers for some or all of your healthcare services, as agreed to in their OEBB contract.

Contact the carrier if you need help: estimating your portion of the cost for a procedure, understanding how a claim was paid, finding an in-network provider, completing their online health assessment or getting a new ID card.

Your Employer knows the most about your specific plan options and your monthly cost for coverage. Each employer decides which OEBB plans to offer their employees, and they negotiate different financial contributions to their employee benefit packages. They also may set their own enrollment deadlines or have their own policies apart from OEBB.

Contact your employer if you need to: make a change to your benefits due to a life event (like getting married or having a baby), determine your monthly cost for coverage, plan for retirement, understand or correct your payroll deductions.

Your Providers are the professionals (doctors, dentists, specialists, etc.) who provide your healthcare, examine and diagnose illnesses and prescribe treatments.

Contact your provider if you need to: make an appointment, estimate the total cost of a procedure, pay your portion (copay or coinsurance) for a service, get advice regarding symptoms or results of lab tests.

Avoid These Common Mistakes

1. **Know YOUR monthly cost for coverage.** The MyOEBB system shows the full premium cost, but most employers contribute toward that, so the amount you pay may be different. Get your specific plan option costs from your employer.

2. **Make sure your doctors/providers are in-network for the plans you select.** Some plans have limited networks and no out-of-network coverage. Be sure your plan will cover services where you want to receive them.

3. **Double-check your dependents have the right coverage.** Each dependent needs to be added to each plan (medical, dental, vision, etc.) if you want them to be covered.

4. **Before you decline dental for yourself or a dependent, recognize a 12-month wait will apply** if you choose to add dental coverage at a future Open Enrollment.

5. **Don't wait until the last minute!** OEBB and insurance carrier offices are closed on weekends and holidays and may not be available to help you during these times. Decide early, enroll early.

Medical/Rx Benefits

Kaiser Permanente
Moda Health

Medical/Rx Benefits:
Kaiser Permanente

Quality care with you at the center

To be healthy, you need quality care that's simple, personalized and hassle-free. At Kaiser Permanente, care and coverage come together – so you get everything you need to stay on top of your health in one easy-to-use package.

Our physician-led care teams work together to keep you healthy by delivering high-quality, personalized care.

Great care from great doctors

Our doctors come from top medical schools, and many of them teach at world-renowned universities. No matter which personal doctor you choose, you'll be in highly skilled, experienced hands — and your health is their main concern.

As your biggest health advocate, your doctor will coordinate your care journey, and you'll work closely together to make decisions about your health.

Better care with a connected team

Your doctor, nurses and other specialists all work together to keep you healthy. They're connected to each other, and to you, through your electronic health record. So they know important things about you and your health — like when you're due for a screening and what medications you're taking. That way, you get personalized care that's right for you.

Personalized care for all members

Care at Kaiser Permanente isn't one-size-fits-all. We believe your story, background and values are as important as your health history. To help deliver care that's sensitive to all cultures, ethnicities and lifestyles, we:

- Strive to hire doctors and staff who speak more than one language
- Offer telephone interpretation services in more than 150 languages
- Train our care teams on how to connect with and care for people of all backgrounds
- Provide 5 Salud en Español modules where members interact with Spanish speakers from beginning to end — from reception to nurses to doctors

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Medical/Rx Benefits:
Kaiser Permanente

Your care, your way

Get care where, when and how you want it. With more options to choose from, it's easier to stay on top of your health.

Choose how you get care

In person	Visit your doctor for routine care, preventive services, care when you're not feeling well and more.
Phone	Have a condition that doesn't require an in-person exam? Save yourself a trip to the office by scheduling a call with a Kaiser Permanente doctor.[1,2]
Video	Want a convenient, secure way to see a doctor wherever you are? Meet face-to-face with a Kaiser Permanente doctor on your computer, smartphone or tablet.[1,2] Learn more at: **kp.org/telehealth/nw** or call us to see if video visits are available to you.

Other ways to get care in the moment

24/7 care and advice by phone	Call us for advice when you need it most. We'll help you find out what care is right for you, schedule appointments and more.
Email	Message your doctor's office anytime with nonurgent health questions.[2] You'll get a response usually within 2 business days.
Online	Manage your health, find nearby locations and take advantage of health guides and other resources. You can also download the Kaiser Permanente app to keep up with your care on the go.[3]

[1]When appropriate and available.
[2]These features are available when you get care at Kaiser Permanente facilities.
[3]To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org

Medical/Rx Benefits:
Kaiser Permanente

Care when and where you need it

It's easy for you and your family to get the care you need when you need it. There are many Kaiser Permanente facilities in your area, offering convenient hours and a wide range of care and services.

Convenient care near you

With multiple locations to choose from, it's easy to find one near home or work. You can also see different doctors at different locations — whatever works best for you.

Finding the right location

Choosing a convenient place to get care is simple — just hop online or grab your smartphone.

- Visit **kp.org/facilities** to search by ZIP code, keyword or the type of service you need.
- Search on your smartphone with the location finder on the Kaiser Permanente mobile app.[1]

Many services under one roof

Most of our facilities offer a variety of care and services, so you can take care of several health care needs in one visit. You can see your doctor or specialist, get a lab test or an X-ray, and pick up your medications — all without leaving the building.

Getting care anytime, anywhere

Urgent care
Many facilities offer services for nonemergency, urgent medical needs that require immediate attention — open 7 days a week.[2]

Emergency care
If you ever need emergency care, you're covered. You can always get care at any Kaiser Permanente or non–Kaiser Permanente hospital emergency department.[3]

Care while traveling
If you get hurt or sick while traveling, we'll help you get care. We can also help you before you leave town by checking to see if you need a vaccination, refilling prescriptions and more. Just call our 24/7 Away from Home Travel Line at **951.268.3900** or visit **kp.org/travel**.

Visiting member care
You can get care in all or parts of California, Colorado, Georgia, Hawaii, Maryland, Virginia, Washington and Washington, D.C. as a visiting member. Call our Away from Home Travel Line at **951.268.3900** and let them know you plan to visit another Kaiser Permanente service area for care. Dependent children are covered for routine, continuing and follow-up care when they are temporarily residing outside the service area. We also cover urgent and emergency care.

[1]To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.
[2]An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms and frequent urination or a burning sensation when urinating.
[3]If you reasonably believe you have an emergency medical condition, call **911** or go to the nearest emergency department. An emergency medical condition is a medical or psychiatric condition that requires immediate medical attention to prevent serious jeopardy to your health. For the complete definition of an emergency medical condition, please refer to your Evidence of Coverage (EOC) or other coverage documents.

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Medical/Rx Benefits:
Kaiser Permanente

2018–2019 medical benefits summary

Plan Benefits	Plan 1	Plan 2	Plan 3
Plan Year Deductible	None	$800/individual[1] $2,400/family[2]	$1,600/individual[1] $3,200/family[2]
Out-of-pocket maximum per plan year	$1,500/individual[1] $3,000/family[2]	$4,000/individual[1] $12,000/family[2]	$6,550/individual[1] $13,100/family[2]
Preventive care services	$0	$0	$0
Prenatal care	$0	$0	$0
Well-baby routine visits	$0	$0	$0
Preventive tests	$0	$0	$0
Office visit copay	$20	$25	20% after deductible
Specialist copay	$30	$35	20% after deductible
Outpatient surgery	$75	20% after deductible	20% after deductible
Emergency room copay	$100	20% after deductible	20% after deductible
Hospital inpatient care	$100 per day, up to $500 per admission max	20% after deductible	20% after deductible
Bariatric surgery[3]	$500 + hospital inpatient care cost share	$500 + 20% after deductible	$500 + 20% after deductible
Lab/X-ray/diagnostics	$20	$25	20% after deductible
Prescription Mail-order pharmacy is available at 2 copays for a 90-day supply	$5 generic $25 formulary brand $45 non-formulary brand 25% up to $100 specialty	$5 generic $25 formulary brand $45 non-formulary brand 25% up to $100 specialty	20% after deductible
Prescription annual out-of-pocket maximum per person	$1,100	$1,100	Subject to medical out-of-pocket maximum
Self-referred alternative care: chiropractic, naturopathy, and acupuncture	$20 $2,000 combined annual benefit maximum applies to alternative care services	$25 $2,000 combined annual benefit maximum applies to alternative care services	20% after deductible $2,000 combined annual benefit maximum applies to alternative care services
Routine eye exam	$5	$5	20% after deductible

[1]For subscriber only coverage per year
[2]For a family of 2 or more members per year
[3]See Plan Handbook for specific criteria regarding this benefit

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, exclusions and limitations, claims review, and adjudication procedures, please see your Member Handbook, also known as the Evidence of Coverage (EOC), or call Member Services. In the case of a conflict between this summary and the EOC, the EOC will prevail.

