



Oregon Educators
Benefit Board

2019-20 Plan Year



Your Health, *Your Way*



**Enrollment
Required**
Starting August 15
OEBBenroll.com



Benefits Open Enrollment Guide

OEBBinfo.com

What's Inside

! Action Required	2
Getting Started	3
Definitions for Benefit Terms	4
Out-of-Area Dependents.....	6
Early Retiree Information	7
Avoid These Common Mistakes	8
Who You Gonna Call?.....	9
Wellness Program.....	10
Medical/Rx Benefits	11
Medical/Rx Benefits: Kaiser Permanente.....	12
Benefit Summary: Kaiser Permanente Plans 1, 2 & 3	15
Medical/Rx Benefits: Moda Health	16
How the New Plans Work	17
Coordinated Care	18
Finding In-Network Providers	19
Benefit Summary: Moda Health Plan 1	20
Benefit Summary: Moda Health Plan 2	21
Benefit Summary: Moda Health Plan 3	22
Benefit Summary: Moda Health Plan 4	23
Benefit Summary: Moda Health Plan 5	24
Choosing a PCP 360	26
HSAs (Health Savings Accounts)	27
Benefit Summary: Moda Health Plan 6 (HSA Optional).....	28
Benefit Summary: Moda Health Plan 7 (HSA Optional).....	29
Pharmacy Benefits: Moda Health	30
12-Month Waiting Period (when delaying dental coverage)	32
Dental Benefits	33
Dental Benefits: Kaiser Permanente	34
Dental Benefits: Willamette Dental Group.....	36
Dental Benefits: Delta Dental (Moda Health).....	38
Vision Benefits	41
Vision Benefits: Kaiser Permanente	42
Vision Benefits: Moda Health	43
Vision Benefits: VSP.....	44
Optional Benefits	45
Life and AD&D Insurance: The Standard	46
Short and Long Term Disability Insurance: The Standard.....	47
Long Term Care Insurance: Unum	48
Employee Assistance Program: Reliant Behavioral Health	48

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 2019-20.
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, 2019.
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 2019-20.**
Your current medical, dental and vision elections will NOT roll over into 2019-20. 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

Getting Started

Definitions

Out-of-Area Dependents

Early Retirees

Common Mistakes

Contact Information

Wellness Program

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.

Balance Billing When out-of-network providers bill you for the difference between your maximum plan allowance and their billed charges. In-network providers don't do this.

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.

Coordinated Care Moda medical plans allow each covered individual the option to participate in coordinated care by choosing a PCP 360. Participating individuals receive a lower individual deductible, a lower individual out-of-pocket maximum, and lower costs for office visits, specialist visits and alternative care visits (compared to those enrolled in a Moda medical plan who do not choose a PCP 360 and therefore receive the non-coordinated care benefit).

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).

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.

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

Non-Coordinated Care Moda medical plans allow each covered individual the option to participate in coordinated care by choosing a PCP 360. If an individual enrolled in a Moda medical plan does not choose a PCP 360, they receive the “non-coordinated care” benefit which includes a higher individual deductible, a higher individual out-of-pocket maximum, and higher costs for office visits, specialist visits and alternative care visits (compared to those who choose coordinated care).

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.

PCP 360 (applies only to Moda medical plans) A PCP 360 is a high-quality provider who has contracted with Moda Health to deliver full-circle care, coordinating with other providers as needed. Each individual covered on a Moda medical plan has the option to participate in coordinated care and receive enhanced benefits by choosing a PCP 360. Use Moda Health’s online “Find Care” tool to learn which providers are “PCP 360” providers.

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: 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 Medical Plans, 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 co-insurance 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 Medical Plans (Connexus Network)

If a dependent lives outside the Connexus network area, the OEBC employee must update the dependent's address in the MyOEBC 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.

See Page 19 for out-of-area coordinated care and PCP 360 options.

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 and members may be balance billed for any additional charges.

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 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

An “Early Retiree” is 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.

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 Medicare eligibility gained due to turning age 65. **It is your responsibility to notify your employer if you become eligible for Medicare prior to age 65 due to a disability.** Failure to report this information could cause denial of your medical claims.

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

Avoid These Common Mistakes

- 1. Know YOUR monthly cost for coverage.** The MyOEBC 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. Make sure everyone you cover meets one of the definitions of an eligible dependent.** Grandchildren are only eligible for OEBC 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 OEBC website at: www.oregon.gov/oha/OEBC/Pages/Eligibility.aspx
- 5. 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.
- 6. Don't wait until the last minute!** OEBC 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.

Who You Gonna Call?

A quick guide to “Who Does What” with your benefits



888.469.6322
OEBBinfo.com



866.923.0409
modahealth.com/oebb



866.223.2375
my.kp.org/oebb



855.433.6825
willamettedental.com/oebb



800.877.7195
vsp.com



866.756.8115
standard.com/mybenefits/oebb



866.750.1327
myrbh.com



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.

Focus on You with OEBB's

Wellness Program

What's New

- Mindfulness app - coming Oct. 1, 2019!
- Resiliency webinars
- Enhanced OEBBwellness.com website
- Quarterly theme-focused wellness newsletter

You'll Still Have Access to:

- WW (formerly Weight Watchers)
- Healthy Team Healthy U
- Health coaching
- Assistance with ongoing health conditions



oebb

Oregon Educators Benefit Board

Discover all the tools and resources available at:

OEBBwellness.com



OEBB has revamped the wellness program to make it easier to Focus on You.