Medical/Rx Benefits:
Moda Health

Welcome to high-quality, compassionate health coverage at a great value.

For more than nine years, Moda Health Plan, Inc. and Delta Dental Plan of Oregon have provided OEBB members like you integrated, whole health plans with robust programs and services. Our plans include nearby providers who work together to keep you and your family well.

As a Moda member, you'll find:

- A broad choice of quality providers in Oregon, Washington and Idaho
- Robust benefits that cover the care you need
- Medical, pharmacy, vision and dental benefits by one health partner
- Team-based, coordinated care that's centered on you
- Caring customer service to help you every step of the way

As your health partner, we offer all of this and more—and we're excited to help you start on a journey to be better.

Because together, we can be more. We can be better.

How your plan works

Better than anyone, you understand that knowledge is power. When you know your plan, you can get the most out of your benefits.

Preventive care matters

Regular checkups are vital to staying well. When you feel good, it's easier to create healthy moments. These services may include:

- Periodic health exams
- Well-baby care
- Women's annual exams
- Many immunizations
- Colorectal cancer and other screenings

Additional Cost Tier

The Additional Cost Tier (ACT) is designed to encourage exploration of less invasive treatment alternatives. It is important to understand and consider all factors, including additional costs, as you discuss treatment options with your provider.

Medical/Rx Benefits:
Moda Health

The ACT refers to select procedures, including:

- Spine surgery
- Knee and hip replacement[1]
- Arthroscopies (knee and shoulder)
- Advanced imaging
- Sleep studies
- Upper endoscopies
- Tonsillectomies[2]
- Uncomplicated hernia repair

PPO plans

Our PPO plans offer a wide selection of providers to meet your needs. Our PPO Connexus plans combine great benefits to Connexus-contracted providers and hospitals to help you save money.

Our traditional PPO plans give you access to the Connexus Network. By choosing a PPO plan, you'll enjoy:

- Access to more than 80 hospitals & 26,000 providers in Oregon, Washington and Idaho
- In-network and out-of-network benefits
- No primary care selection required

If you're looking for statewide coverage and want to access care through one of the largest PPO networks in Oregon, our PPO plans may be the best option for you.

Professional services

Primary care and specialist office visit services performed by a licensed healthcare provider. When you see a participating Moda Medical Home provider, you will have a better benefit for incentive and primary care office visits. It is also important to remember that if you select a Synergy or Summit medical plan, you must select a Medical Home with Moda and use that clinic for all of your primary care needs in order to receive in-network benefits.

Incentive services

Our incentive services offer you lower copayments for office visits for chronic conditions such as:

- Asthma
- Heart conditions
- Cholesterol
- Diabetes
- High blood pressure

Medical Homes make care personal

Once your Synergy or Summit plan is active, you'll need to pick a Moda Medical Home. Your Medical Home is the place you go for your primary care needs. Your primary care providers will work together with you and the rest of your care team on the best treatments for you. This team-based approach offers:

- Faster, easier ways to find care
- Support in meeting your health goals
- Personalized care centered on you
- Lower out-of-pocket costs with your Medical Home

Learn more at: modahealth.com/oebb under the Medical Home tab.

1 Benefit is subject to a reference price limitation of $25,000 under the Connexus Network plans.
2 Additional Cost Tier applies to members under age 18 who have chronic tonsillitis or sleep apnea.

Medical/Rx Benefits:
Moda Health

Networks that protect you

Health happens, whether at home or on the road. We want to make sure you stay covered, no matter where you go. So we've made it easy for you to find in-network coverage.

All plans include a provider network

Each medical plan comes with a provider network. This is a group of licensed medical professionals, clinics, pharmacies, labs and hospitals located in a certain area. These providers offer quality care and services to Moda Health members at an agreed-upon cost.

In- and out-of-network care

It's important to remember you may pay more for services from out-of-network providers than from in-network providers. Out-of-network providers may also bill you for the difference between your maximum plan allowance and their billed charges. This is known as "balance billing." In-network providers don't do this. See our plan summaries or your Member Handbook to learn more about in-network and out-of-network benefits and costs.

Options near you

Synergy Network

This network serves you living or working in the Portland metro area, Southwest Washington, the Oregon coast, the Columbia River Gorge, Salem, Eugene, central and southern Oregon communities. It connects you with high-quality care close to home. You can choose a Medical Home from a diverse and wide selection of participating providers, including:

- Adventist Health
- Asante
- Bay Area Hospital
- Columbia Memorial Hospital
- Legacy Health
- Legacy Silverton Hospital
- Mid-Columbia Medical Center
- Oregon Health & Science University (OHSU)
- PeaceHealth
- Salem Clinic
- Salem Health
- Samaritan Health
- Santiam Hospital
- Sky Lakes Medical Center
- St. Charles Medical Center
- Tillamook Regional Medical Center
- Tuality Healthcare

This network covers these counties:

Benton, Clackamas, Clark, Clatsop, Columbia, Coos, Crook, Curry, Deschutes, Douglas, Hood River, Jackson, Jefferson, Josephine, Klamath, Lane, Lincoln, Linn, Marion, Multnomah, Polk, Tillamook, Wasco, Washington and Yamhill.

Medical/Rx Benefits:
Moda Health

Summit Network

This network serves you living or working in eastern Oregon. It connects you with high-quality care at an affordable cost. You can pick a Medical Home from a diverse and wide selection of participating providers in eastern Oregon, SW Washington and Idaho, including:

- Good Shepherd Medical Center
- Grande Ronde Hospital
- Harney District Hospital
- Kadlec Regional Medical Center and Kadlec Health System
- Lake Health District Hospital
- Pioneer Memorial Hospital — Heppner
- Saint Alphonsus Medical Center — Baker City, Nampa and Ontario
- Saint Alphonsus Regional Medical Center — Boise
- St. Anthony Hospital
- Trios Southridge Hospital and Trios Health Medical Group
- Wallowa Memorial Hospital

This network covers these counties:

Baker, Gilliam, Grant, Harney, Lake, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa and Wheeler.

Connect with care across the state

Connexus Network

When you want a broad selection of providers across Oregon, Connexus Network has you covered. You'll find in-network doctors and specialists just about everywhere—even in some outlying places.

Is your provider in a network?

Find out by visiting modahealth.com and choosing Find Care, Moda's online provider directory. Simply select a network option and look for providers near you.

Travel with peace of mind

When you hit the road, care is never far. While traveling outside the network service area, you can receive care through the First Health Travel Network, paid at the in-network amount. Other covered care received while traveling is paid at the out-of-network amount. Traveling for the purpose of seeking care does not qualify for the travel network benefit.

Outside the United States, you may access any provider for in-network emergency or urgent care. This care is subject to balance billing.

Medical/Rx Benefits:
Moda Health

	Alder CCM	
	In-network, you pay	Out-of-network, you pay[2]
Plan-year costs		
Deductible per person / family	$400 / $1,200	$800 / $2,400
Out-of-pocket max per person	$3,000	$6,000
Out-of-pocket max per family	$9,000	$18,000
Maximum cost share per person (includes OOP and ACT)	$7,350	N/A
Maximum cost share per family (includes OOP and ACT)	$14,700	N/A
Preventive care		
Moda Medical Home wellness visit (ages 21 and over)[3]	$0[1]	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations[3]	$0[1]	50%
Incentive care		
Moda Medical Home incentive office visits (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)[3]	$10 copay[1]	50%
Professional services		
Moda Medical Home primary care office visits[3]	$20 copay[1]	50%
Specialist office visits	20%	50%
Mental health office visits	$20 copay[1]	50%
Chemical dependency services	$0[1]	50%
Virtual Visits	$10 copay	N/A
Alternative care services ($2,000 plan year maximum)		
Acupuncture/chiropractic/naturopathic care	20%	50%
All other services (e.g., labs, diagnostics, etc.)	20%	50%
Maternity care		
Physician or midwife services and hospital stay	20%	50%
Outpatient and hospital services		
Inpatient care and outpatient hospital/facility care	20%	50%
Skilled nursing facility care (60 days per plan year)	20%	50%
Surgery	20%	50%
ACT 100: Sleep studies, specified imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupplementation, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea	$100 copay + 20%	$100 copay + 50%
ACT 500: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 50%
Gastric bypass (Roux-en-Y)[4]	$500 copay + 20%	Not covered
Emergency care		
Urgent care visit	$50[1]	
Emergency room (copay waived if admitted)	$100 copay + 20%	
Ambulance	20%	
Other covered services		
Hearing aids and bone-anchored hearing aids — $4,000 max/48 months for members 26 and older	10%	50%
Physical, occupational and speech therapy (including physical therapy performed in conjunction with alternative care) — Inpatient limitations: 30 days per plan year/60 days for spinal or head injury. Outpatient limitations: 30 sessions per plan year/up to 60 sessions for spinal or head injury.	20%	50%
Outpatient diagnostic lab and X-ray	20%	50%
Durable medical equipment	20%	50%

[1]Deductible waived. All amounts reflect member responsibility. [2]Out-of-network coinsurance based on MPA for these services. [3]To receive the copay benefit, members must see a provider at their preselected Moda Medical Home. [4]This benefit is available to subscriber and spouse/partners and dependents age 18 and older. Members must use an approved Moda Health Center of Excellence. Benefit is subject to a reference price of $20,000 for the facility charge. Travel benefits are available for services that are subject to reference pricing. Please see your handbook for more details.

CCM Synergy/Summit Plans

Alder, Birch, Cedar, Dogwood (not HSA-Compliant)

Birch CCM		Cedar CCM		Dogwood CCM	
In-network, you pay	Out-of-network, you pay[2]	In-network, you pay	Out-of-network, you pay[2]	In-network, you pay	Out-of-network, you pay[2]
$800 / $2,400	$1,600 / $4,800	$1,200 / $3,600	$2,400 / $7,200	$1,600 / $4,800	$3,200 / $9,600
$4,000	$8,000	$5,000	$10,000	$6,850	$13,700
$12,000	$24,000	$13,700	$27,400	$13,700	$27,400
$7,350	N/A	$7,350	N/A	$7,350	N/A
$14,700	N/A	$14,700	N/A	$14,700	N/A
$0[1]	Not covered	$0[1]	Not covered	$0[1]	Not covered
$0[1]	50%	$0[1]	50%	$0[1]	50%
$15 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%
$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%
20%	50%	20%	50%	20%	50%
$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%
$0[1]	50%	$0[1]	50%	$0[1]	50%
$10 copay	N/A	$10 copay	N/A	$10 copay	N/A
20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%
$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered
$50[1]		$50[1]		$50[1]	
$100 copay + 20%		$100 copay + 20%		$100 copay + 20%	
20%		20%		20%	
10%	50%	10%	50%	10%	50%
20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%

Medical and Rx copays (excluding ACT), coinsurance and deductibles apply to the medical out-of-pocket maximum.
Medical out-of-pocket and ACT copays apply to the maximum cost share.
For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

Medical/Rx Benefits:
Moda Health

	Birch PPO	
	In-network, you pay	Out-of-network, you pay[2]
Plan-year costs		
Deductible per person / family	$800 / $2,400	$1,600 / $4,800
Out-of-pocket max per person	$4,000	$8,000
Out-of-pocket max per family	$12,000	$24,000
Maximum cost share per person (includes OOP, ACT and Rx)	$7,350	N/A
Maximum cost share per family (includes OOP, ACT and Rx)	$14,700	N/A
Preventive care		
Moda Medical Home wellness visit (ages 21 and over)	$0[1]	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations	$0[1]	50%
Incentive care		
Moda Medical Home incentive office visits (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)	$15 copay[1]	50%
Incentive office and home visits (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)	20%[1]	50%
Professional services		
Moda Medical Home primary care office visits	$30 copay[1]	50%
Primary care and specialist office visits	20%	50%
Mental health office visits	$30 copay[1]	50%
Chemical dependency services	$0[1]	50%
Virtual Visits	$10 copay	N/A
Alternative care services ($2,000 plan year maximum)		
Acupuncture/chiropractic/naturopathic care	20%	50%
All other services (e.g., labs, diagnostics, etc.)	20%	50%
Maternity care		
Physician or midwife services and hospital stay	20%	50%
Outpatient and hospital services		
Inpatient care and outpatient hospital/facility care	20%	50%
Skilled nursing facility care (60 days per plan year)	20%	50%
Surgery	20%	50%
ACT 100: Sleep studies, specified imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupplementation, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea	$100 copay + 20%	$100 copay + 50%
ACT 500: Spine surgery, knee and hip replacement[3], knee and shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 50%
Gastric bypass (Roux-en-Y)[4]	$500 copay + 20%	Not covered
Emergency care		
Urgent care visit	$50[1]	
Emergency room (copay waived if admitted)	$100 copay + 20%	
Ambulance	20%	
Other covered services		
Hearing aids and bone-anchored hearing aids — $4,000 max/48 months for members 26 and older	10%	50%
Physical, occupational and speech therapy (including physical therapy performed in conjunction with alternative care) — Inpatient limitations: 30 days per plan year/60 days for spinal or head injury. Outpatient limitations: 30 sessions per plan year/up to 60 sessions for spinal or head injury.	20%	50%
Outpatient diagnostic lab and X-ray	20%	50%
Durable medical equipment	20%	50%

[1]Deductible waived. All amounts reflect member responsibility. [2]Out-of-network coinsurance based on MPA for these services. [3]To receive the copay benefit, members must see a provider at their preselected Moda Medical Home. [4]This benefit is available to subscriber and spouse/partners and dependents age 18 and older. Members must use an approved Moda Health Center of Excellence. Benefit is subject to a reference price of $20,000 for the facility charge. Travel benefits are available for services that are subject to reference pricing. Please see your handbook for more details.