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
- Offer gender-affirming health care services in an accepting, sensitive, and caring environment for our transgender and gender nonbinary members

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

¹When appropriate and available.

²These features are available when you get care at Kaiser Permanente facilities.

³To 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 Oregon, offering convenient hours and a wide range of care and services.



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 Visit kp.org/urgentcare/nw to see urgent care locations and hours.

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. 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.

¹To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.

²An 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.

³If 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.

Medical/Rx Benefits: Kaiser Permanente

2019-2020 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

¹For subscriber only coverage per year

²For a family of 2 or more members per year

³See 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

High-quality, affordable coverage at a *great value*.

For more than 10 years, Moda Health Plan, Inc. and Delta Dental Plan of Oregon have provided OEBB members like you with 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 wide 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.

How your plan works

This year, we are making it easier to choose the right benefit package for you and for your family. You'll enjoy better benefit choices and better care.

Better benefit choices and better care

You only need to make two choices

- 1 Which plan design works best for your family
- 2 Whether you and your family members want to coordinate your care to receive enhanced benefits

Our plans

Each of our plans has different deductibles and copays, and comes with our largest network – Connexus. Connexus is a statewide network of contracted providers and hospitals. Staying within network will save you money.

You'll also enjoy:

- Access to more than 80 hospitals and 26,000 providers in Oregon, Washington and Idaho
- In-network and out-of-network benefits

Medical/Rx Benefits: Moda Health

Coordinated care

Each plan comes with a coordinated-care option and a non-coordinated care option for you, and for each of your family members.

If you and/or your family members choose coordinated care, you will choose a “PCP 360,” a primary care provider who has agreed to be accountable for your health. Each covered family member can choose if they want coordinated care, and if so, their own PCP 360. Regardless, none of you will need a referral to see a specialist.

Choosing coordinated care means that you will receive **enhanced benefits** like:

- A lower deductible
- A lower out-of-pocket maximum
- Lower cost for office visits, specialist visits and alternative care visits

Whether or not you choose coordinated care, you will pay the same premium, share the same wide Connexus Network of providers and never need referrals. You can join the coordinated-care option at any time of the year.

What is a PCP 360?

A PCP 360 delivers full-circle care, coordinating your care with other providers as needed. They are high quality primary care providers who are willing to be accountable for your health and provide you with lower out-of-pocket costs. You can count on your PCP 360 to provide higher-quality care with lower out-of-pocket costs.

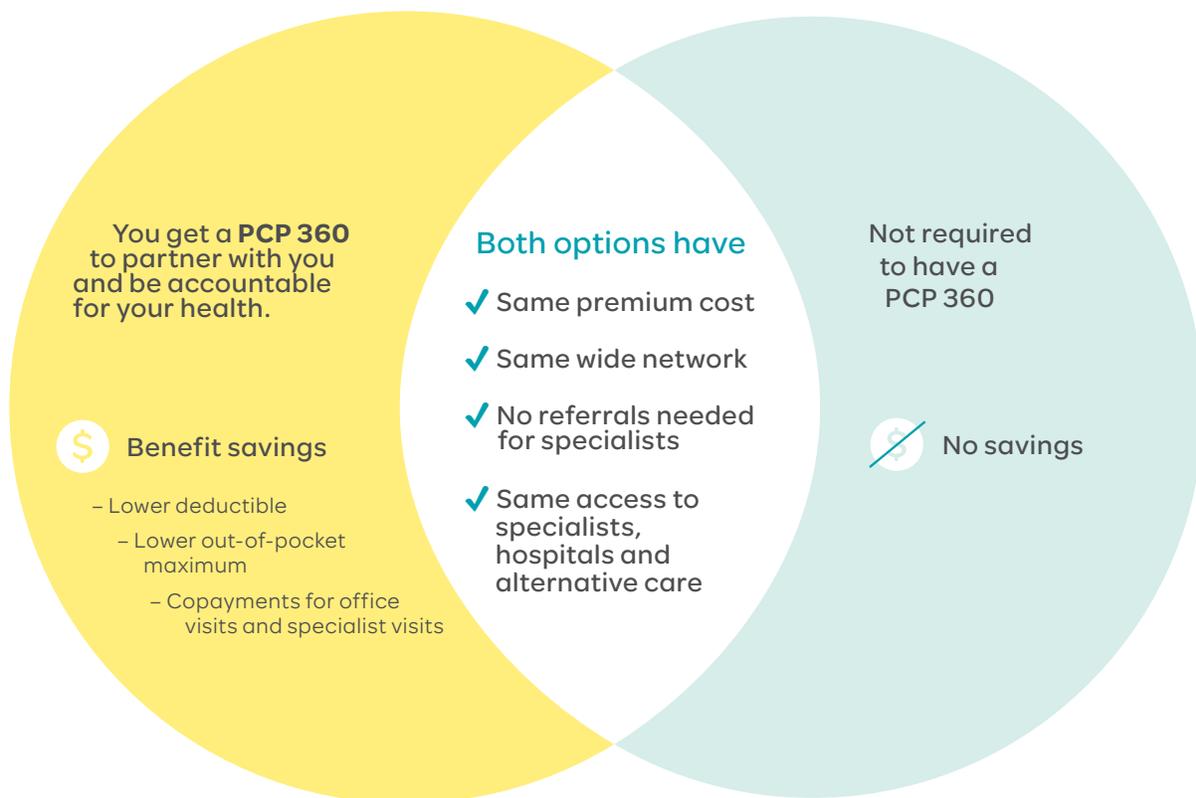


Medical/Rx Benefits: Moda Health

Coordinated care

VS.