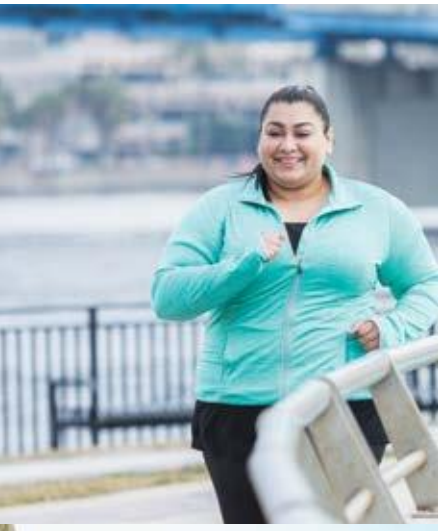
PPO Connexus Plans

Birch, Cedar, Dogwood (not HSA-Compliant)

Cedar PPO		Dogwood PPO	
In-network, you pay	Out-of-network, you pay[2]	In-network, you pay	Out-of-network, you pay[2]
$1,200 / $3,600	$2,400 / $7,200	$1,600 / $4,800	$3,200 / $9,600
$5,000	$10,000	$6,850	$13,700
$13,700	$27,400	$13,700	$27,400
$7,350	N/A	$7,350	N/A
$14,700	N/A	$14,700	N/A
$0[1]	Not covered	$0[1]	Not covered
$0[1]	50%	$0[1]	50%
$15 copay[1]	50%	$15 copay[1]	50%
20%[1]	50%	20%[1]	50%
$30 copay[1]	50%	$30 copay[1]	50%
20%	50%	20%	50%
$30 copay[1]	50%	$30 copay[1]	50%
$0[1]	50%	$0[1]	50%
$10 copay	N/A	$10 copay	N/A
20%	50%	20%	50%
20%	50%	20%	50%
20%	50%	20%	50%
20%	50%	20%	50%
20%	50%	20%	50%
20%	50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%
$500 copay + 20%	Not covered	$500 copay + 20%	Not covered
$50[1]		$50[1]	
$100 copay + 20%		$100 copay + 20%	
20%		20%	
10%	50%	10%	50%
20%	50%	20%	50%
20%	50%	20%	50%
20%	50%	20%	50%

Medical and Rx copays (excluding ACT), coinsurance and deductibles apply to the medical out-of-pocket maximum.
Medical out-of-pocket and ACT copays apply to the maximum cost share.
For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

Medical/Rx Benefits:
Moda Health



Be a better saver with an HSA

Our health savings account (HSA)-compliant, high-deductible health plans (HDHP) give you flexibility and choice. You have the freedom to choose any financial institution for your HSA.

Evergreen and Fir plans

You can use HSA tax-free dollars to pay for deductibles, coinsurance and other qualified expenses not covered by your health plan. HSA members enjoy a number of tax advantages, including:

- Contributions made on a tax-advantaged basis
- Unused funds carried over from year to year, growing tax-deferred
- Tax-free withdrawal of funds to pay for qualified medical expenses

Eligibility

To be eligible to participate in an HSA plan, you must:

- Be covered by a qualified high-deductible health plan
- Not be covered under another non-HSA-compliant medical plan (including your spouse's plan)
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return

Prescriptions

Your pharmacy benefit is covered under the medical portion of the Evergreen and Fir plans. The plans include value-tier medications that waive your annual deductible. Just present your ID card at a participating pharmacy to use this benefit.

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HSA-Compliant Plans

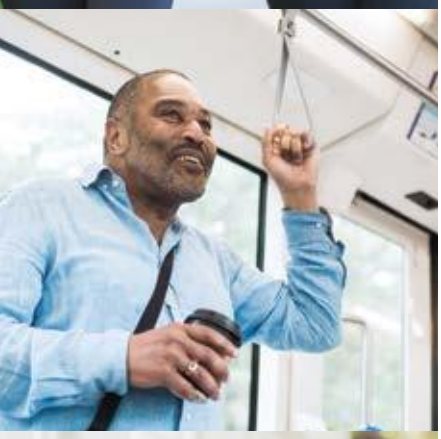
CCM Synergy/Summit Networks and PPO Connexus Network

	Evergreen HDHP CCM and PPO (HSA compatible)		Fir HDHP CCM and PPO (HSA compatible)	
	In-network, you pay	Out-of-network, you pay[2]	In-network, you pay	Out-of-network, you pay[2]
Plan-year costs				
Subscriber-only plan deductible[3]	$1,600	$3,200	$2,000	$4,000
Deductible per family[4]	$3,200	$6,400	$4,000	$8,000
Subscriber-only plan out-of-pocket max[3]	$6,550	$13,100	$6,650	$13,300
Out-of-pocket max per family[4]	$13,100	$26,200	$13,300	$26,600
Embedded per member out-of-pocket max	$6,550	$13,100	$6,650	$13,300
Preventive care				
Moda Medical Home wellness visit (ages 21 and over)[5]	$0[1]	Not covered	$0[1]	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations[5]	$0[1]	50%	$0[1]	50%
Incentive care				
Incentive office and home visits (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)[5]	20%	50%	20%	50%
Professional services				
Office visits[5]	20%	50%	20%	50%
Mental health and chemical dependency services	20%	50%	20%	50%
Virtual Visits (subject to the deductible)	$10 copay	N/A	$10 copay	N/A
Alternative care services ($2,000 plan year maximum)				
Acupuncture/chiropractic/naturopathic care	20%	50%	20%	50%
All other services (e.g., labs, diagnostics, etc.)	20%	50%	20%	50%
Maternity care				
Physician or midwife services and hospital stay	20%	50%	20%	50%
Outpatient and hospital services				
Inpatient care and outpatient hospital/facility care	20%	50%	20%	50%
Skilled nursing facility care (60 days per plan year)	20%	50%	20%	50%
Surgery	20%	50%	20%	50%
Sleep studies, specified imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupp-lementation, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea	20%	50%	20%	50%
Spine surgery, knee and hip replacement,[6] knee and shoulder arthroscopy, uncomplicated hernia repair	20%	50%	20%	50%
Gastric bypass (Roux-en-Y)[7]	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered
Emergency care				
Urgent care visit	20%		20%	
Emergency room	20%		20%	
Ambulance	20%		20%	
Other covered services				
Hearing aids and bone-anchored hearing aids — $4,000 max/48 months for members 26 and older	20%	50%	20%	50%
Physical, occupational and speech therapy (including physical therapy performed in conjunction with alternative care) — Inpatient limitations: 30 days per plan year/60 days for spinal or head injury. Outpatient limitations: 30 sessions per plan year/up to 60 sessions for spinal or head injury.	20%	50%	20%	50%
Outpatient diagnostic lab and X-ray	20%	50%	20%	50%
Durable medical equipment	20%	50%	20%	50%
Major medical prescription coverage	20%		20%	
Value tier	Evergreen CCM = $0[1] Evergreen PPO = $4[1]		Evergreen CCM = $0[1] Evergreen PPO = $4[1]	

[1]Deductible waived. All amounts reflect member responsibility. [2]Out-of-network coinsurance based on MPA for these services. [3]Individual deductible applies only if employee is enrolling in the plan with no other family members. [4]Family deductible and out-of-pocket maximum can be met by one or more family members. This deductible must be met before benefits will be paid. Deductible and copayments apply toward the plan-year out-of-pocket maximum. [5]For plans in the Summit or Synergy network, members must see a provider at their preselected Moda Medical Home to receive the in-network benefit for primary care and preventive services. [6]Benefit is subject to a reference price of $25,000 on Connexus and applies to the facility charge. This is not applicable to Summit or Synergy. Travel benefits are available for services that are subject to reference pricing. Please see your handbook for more details. [7]This benefit is available to subscriber and spouse/partners and dependents age 18 and older. Members must use an approved Moda Health Center of Excellence. Benefit is subject to a reference price of $20,000 for the facility charge.

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

Rx Benefits:
Moda Health



Expect quality pharmacy benefits

Quality prescription coverage is right at the heart of a great plan. We're here to support your pharmacy needs, every step of the way.

Access medications your way

As the administrator of the Oregon Prescription Drug Program (OPDP), we take pride in actively managing your pharmacy benefits. We provide quality, comprehensive coverage that reflects the most current industry standards.

Through the prescription program, you can access a high-performance formulary (a list of prescription drugs) with options under the value, select generic and preferred tiers. Each tier has a copay or coinsurance amount set by the plan.