Non-coordinated care



What does coordinated care really mean?

With coordinated care, you can count on higher quality care for a lower cost. Your PCP 360 will be accountable for your care, as well as for meeting certain standards for safety and effectiveness. They will be there when you need them, and will help you get the information and services that work best for you.

Medical/Rx Benefits: Moda Health

A network that *protects* 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 the Connexus Network

Each medical plan comes with our Connexus provider network. Within the Connexus Network, members have access to more than 30,000 providers, 87 hospitals and 64,000 pharmacies across Oregon, Idaho, Southern Washington and Northern California. 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.

Connect with care across the state

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.

How coordinated care works for out-of-area members

Dependents (for example: college students) who live part-time out of the Connexus Network service area can still choose a

PCP 360 for coordinated care and receive enhanced benefits. Please let your employer and Moda Customer Service know their address. That way, they can access our travel network to get in-network benefits for services they receive away from home. They will receive benefits at the "not my chosen PCP 360" level if they get primary care from someone other than their designated PCP outside of the Connexus Network service area.

Retiree members, members with COBRA and dependents who live full-time outside of the Connexus Network service area are not eligible for coordinated care and enhanced benefits.

Is your provider in a network?

Find out by visiting modahealth.com and choosing Find Care, Moda's online provider directory. Simply select the Connexus 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. Please note that traveling for the purpose of seeking care does not qualify for the travel network benefit. It would be paid as out-of-network.

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

2019–20 Medical plan benefit table

	Medical Plan 1 Connexus Network ⁵		
	Coordinated care	Non-coordinated care	Out-of-network, you pay ²
	In-network, you pay	In-network, you pay	
Plan-year costs			
Deductible per person / family	\$400 / \$1,500	\$500 / \$1,500	\$800 / \$2,400
Out-of-pocket max per person	\$2,850	\$3,250	\$6,000
Out-of-pocket max per family	\$9,750	\$9,750	\$18,000
Maximum cost share per person (includes OOP and ACT)	\$7,900	\$7,900	N/A
Maximum cost share per family (includes OOP and ACT)	\$15,800	\$15,800	N/A
Preventive care			
PCP 360 wellness visit (ages 21 and over) ³	\$0 ¹	\$0 ¹	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations ³	\$0 ¹	\$0 ¹	50%
Professional services			
Primary care office visits	\$20 copay^{1,3}	20%	50%
Primary care office visits with a provider other than your chosen PCP 360	\$40 copay ¹	N/A	50%
Specialist office visits	\$40 copay¹	20%	50%
Mental health office visits	\$20 copay ¹	\$20 copay ¹	50%
Chemical dependency services	\$20 copay ¹	\$20 copay ¹	50%
Virtual Visits	\$10 copay ¹	\$10 copay ¹	N/A
Alternative care services (\$2,000 plan year maximum)			
Acupuncture/chiropractic manipulation/naturopathic remedies ⁶	\$20 copay¹	20%	50%
Maternity care			
Physician or midwife services and hospital stay	20%	20%	50%
Outpatient and hospital services			
Inpatient care and outpatient hospital/facility care	20%	20%	50%
Skilled nursing facility care (60 days per plan year)	20%	20%	50%
Surgery	20%	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 + 20%	\$100 copay + 50%
ACT 500: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%
Gastric bypass (Roux-en-Y) ⁴	\$500 copay + 20%	\$500 copay + 20%	Not covered
Emergency care			
Urgent care visit	\$40 copay¹	20%	20%
Emergency room (copay waived if admitted)	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 20%
Ambulance	20%	20%	20%
Other covered services			
Hearing aids and bone-anchored hearing aids – \$4,000 max/48 months for members 26 and older	10%	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%	20%	50%
Outpatient diagnostic lab and X-ray	20%	20%	50%
Durable medical equipment	20%	20%	50%

Medical/Rx Benefits: Moda Health

Medical Plan 2 Connexus Network ⁵		
Coordinated care	Non-coordinated care	Out-of-network, you pay ²
In-network, you pay	In-network, you pay	
\$800 / \$2,700	\$900 / \$2,700	\$1,600 / \$4,800
\$3,850	\$4,250	\$8,000
\$12,750	\$12,750	\$24,000
\$7,900	\$7,900	N/A
\$15,800	\$15,800	N/A
\$0 ¹	\$0 ¹	Not covered
\$0 ¹	\$0 ¹	50%
\$20 copay^{1,3}	20%	50%
\$40 copay ¹	N/A	50%
\$40 copay¹	20%	50%
\$20 copay ¹	\$20 copay ¹	50%
\$20 copay ¹	\$20 copay ¹	50%
\$10 copay ¹	\$10 copay ¹	N/A
\$20 copay¹	20%	50%
20%	20%	50%
20%	20%	50%
20%	20%	50%
20%	20%	50%
\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 50%
\$500 copay + 20%	\$500 copay + 20%	\$500 copay + 50%
\$500 copay + 20%	\$500 copay + 20%	Not covered
\$40 copay¹	20%	20%
\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 20%
20%	20%	20%
10%	10%	50%
20%	20%	50%
20%	20%	50%
20%	20%	50%

highlight = enhanced benefits

- 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 their chosen PCP 360.
- 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.
- 5 If enrolled in a Moda medical plan, each covered individual must select a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the far left column under that plan when using a provider in the Connexus network. If an individual has not selected a PCP 360 with Moda, they will receive the "non-coordinated" benefit shown in the center column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level (far right column under that plan) regardless of whether the individual has selected a PCP 360 with Moda or not.
- 6 For all other services (eg. Labs, diagnostics, specified imaging (MRI, CT,PET), office visits, etc) will be subject to the appropriate benefit level listed for each services provided.

Medical copays (excluding ACT), coinsurance and deductibles apply to the medical out-of-pocket maximum.

Medical out-of-pocket, ACT copays, Rx copays and Rx coinsurance 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

2019–20 Medical plan benefit table

	Medical Plan 3 Connexus Network ⁵		
	Coordinated care	Non-coordinated care	Out-of-network, you pay ²
	In-network, you pay	In-network, you pay	
Plan-year costs			
Deductible per person / family	\$1,200 / \$3,900	\$1,300 / \$3,900	\$2,400 / \$7,200
Out-of-pocket max per person	\$4,850	\$5,250	\$10,000
Out-of-pocket max per family	\$15,750	\$15,750	\$27,400
Maximum cost share per person (includes OOP and ACT)	\$7,900	\$7,900	N/A
Maximum cost share per family (includes OOP and ACT)	\$15,800	\$15,800	N/A
Preventive care			
PCP 360 wellness visit (ages 21 and over) ³	\$0 ¹	\$0 ¹	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations ³	\$0 ¹	\$0 ¹	50%
Professional services			
Primary care office visits	\$25 copay^{1,3}	25%	50%
Primary care office visits with a provider other than your chosen PCP 360	\$50 copay ¹	N/A	50%
Specialist office visits	\$50 copay¹	25%	50%
Mental health office visits	\$25 copay ¹	\$25 copay ¹	50%
Chemical dependency services	\$25 copay ¹	\$25 copay ¹	50%
Virtual Visits	\$10 copay ¹	\$10 copay ¹	N/A
Alternative care services (\$2,000 plan year maximum)			
Acupuncture/chiropractic manipulation/naturopathic remedies ⁶	\$25 copay¹	25%	50%
Maternity care			
Physician or midwife services and hospital stay	25%	25%	50%
Outpatient and hospital services			
Inpatient care and outpatient hospital/facility care	25%	25%	50%
Skilled nursing facility care (60 days per plan year)	25%	25%	50%
Surgery	25%	25%	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 + 25%	\$100 copay + 25%	\$100 copay + 50%
ACT 500: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%
Gastric bypass (Roux-en-Y) ⁴	\$500 copay + 25%	\$500 copay + 25%	Not covered
Emergency care			
Urgent care visit	\$50 copay¹	25%	25%
Emergency room (copay waived if admitted)	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 25%
Ambulance	25%	25%	25%
Other covered services			
Hearing aids and bone-anchored hearing aids – \$4,000 max/48 months for members 26 and older	10%	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.	25%	25%	50%
Outpatient diagnostic lab and X-ray	25%	25%	50%
Durable medical equipment	25%	25%	50%

Medical/Rx Benefits: Moda Health

Medical Plan 4 Connexus Network ⁵		
Coordinated care	Non-coordinated care	Out-of-network, you pay ²
In-network, you pay	In-network, you pay	
\$1,600 / \$5,100	\$1,700 / \$5,100	\$3,200 / \$9,600
\$6,700	\$7,100	\$13,700
\$15,800	\$15,800	\$27,400
\$7,900	\$7,900	N/A
\$15,800	\$15,800	N/A
\$0 ¹	\$0 ¹	Not covered
\$0 ¹	\$0 ¹	50%
\$25 copay ^{1,3}	25%	50%
\$50 copay ¹	N/A	50%
\$50 copay ¹	25%	50%
\$25 copay ¹	\$25 copay ¹	50%
\$25 copay ¹	\$25 copay ¹	50%
\$10 copay ¹	\$10 copay ¹	N/A
\$25 copay ¹	25%	50%
25%	25%	50%
25%	25%	50%
25%	25%	50%
\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 50%
\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%
\$500 copay + 25%	\$500 copay + 25%	Not covered
\$50 copay ¹	25%	25%
\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 25%
25%	25%	25%
10%	10%	50%
25%	25%	50%
25%	25%	50%
25%	25%	50%

highlight = enhanced benefits

- 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 their chosen PCP 360.
- 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.
- 5 If enrolled in a Moda medical plan, each covered individual must select a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the far left column under that plan when using a provider in the Connexus network. If an individual has not selected a PCP 360 with Moda, they will receive the "non-coordinated" benefit shown in the center column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level (far right column under that plan) regardless of whether the individual has selected a PCP 360 with Moda or not.
- 6 For all other services (eg. Labs, diagnostics, specified imaging (MRI, CT,PET), office visits, etc) will be subject to the appropriate benefit level listed for each services provided.