Pharmacy plan savings

There are a few ways to save on prescription drug costs. Use your 90-day mail-order benefit through Postal Prescription Services (PPS). You can receive significant savings by using the mail-order benefit.

You can fill a 90-day prescription for value, select generic and preferred medications at any Choice 90 pharmacy. To find Choice 90 participating pharmacies, you should select "Choice 90" when searching for participating pharmacies through myModa.

You may have more savings options through our preferred pharmacy partners. Log in to myModa and choose Find Care to use the Pharmacy Locator and get started.

Value-tier medications

Value medications include commonly prescribed products used to treat chronic medical conditions and preserve health. They are identified — based on the latest clinical information and medical literature — as being safe, effective, cost-preferred treatment options.

The Moda Health OEBB value tier includes products for the following health issues:

- Asthma
- Heart, cholesterol, high blood pressure
- Diabetes
- Osteoporosis
- Depression

A list of medications included under the value tier can be found on the pharmacy tab at: modahealth.com/oebb

Ardon Health specialty pharmacy services

Ardon Health is the specialty and mail-order pharmacy for you to access. Operating out of Portland, Oregon, specialty medications are conveniently delivered free to a patient's home or physician's office. To get started or ask questions, call Ardon Customer Service toll-free at 855.425.4085. TTY users, please call 711.

Rx Benefits:
Moda Health

Alder, Birch, Cedar and Dogwood CCM plans — 2018–19 Prescription drug plan benefit table[1]

	Retail	Mail order	Specialty
	For a 31-day supply,[2] you pay	For a 90-day supply, you pay	For a 31-day supply, you pay
Value	$0	$0	N/A
Select generic	$8	$16	N/A
Preferred[3,4]	25%, up to $50 max	25%, up to $100 max	25%, up to $100 max
Nonpreferred brand name[4]	50%, up to $150 max	50%, up to $300 max	50%, up to $300 max

Birch, Cedar and Dogwood PPO plans — 2018–19 Prescription drug plan benefit table[5]

	Retail	Mail order	Specialty
	For a 31-day supply,[2] you pay	For a 90-day supply, you pay	For a 31-day supply, you pay
Value	$4	$8	N/A
Select generic	$12	$24	N/A
Preferred[3,4]	25%, up to $75 max	25%, up to $150 max	25%, up to $200 max
Nonpreferred brand name[4]	50%, up to $175 max	50%, up to $450 max	50%, up to $500 max

[1]Pharmacy expenses in Synergy and Summit Networks accrue toward the medical plan's out-of-pocket max. [2]A 90-day supply for value and select generic medications is available at retail pharmacies for three times the 31-day copay. [3]This benefit level includes select generic medications that have been identified as having no more favorable outcomes from a clinical perspective than other cost-effective generics. [4]Copay maximum is per prescription. A formulary exception must be approved for high-cost generics and non-preferred brand prescription medication. [5]Pharmacy expenses in the Connexus Network accrue toward the medical plan's maximum cost share.

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

OPDP Oregon Prescription Drug Program

12-Month Waiting Period

If You Delay Enrolling in Dental Coverage

If you or a dependent don't enroll in dental coverage when initially eligible, then choose to enroll during an Open Enrollment period, you or your dependent will be considered a "late enrollee."

You or your dependent will be subject to a **12-month waiting period** on all dental plans. This means **only diagnostic and preventive care will be covered** for the first 12 months of coverage.

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Dental Benefits

Delta Dental (Moda Health)

Kaiser Permanente

Willamette Dental Group

Dental Benefits:
Delta Dental (Moda Health)

Quality coverage for your total health

Our Delta Dental of Oregon plans connect you with great benefits and quality in-network dentists.

You can count on:

- Freedom to choose a dentist
- Contracted-fee savings from participating dentists
- Savings from in-network dentists
- Cleanings every six months
- Predetermination of benefits if requested in a pretreatment plan
- No claim forms
- Superior customer service

Our dental plans also include useful online tools, resources and special programs for those of you who may need extra attention for your pearly whites.

Delta Dental networks go where you go

Each Delta Dental of Oregon plan comes with a Delta Dental network. It includes thousands of dentists across the state and country.

In-network dentists agree to accept our contracted fees as full payment. They also don't balance bill—the difference between what we pay and the dentist's fees. This can help you save on out-of-pocket costs. If you see providers outside the network, you may pay more for care.

Delta Dental Premier® Network

This is the largest dental network in Oregon and nationwide. It includes more than 2,400 providers in Oregon and over 154,000 Delta Dental Premier Dentists nationwide. To have access to our Premier Network, you will want to select Dental Plan 1, 5 or 6.

Delta Dental PPO℠ Network

This is one of the largest preferred provider organization (PPO) dental networks in Oregon and across the country. It includes more than 1,300 participating providers in Oregon and offers access to over 108,000 Delta Dental PPO dentists nationwide. These providers have agreed to lower contracted rates, which means more savings for you. In order to access the PPO network savings, you will want to select the Exclusive PPO plan.

Exclusive PPO plan option

The Exclusive PPO plan option uses the Delta Dental PPO Network. It is important to keep in mind that the Exclusive PPO plan does not pay for services provided by a Premier or non-contracted dentist.

Health through Oral Wellness® program

All plans include access to the Health through Oral Wellness Program. This patient-centered program provides enhanced benefits designed to help you maintain better oral health through risk assessment, education and additional evidence-based preventive care.

Dental Optimizer™

This set of online tools makes great dental health a little easier. From risk assessment quizzes to a treatment cost calculator, you can use it to:

- Ask a dentist questions
- Learn about preventing dental diseases
- Look up new and effective treatments
- Find out how to lower your costs

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Dental Benefits:
Delta Dental (Moda Health)

	Plan 1[2]	Plan 5	Plan 6[3]	Exclusive PPO[4]
Network	Premier			PPO
	In-network, you pay			In-network, you pay
Plan-year costs				
Deductible	$50	$50	$50	$50
Benefit maximum	$2,200	$1,700	$1,200	$1,500
Preventive and diagnostic services[1]				
Exam and prophylaxis/cleanings (once every six months)	30% - 0%	30% - 0%	0%	0%
Bitewing X-rays (once every 12 months)	30% - 0%	30% - 0%	0%	0%
Topical fluoride application (ages 18 and under)	30% - 0%	30% - 0%	0%	0%
Sealants and space maintainers	30% - 0%	30% - 0%	0%	0%
Restorative services				
Fillings (posterior teeth paid to amalgam fee)	30% - 0%	30% - 0%	20%	10%
Inlays (amalgam reimbursement fee)	30% - 0%	30% - 0%	20%	10%
Oral surgery and extractions	30% - 0%	30% - 0%	20%	10%
Endodontics and periodontics	30% - 0%	30% - 0%	20%	10%
Major restorative services				
Gold or porcelain crowns	30% - 0%	30%	50%	20%
Implants	30% - 0%	50%	50%	20%
Onlays	30% - 0%	30%	50%	20%
Prosthodontics services				
Dentures and partial dentures	30% - 0%	50%	50%	20%
Bridges	30% - 0%	50%	50%	20%
Nitrous Oxide	50%	50%	50%	50%
Other services				
Occlusal guards (night guards[5] and athletic mouthguards)	50%	50%	50%	50%
Orthodontic services[1,6]				
Lifetime maximum — $1,800	20%	20%	N/A	20%

[1]*Deductible waived.* [2]*Under this incentive plan, benefits start at 70 percent for your first plan year of coverage. Thereafter, benefit payments increase by 10 percent each plan year (up to a maximum benefit of 100 percent) provided the individual has visited the dentist at least once during the previous plan year. Failure to do so will cause a 10 percent reduction in benefit payment the following plan year, although payment will never fall below 70 percent.* [3]*Moving from a constant benefit plan (6 or Exclusive PPO) to an incentive benefit plan (1 or 5) will cause the benefit level to start at 70 percent.* [4]***This plan has no out-of-network benefit.*** *Services performed outside the Delta Dental PPO network are not covered unless for a dental emergency.* [5]*$150 maximum, once every five years.* [6]*Orthodontic services do not apply toward the plan-year benefit maximum.*

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

DELTA DENTAL

Delta Dental of Oregon & Alaska

! Please note: Exclusive PPO Plan has no out-of-network benefit.