Medical copays (excluding ACT), coinsurance and deductibles apply to the medical out-of-pocket maximum.

Medical out-of-pocket, ACT copays, Rx copays and Rx coinsurance 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

2019 – 20 Medical plan benefit table

	Medical Plan 5 Connexus Network ⁵		
	Coordinated care	Non-coordinated care	Out-of-network, you pay ⁶
	In-network, you pay	In-network, you pay	
Plan-year costs			
Deductible per person / family	\$2,000 / \$6,300	\$2,100 / \$6,300	\$4,000 / \$12,600
Out-of-pocket max per person	\$6,800	\$7,200	\$13,700
Out-of-pocket max per family	\$15,800	\$15,800	\$27,400
Maximum cost share per person (includes OOP and ACT)	\$7,900	\$7,900	N/A
Maximum cost share per family (includes OOP and ACT)	\$15,800	\$15,800	N/A
Preventive care			
PCP 360 wellness visit (ages 21 and over) ³	\$0 ¹	\$0 ¹	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations ³	\$0 ¹	\$0 ¹	50%
Professional services			
Primary care office visits	\$30 copay ^{1,3}	25%	50%
Primary care office visits with a provider other than your chosen PCP 360	\$50 copay ¹	N/A	50%
Specialist office visits	\$50 copay ¹	25%	50%
Mental health office visits	\$30 copay ¹	\$30 copay ¹	50%
Chemical dependency services	\$30 copay ¹	\$30 copay ¹	50%
Virtual Visits	\$10 copay ¹	\$10 copay ¹	N/A
Alternative care services (\$2,000 plan year maximum)			
Acupuncture/chiropractic manipulation/naturopathic remedies ⁶	\$30 copay ¹	25%	50%
Maternity care			
Physician or midwife services and hospital stay	25%	25%	50%
Outpatient and hospital services			
Inpatient care and outpatient hospital/facility care	25%	25%	50%
Skilled nursing facility care (60 days per plan year)	25%	25%	50%
Surgery	25%	25%	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 + 25%	\$100 copay + 25%	\$100 copay + 50%
ACT 500: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	\$500 copay + 25%	\$500 copay + 25%	\$500 copay + 50%
Gastric bypass (Roux-en-Y) ⁴	\$500 copay + 25%	\$500 copay + 25%	Not covered
Emergency care			
Urgent care visit	\$50 copay ¹	25%	25%
Emergency room (copay waived if admitted)	\$100 copay + 25%	\$100 copay + 25%	\$100 copay + 25%
Ambulance	25%	25%	25%
Other covered services			
Hearing aids and bone-anchored hearing aids – \$4,000 max/48 months for members 26 and older	10%	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.	25%	25%	50%
Outpatient diagnostic lab and X-ray	25%	25%	50%
Durable medical equipment	25%	25%	50%



highlight = enhanced benefits

- 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 their chosen PCP 360.
- 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.
- 5 If enrolled in a Moda medical plan, each covered individual must select a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the far left column under that plan when using a provider in the Connexus network. If an individual has not selected a PCP 360 with Moda, they will receive the "non-coordinated" benefit shown in the center column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level (far right column under that plan) regardless of whether the individual has selected a PCP 360 with Moda or not.
- 6 For all other services (eg. Labs, diagnostics, specified imaging (MRI, CT,PET), office visits, etc) will be subject to the appropriate benefit level listed for each services provided.

Medical copays (excluding ACT), coinsurance and deductibles apply to the medical out-of-pocket maximum.

Medical out-of-pocket, ACT copays, Rx copays and Rx coinsurance 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.

Plans 6 and 7 with the HSA option

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 Plans 6 and 7. The plans include value-tier medications that waive your annual deductible. Just present your ID card at a participating pharmacy to use this benefit.



Medical/Rx Benefits: Moda Health

2019 – 20 Medical HDHP plan benefit table

	Medical Plan 6 Connexus Network HSA Optional		
	Coordinated care	Non-coordinated care	Out-of-network, you pay ²
	In-network, you pay	In-network, you pay	
Plan-year costs			
Subscriber-only plan deductible ³	\$1,600	\$1,700	\$3,200
Deductible per family ⁴	\$3,400	\$3,400	\$6,400
Individual out-of-pocket max	\$6,400	\$6,750	\$13,100
Out-of-pocket max per family ⁴	\$13,500	\$13,500	\$26,200
Embedded per member out-of-pocket max			
Preventive care			
PCP 360 wellness visit (ages 21 and over)	\$0 ¹	\$0 ¹	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations	\$0 ¹	\$0 ¹	50%
Professional services			
Primary care office visits	15%	20%	50%
Primary care office visits with a provider other than your chosen PCP 360	15%	N/A	50%
Specialist office visits	15%	20%	50%
Mental health office visits	15%	20%	50%
Chemical dependency services	15%	20%	50%
Virtual Visits	\$10 copay	\$10 copay	N/A
Alternative care services (\$2,000 plan year maximum)			
Acupuncture/chiropractic/naturopathic care ⁸	20%	25%	50%
Maternity care			
Physician or midwife services and hospital stay	20%	25%	50%
Outpatient and hospital services			
Inpatient care and outpatient hospital/facility care	20%	25%	50%
Skilled nursing facility care (60 days per plan year)	20%	25%	50%
Surgery	20%	25%	50%
Sleep studies, specified imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupplementation, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea	20%	25%	50%
Spine surgery, knee and hip replacement, ⁵ knee and shoulder arthroscopy, uncomplicated hernia repair	20%	25%	50%
Gastric bypass (Roux-en-Y) ⁶	\$500 copay + 20%	\$500 copay + 25%	Not covered
Emergency care			
Urgent care visit	15%	20%	20%
Emergency room	20%	25%	25%
Ambulance	20%	25%	25%
Other covered services			
Hearing aids and bone-anchored hearing aids – \$4,000 max/48 months for members 26 and older	20%	25%	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%	25%	50%
Outpatient diagnostic lab and X-ray	20%	25%	50%
Durable medical equipment	20%	25%	50%
Major medical prescription coverage ⁷	20%	25%	50%
Value tier	\$4 per 31 day supply ¹	\$4 per 31 day supply ¹	\$4 per 31 day supply ¹

Medical Plan 7 Connexus Network HSA Optional		
Coordinated care	Non-coordinated care	Out-of-network, you pay ²
In-network, you pay	In-network, you pay	
\$2,000	\$2,100	\$4,000
\$4,200	\$4,200	\$8,000
\$6,500	\$6,750	\$13,300
\$13,500	\$13,500	\$26,600
\$0 ¹	\$0 ¹	Not covered
\$0 ¹	\$0 ¹	50%
20%	25%	50%
20%	N/A	50%
20%	25%	50%
20%	25%	50%
20%	25%	50%
\$10 copay	\$10 copay	N/A
20%	25%	50%
\$500 copay + 20%	\$500 copay + 25%	Not covered
20%	25%	25%
20%	25%	25%
20%	25%	25%
20%	25%	50%
\$4 per 31 day supply ¹	\$4 per 31 day supply ¹	\$4 per 31 day supply ¹

highlight = enhanced benefits

- 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 Benefit is subject to a reference price of \$25,000 on Connexus and applies to the facility charge. Travel benefits are available for services that are subject to reference pricing. Please see your handbook for more details.
- 6 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.
- 7 A formulary exception must be approved for high-cost generics and non-preferred brand prescription medication.
- 8 For all other services (eg. Labs, diagnostics, specified imaging (MRI, CT,PET), office visits, etc) will be subject to the appropriate benefit level listed for each services provided.

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

Pharmacy 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 our specialty and mail-order pharmacy. Operating out of Portland, Oregon, specialty medications are conveniently delivered free to a patient's home or physician's office. Ardon Health provides specialty medications for conditions including Crohn's disease, hepatitis C, multiple sclerosis, rheumatoid arthritis and more. You can learn about Ardon Health at ardonhealth.com. You can also call Ardon Customer Service toll-free at 855-425-4085. TTY users, please call 711.

Pharmacy Benefits: Moda Health

Pharmacy benefits

	Medical Plans 1-5		Medical Plans 6-7	
	Coordinated care	Non-coordinated care	Coordinated care	Non-coordinated care
Out-of-pocket maximum	Accrues towards maximum cost share		Accrues towards out-of-pocket max	
Value	\$4 per 31-day supply ¹	\$4 per 31-day supply ¹	\$4 per 31-day supply*	\$4 per 31-day supply*
Select generic	\$12 per 31-day supply ¹	\$12 per 31-day supply ¹	20%	25%
Preferred ^{2,3}	25% up to \$75 per 31-day supply ¹	25% up to \$75 per 31-day supply ¹	20%	25%
Non-preferred brand ³	50% up to \$175 per 31-day supply ¹	50% up to \$175 per 31-day supply ¹	20%	25%
Mail				
Value	\$8 per 90-day supply	\$8 per 90-day supply		
Select generic	\$24 per 90-day supply	\$24 per 90-day supply	20%	25%
Preferred ^{2,3}	25% up to \$150 per 90-day supply	25% up to \$150 per 90-day supply	20%	25%
Non-preferred brand ³	50% up to \$450 per 90-day supply	50% up to \$450 per 90-day supply	20%	25%
Specialty				
Preferred ^{2,3}	25% up to \$200 per 90-day supply	25% up to \$200 per 90-day supply	20%	25%
Non-preferred brand ³	50% up to \$500 per 90-day supply	50% up to \$500 per 90-day supply	20%	25%

*Deductible waived. All amounts reflect member responsibility.

1 A 90-day supply for value, select generic, preferred, and non-preferred medications is available at retail pharmacies for three times the 31-day copay.

2 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.

3 Copay maximum is per prescription. A formulary exception must be approved for high-cost generics and non-preferred brand prescription medication.

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

! 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.



Dental Benefits

Kaiser Permanente

Willamette
Dental Group

Delta Dental
(Moda Health)

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

Integrated approach

Our dentists collaborate with your doctors, providing integrated care, which helps you rest easy, knowing we are looking out for your total health.

Your dental team has access to your health history, so the team can alert you to important health screenings or tests you may need.

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.



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, 7 a.m. to 6 p.m., and Saturday, 7:30 a.m. to 4 p.m.

Valley River Dental Office in Eugene is closed on Wednesdays.