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Dental Benefits:
Kaiser Permanente

Kaiser Permanente dental coverage

We believe in total health, beginning with outstanding dental and oral care. That's why every member gets a personalized prevention and treatment plan. And that's why dental preventive care is at the core of our philosophy.

Our philosophy of care

We emphasize preventive care to help keep your teeth and gums healthy. You'll receive a personalized prevention and treatment plan after we assess your risk for dental disease.

Quality

For more than 2 decades, we've received the highest level of accreditation from the Accreditation Association for Ambulatory Health Care (AAAHC). This means our Dental Program has met rigorous national standards. Currently we are the only dental practice in the Pacific Northwest with AAAHC accreditation.

Integrated approach

Our comprehensive electronic health record system gives Dental Program providers access to your health history. Our dentists can communicate with your medical clinicians, providing integrated care, which helps you rest easy, knowing we are looking out for your total health.

Urgent and emergency care

Emergency dental conditions include severe swelling or infection, severe traumatic injury to teeth, bleeding that doesn't stop — and extreme pain. If you need emergency care, please call the Appointment Center any time, any day.

Getting convenient care

Hours are Monday through Friday, 6:30 a.m. to 6 p.m., and Saturday, 7:30 a.m. to 4 p.m.

Portland 503.286.6868

Salem 503.370.4311

Eugene-Springfield 1.800.448.6118

Vancouver 360.254.9158

Longview 360.575.4800

Language interpretation services:
Use the numbers above.

TTY (all areas) 711

For more information visit: **kp.org/dental/nw**

Dental Benefits:
Kaiser Permanente

2018–2019 dental benefits summary

Plan benefits	Dental Plan†
Dental office visit copayment*	$20
Deductible	None
Plan year maximum	$4,000
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	$0
Routine fillings, inlays, and stainless steel crowns[1,2,3]	$0
Simple tooth extractions[3]	$0
Surgical tooth extractions, including diagnosis and evaluation[3]	$50
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing[3]	$0
Root canal and related therapy including diagnosis and evaluation[3]	$50
Gold or porcelain crowns and onlays[3]	$250
Full and partial dentures, relines, rebases[3]	$100
Bridge retainers and pontics[3]	$250
Orthodontic treatment[3]	$2,500 copay +$20 per visit
Implants	50% (limit of 4 per lifetime)
Occlusal guards (night guards) and athletic mouth guards	10%

*Office visit copayment applies at each visit, in addition to any plan copayments for services.
[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 may request composite fillings, which are considered a buy-up, and additional fees may apply.
[3]Benefit is subject to a 12-month benefit waiting period for late enrollees.

Please note: †Services must be provided by a contracted Kaiser Permanente provider in order for benefits to be payable. See handbook for details.

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Dental Benefits:
Willamette Dental Group

Willamette Dental Group

For almost 50 years, Willamette Dental Group has proudly partnered with public employers throughout the Pacific Northwest, offering high-quality dental care and outstanding insurance coverage to more than 450,000 patients.

Our evidence-based, proactive treatment approach to dental care focuses on what matters most: providing quality, individualized care to each patient that educates for the future rather than only solving the immediate issues at hand.

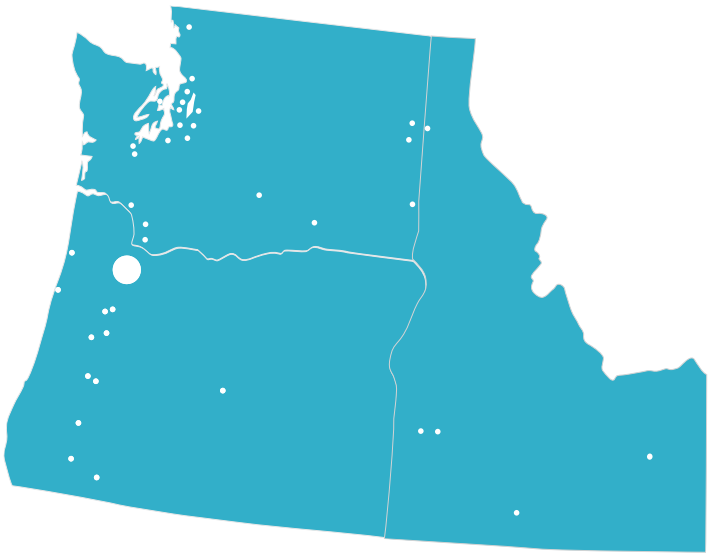
2018-19 Plan Changes

Complete Upper or Lower Denture	$100
Porcelain-Metal Crowns	$250
Bridge (per tooth)	$250
Root Canal Therapy	$50
Surgical Extractions	$50
Comprehensive Orthodontia	$2,500

Quick Facts

- Most services covered at 100% with office visit copay
- Affordable orthodontic coverage for adults and children
- OEBB patient satisfaction averages over 96%
- Most offices open 7am to 6 pm Mon-Fri with Saturday appointments available

More Than 50 Dental Office Locations



Locations Include:

Albany, OR
Bend, OR
Boise, ID
Corvallis, OR
Eugene, OR
Grants Pass, OR
Lincoln City, OR
Medford, OR
Meridian, ID
Portland Metro (multiple locations)
Richland, WA
Roseburg, OR
Salem, OR (2 locations)
Springfield, OR
Tillamook, OR
Vancouver, WA

Learn more about providers and locations at: **willamettedental.com/oebb**

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Dental Benefits:
Willamette Dental Group

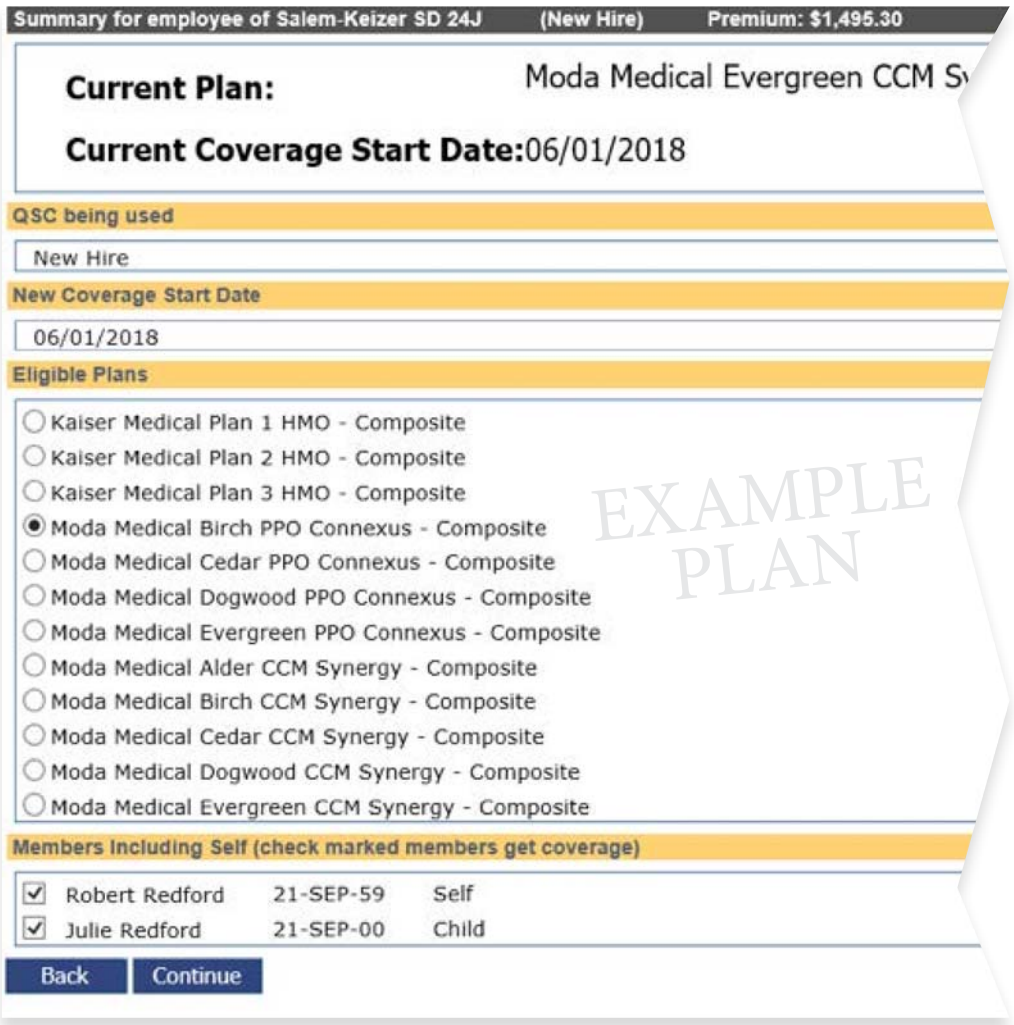
! To receive the excellent benefits of the Willamette Dental Group plan, members must use a Willamette Dental Group provider at one of our more than 50 Willamette Dental Group dental office locations.