Dental Appointment Center..... 1-800-813-2000

TTY711

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

2019-2020 dental benefits summary

Plan benefits	Dental Plan ¹
Dental office visit copay ²	\$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 ^{3,4,5}	\$0
Simple tooth extractions ⁵	\$0
Surgical tooth extractions, including diagnosis and evaluation ⁵	\$50
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing ⁵	\$0
Root canal and related therapy including diagnosis and evaluation ⁵	\$50
Gold or porcelain crowns and onlays ⁵	\$250
Full and partial dentures, relines, rebases ⁵	\$100
Bridge retainers and pontics ⁵	\$250
Orthodontic treatment ⁵	\$2,500 copay +\$20 per visit
Implants	50% (limit of 4 per lifetime)
Occlusal guards (night guards) and athletic mouth guards	10%

¹Services must be provided by a contracted Kaiser Permanente provider in order for benefits to be payable. See handbook for details.

²Office visit copay applies at each visit, in addition to any plan copays for services.

³Posterior fillings paid to amalgam fee.

⁴Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors, and one-surface composite posteriors.

⁵Patients may request composite fillings, which are considered a buy-up, and additional fees may apply.

⁵Benefit is subject to a 12-month benefit waiting period for late enrollees.

Dental Benefits: Willamette Dental Group

For nearly 50 years, Willamette Dental Group has proudly partnered with public employers throughout the Pacific Northwest to offer high quality dental care and comprehensive insurance coverage to educators and their families.

Our evidence-based, proactive treatment approach 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.

2019/20 PLAN CHANGES

Dental Implant Surgery Implant benefit maximum of \$1,500 per calendar year

QUICK FACTS



No annual maximum, no deductibles



OEBB patient satisfaction averages over 96%



Services covered at predictable, low copays

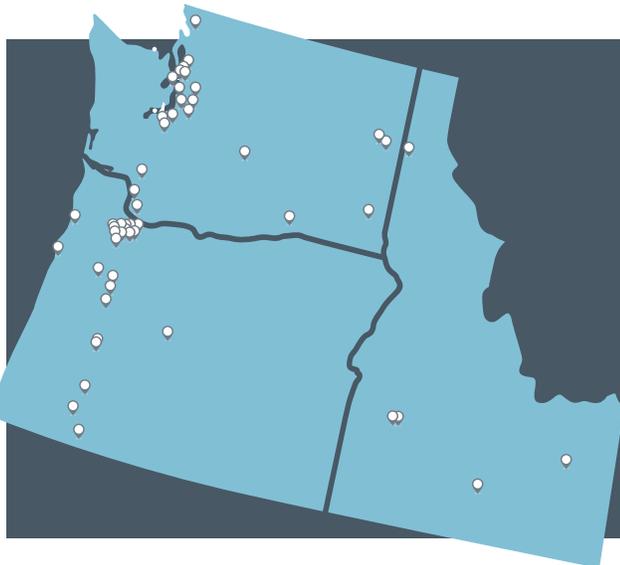


Most offices open 7AM to 6PM Mon – Fri with Saturday appointments available



Affordable orthodontic coverage for adults and children

MORE THAN 50 DENTAL OFFICE LOCATIONS



Locations Include:

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

Learn more about providers and locations at oebb.willamettedental.com

Form No. 044-OR91(5/19) Underwritten by Willamette Dental Insurance, Inc.

SUMMARY OF BENEFITS

Group Number: OR91, Effective Date: October 1, 2019



Oregon Educators Benefit Board

Annual Maximum	No Annual Maximum ¹
Deductible	No Deductible
General or Orthodontic Office Visit	You pay \$20 per Visit ²
Diagnostic & Preventive Services	
Routine & Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
Restorative Dentistry³	
Fillings	Covered with the Office Visit Copay
Porcelain-Metal Crown	You pay a \$250 Copay ⁴
Prosthodontics³	
Complete Upper or Lower Denture	You pay a \$100 Copay ⁴
Bridge (per Tooth)	You pay a \$250 Copay ⁴
Endodontics & Periodontics³	
Root Canal Therapy	You pay a \$50 Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
Oral Surgery³	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You pay a \$50 Copay
Orthodontia Treatment³	
Pre-Orthodontia Treatment	You pay a \$150 Copay ⁵
Comprehensive Orthodontia Treatment	You pay a \$2,500 Copay
Dental Implants³	
Dental Implant Surgery	Implant benefit maximum of \$1,500 per calendar year
Miscellaneous³	
Occlusal Guard	Covered with the Office Visit Copay
Athletic Mouth Guard	You pay a \$100 Copay
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You pay a \$15 Copay
Specialty Office Visit	You pay \$20 per Visit ²
Out of Area Emergency Care Reimbursement	You pay charges in excess of \$100

¹Benefits for implant surgery have a benefit maximum, if covered.

²An office visit copayment applies at each visit, in addition to any copayments for services.

³Benefit is subject to a 12-month waiting period for members who previously waived dental coverage.

⁴Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit.

⁵Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Underwritten by Willamette Dental Insurance, Inc. 6950 NE Campus Way, Hillsboro, OR 97124

Presented are just some of the most common procedures covered in your plan. Please see the Certificate of Coverage for a complete plan description, limitations, and exclusions.

Dental Benefits: Delta Dental

Quality coverage for your **smile**

With Delta Dental of Oregon plans, you'll have access to Delta Dental, the nation's largest dental network.