Benefits	
Annual Maximum	No Annual Maximum
Deductible	No Deductible
General Office Visit	$20 per visit*
Diagnostic & Preventive Services	
Routine & Emergency Exams	Covered at 100%
All X-rays	Covered at 100%
Teeth Cleaning	Covered at 100%
Fluoride Treatment	Covered at 100%
Sealants (per tooth)	Covered at 100%
Periodontal Evaluation	Covered at 100%
Restorative Dentistry & Prosthodontics**	
Fillings	Covered at 100%
Stainless Steel Crown	Covered at 100%
Porcelain-Metal Crowns	$250
Complete Upper or Lower Denture	$100
Bridge (per tooth)	$250
Endodontics & Periodontics**	
Root Canal Therapy	$50
Root Planing (per quadrant)	Covered at 100%
Oral Surgery**	
Routine Extraction	Covered at 100%
Surgical Extraction	$50
Orthodontic Services**	
Pre-Orthodontic Service	$150***
Comprehensive Orthodontia	$2,500
Miscellaneous**	
Nitrous Oxide (per visit)	$15
Occlusal (Night) Guard	Covered at 100%
Athletic Mouth Guard	$100
Out of Area Emergency Care is Reimbursed Up to $100	

* Office visit copayment applies at each visit
** Benefit is subject to a 12-month waiting period for members who previously waived dental coverage
*** Fee credited towards orthodontic copayment if patient accepts treatment plan

Don't Forget to Enroll Your Dependents

Dependents are not automatically enrolled in all coverage! Please be sure to select which coverages you want for each family member when you enroll.



Don't forget to check the box for each eligible dependent you want covered!

Dependent Eligibility

Make sure everyone you cover meets one of the definitions of an eligible dependent.

Grandchildren are only eligible for OEBB coverage when the eligible employee is the court-ordered legal guardian or adoptive parent of the grandchild. Definitions of eligible dependents, including child, spouse and eligible domestic partner, can be found on the OEBB website at: **www.oregon.gov/oha/OEBB/Pages/Eligibility.aspx**

Vision Benefits

Kaiser Permanente

Moda Health

VSP

Vision Benefits:
Kaiser Permanente

Kaiser Permanente vision coverage

At Vision Essentials by Kaiser Permanente, we see eye care differently. Healthy sight is more than glasses and contact lenses. Our optometrists and ophthalmologists provide comprehensive eye care, including routine eye exams, to help keep your vision sharp and your eyes healthy.

Integrated care

Through our electronic health record system, all your care providers can see a comprehensive picture of your health and act as part of a team to help you make better health care decisions.

Providers will notify you of gaps in your health care and help you schedule preventive appointments, including vaccinations, physicals and important eye health screenings.

Convenience

We have 10 clinic locations from Salem to Longview, most located in medical offices. To schedule an exam, order contact lenses or find a location near you, visit **kp2020.org** or call **1.800.813.2000 (TTY 711).**

2018–2019 vision benefits summary

Plan benefits	Vision plan[1]
Vision exam	Covered under your Kaiser Permanente medical plan with applicable cost share
Hardware allowance[2]	
Prescription hardware – frames, lenses, and contact lenses	$250
Nonprescription hardware – sunglasses and digital eyestrain glasses	$100
Additional Benefits	
50/50 Protection Plan	Included
Second pair of complete glasses	Save 30%

[1]Must be enrolled in a Kaiser Permanente medical plan to enroll in the Kaiser Permanente vision plan.
[2]Once per plan year, members can choose $250 prescription hardware benefit or $100 nonprescription hardware benefit (not both).

Vision Benefits:
Moda Health

Bringing it all into focus

Seeing is believing when it comes to better health. These vision plans ensure that you can focus on feeling your best.

2018–19 Vision plan benefit table

	Opal	Pearl	Quartz
Benefit maximum	$600	$400	$250
	What you pay		
Eye examinations (including refraction) *Frequency: Once per plan year*	0%[1]		
Lenses[2] *Frequency: Contacts (including disposable contacts) or one pair of lenses per plan year*	0%[1]		
Frames *Frequency: One pair per plan year for members under 17 years old. One pair every two plan years for members 17 and older.*	0%[1]		

[1] *Subject to benefit maximum.*

[2] *Includes single vision, bifocal, trifocal or contacts.*

Limitations and exclusions

- Vision exam and hardware benefits are all subject to the plan-year benefit maximum.
- Percentages shown reflect what members pay for covered vision exam, frames and lenses.
- Noncovered, excluded services are the member's responsibility and do not apply toward the plan-year maximum.

For more limitations and exclusions, visit ***modahealth.com/oebb*** *and refer to your Member Handbook.*

Vision Benefits: VSP®

VSP Choice Plus Plan — VSP Provider Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Choice Network Provider		
WellVision® Exam	• Focuses on your eyes and overall wellness • Check to see if your Costco doctor is a participating provider before making an appointment. • Every 12 months	**$10**
Prescription Glasses		**$20**
Frame	• $300 allowance for a wide selection of frames • $320 allowance for featured frame brands • 20% savings on the amount over your allowance • Frame allowance is equivalent to $165 Costco® / Wal-Mart® based on Costco® / Wal-Mart® pricing • Every 12 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Polycarbonate lenses • Scratch-resistant and UV coating • Anti-reflective coatings • Progressive lenses • Average savings of 20-25% on other lens enhancements • Every 12 months	$0 $0 $15 $15
Contacts (instead of glasses)	• $300 allowance for contacts (in lieu of frames and lenses) • Contact lens exam (fitting and evaluation) • 15% off of contact lens exam services • Every 12 months	Up to $60
Suncare	• $300 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts • Every 12 months	$20

VSP Choice Plan® — VSP Provider Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Choice Network Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Check to see if your Costco doctor is a participating provider before making an appointment. • Every 12 months	**$10**
Prescription Glasses		**$20**
Frame	• $150 allowance for a wide selection of frames • $170 allowance for featured frame brands • 20% savings on the amount over your allowance • Frame allowance is equivalent to $80 Costco / Wal-Mart based on Costco / Wal-Mart pricing • Every 12 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Scratch-resistant and UV coating • Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average savings of 20-25% on other lens enhancements • Every 12 months	$0 $55 $95 – $105 $150 – $175
Contacts (instead of glasses)	• $150 allowance for contacts (in lieu of frames and lenses) • Contact lens exam (fitting and evaluation) • 15% off of contact lens exam services • Every 12 months	Up to $60
Suncare	• $150 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts • Every 12 months	$20

Diabetic Eyecare Plus Program℠	• Services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details. • As needed	$20
Extra Savings	Glasses and Sunglasses • Extra $20 to spend on featured frame brands. Go to vsp.com/specialoffers for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP Choice Network provider within 12 months of your last WellVision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Out-of-network Providers

Visit vsp.com for details, if you plan to see a provider other than a VSP Choice Network Provider.

Exam ..... up to $45	Single Vision Lenses ..... up to $30	Lined Trifocal Lenses ..... up to $65	Contacts ..... up to $105
Frame ..... up to $70	Lined Bifocal Lenses ..... up to $50	Progressive Lenses ..... up to $50	

Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location.

Optional Benefits

The Standard (Life & Disability Insurance)

Unum (Long Term Care)

Reliant Behavioral Health (EAP)

The Standard:
Optional Life Insurance

Don't miss out on your **one-time** opportunity to increase your Optional Life insurance without providing proof of good health!

During the 2018-19 enrollment period, The Standard is offering a **one-time** true open enrollment for employees.

Are you currently enrolled for less than $200,000 or not enrolled at all? Either way, you can elect and increase your coverage amount during this special, **one-time** enrollment period up to $200,000 without providing proof of good health!

Cost Example:

Age 40, non-tobacco user

- $200,000 of Optional Life insurance is only $17.00 per month
- $100,000 of Optional Life insurance is only $8.50 per month

The guarantee issue amount (the amount of coverage you may elect without providing proof of good health) will increase from $100,000 to $200,000 for all eligible employees, regardless of whether or not you are currently enrolled in the plan. Any amount requested in excess of the guarantee issue amount or after the open enrollment period has ended will be subject to medical underwriting. Eligible employees may elect coverage in units of $10,000, to a maximum of $500,000.

Dependent coverage is available for a spouse/domestic partner in units of $10,000, to a maximum of $500,000 and for eligible children in units of $2,000, to a maximum of $10,000. Optional Dependent Life coverage cannot exceed 100% of the Employee Optional Life coverage.

The guaranteed issue amount for spouse/partner coverage is $30,000. Any amount requested in excess of the guarantee issue amount or after 31 days of becoming first eligible for coverage will be subject to medical underwriting approval.

Life insurance from The Standard also includes helpful life planning and travel assistance tools.

- Travel Assistance* is available to covered employees and their family members when traveling more than 100 miles from home or internationally for up to 180 days. In addition to travel planning, this service includes assistance with lost credit card replacement, passport replacement, legal and medical resources, medical evacuation and repatriation.

- The Life Services Toolkit* is a resource that can help employees and their beneficiaries deal with the loss of a loved one or plan for the future. Employees can access an online portal for estate planning, funeral arrangement, identity theft prevention, financial planning and health and wellness resources. Services for beneficiaries include grief and loss support, financial counseling and legal services.

Optional Life Brochure:
www.standard.com/eforms/10391d_646595.pdf

AD&D – Accidental Death and Dismemberment Insurance

By participating in the group Optional AD&D insurance plan through OEBB, your employer offers you an excellent opportunity to help protect your loved ones. With Optional AD&D coverage, you, your dependents or your beneficiaries as applicable may receive an AD&D insurance benefit in the event of death and dismemberment as a result of a covered accident. You may elect coverage for yourself or elect coverage for yourself and your spouse/domestic partner and/or eligible children.

- Employee coverage in units of $10,000, up to a maximum of $500,000
- Spouse/domestic partner coverage in units of $10,000, up to a maximum of $500,000 (not to exceed the amount of the employee's coverage)
- Children coverage in units of $2,000, up to a maximum of $10,000 (not to exceed the amount of the employee's coverage)

Optional AD&D Brochure:
www.standard.com/eforms/4241_646595.pdf

The Standard:
Short & Long Term Disability

Disability Insurance
Short Term Disability and Long Term Disability insurance are designed to pay a benefit to you in the event you cannot work because of a covered illness, injury or pregnancy. These benefits replace a portion of your income, thus helping you meet your financial commitments in your time of need. Check with your employer for enrollment availability.

Short Term Disability (STD)
STD insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered non-occupational illness, injury or pregnancy. This benefit is income replacement insurance. The weekly benefit amount, calendar day waiting period and benefit duration will depend upon the plan selected by your employer.

Note: If you enroll after you first became eligible or with a qualifying mid-year change event, you will be subject to a late enrollment penalty. This means that if you file a claim for any condition other than an accidental injury during the first 12 months your coverage is effective, STD benefits will not become payable until after you have been continuously disabled for 60 days and remain disabled.

Short Term Disability Brochure:
www.standard.com/eforms/10388d_646595.pdf

Long Term Disability (LTD)
LTD insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness, injury, or pregnancy. This benefit is income replacement insurance. Monthly benefit amount and calendar day waiting period will depend upon the plan selected by your employer.

Long Term Disability Brochure:
www.standard.com/eforms/10386d_646595.pdf

For more information about any of The Standard's Life and Disability plan offerings, please visit our OEBB microsite at:
www.standard.com/mybenefits/oebb

**The Life Services Toolkit is provided through an arrangement with Morneau Shepell, which is not affiliated with The Standard. Travel Assistance is provided through an arrangement with UnitedHealthcare Global, which is not affiliated with The Standard. These services are not insurance products and may be subject to limitations or exclusions.*

Optional Benefits

Unum

OEBB offers **Long-Term Care Insurance** through Unum as a valuable benefit option for participating employers to offer OEBB members. Long-Term Care is the type of care you may need if you couldn't independently perform the basic activities of daily living: bathing, dressing, using the toilet, transferring from one location to another, continence and eating, or if you suffered severe cognitive impairment from a condition such as Alzheimer's disease. If this situation were to occur, this coverage could help pay for a home health aide, an assisted living facility or a private nursing home. Please confirm with your employer whether this benefit is available to you and, if so, how to access it. Learn more at: **w3.unum.com/enroll/OEBB**

Reliant Behavioral Health

OEBB offers **Employee Assistance Program (EAP) benefits** through Reliant Behavioral Health (RBH). This is a free benefit to you if your employer offers this program.

EAP helps you privately solve problems that may interfere with your work, family and life in general. EAP services are FREE to you, your dependents and all household members. EAP services are always confidential and provided by experts.

Confidential Counseling

- 24-hour Crisis Help
- In-person Counseling
- Online Consultations

Other Available Services

- Health Coaching
- Childcare Services
- Adult and Eldercare Services
- Legal Services
- Financial Services
- Mediation Services
- Home Ownership Program
- Simple Will Kit
- Identity Theft Recovery Assistance

If your employer has selected this OEBB benefit, you can access services by calling **1.866.750.1327** or going online to **www.myrbh.com** and using access code: OEBB.

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Oregon Educators Benefit Board

Visit OEBBenroll.com to enroll in benefits.

Action Required! Sept. 15 is the deadline for MOST members. Confirm your enrollment deadline with your employer.

Everyone needs to log in during Open Enrollment starting August 15th!

Plan Ahead!

The MyOEBB enrollment system will be unavailable from **8:00 p.m. Thursday, August 31 until 9:00 a.m. Friday, September 1.** Please plan your enrollment activities accordingly.

Contact OEBB Member Services
888-4My-OEBB (888-469-6322)
oebb.benefits@state.or.us

Regular Hours
(outside Open Enrollment)
Monday-Friday, 8 a.m. - 5 p.m.

Extended Hours
(during Open Enrollment)
Monday-Friday, 7 a.m. - 6 p.m.

Closed weekends & holidays including Monday, September 3, and Saturday, September 15.