Dental benefit highlights

Our Delta Dental of Oregon plans connect you with great benefits and quality in-network dentists. You can count on:

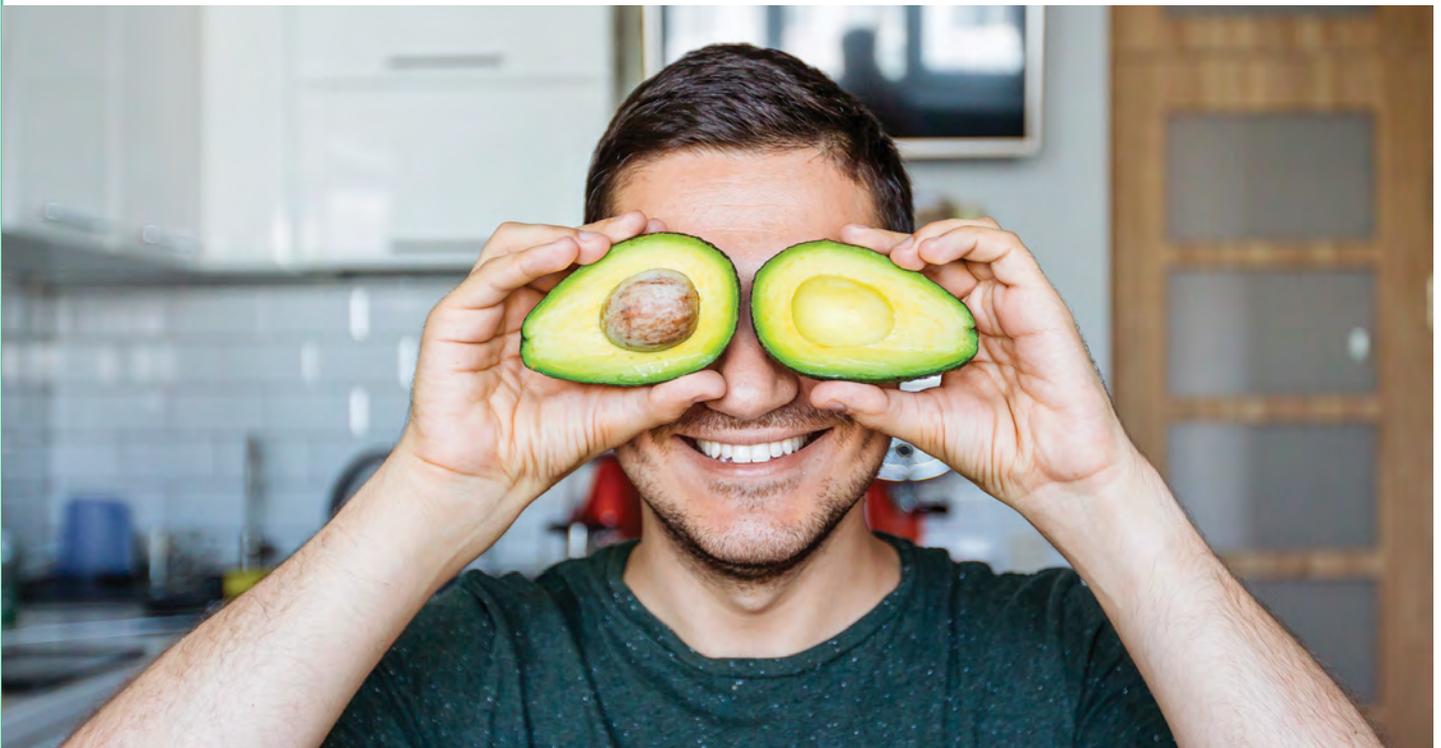
- Freedom to choose a dentist
- Contracted-fee savings from participating dentists
- Savings from in-network dentists
- Cleanings every six months
- Predetermination of benefits if requested in a pretreatment plan
- No claim forms
- Superior customer service

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 156,000 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 PPOSM Network

This is one of the largest preferred provider organization (PPO) dental networks in Oregon and across the country. It includes more than 1,388 participating providers in Oregon and offers access to over 112,451 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 tools

You can use our dental tools to manage your dental health easily, in one online location. Use dental tools to:

- Find a dentist
- Schedule appointments
- View benefits and claims
- Find out your risk for cavities and gum disease
- View articles about dental health topics

Dental Benefits: Delta Dental

2019 - 20 Dental plan benefit table

	Plan 1 ²	Plan 5 ²	Plan 6 ³	Exclusive PPO ^{3,4}
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 services¹				
Exam and prophylaxis/cleanings (once every six months)	30% - 0% ²	30% - 0% ²	0%	0%
Bitewing X-rays (once every 12 months)	30% - 0% ²	30% - 0% ²	0%	0%
Topical fluoride application (ages 18 and under)	30% - 0% ²	30% - 0% ²	0%	0%
Sealants and space maintainers	30% - 0% ²	30% - 0% ²	0%	0%
Restorative services				
Fillings (posterior teeth paid to composite)	30% - 0% ²	30% - 0% ²	20%	10%
Inlays (composite reimbursement fee)	30% - 0% ²	30% - 0% ²	20%	10%
Oral surgery and extractions	30% - 0% ²	30% - 0% ²	20%	10%
Endodontics and periodontics	30% - 0% ²	30% - 0% ²	20%	10%
Major restorative services				
Gold or porcelain crowns	30% - 0% ²	30%	50%	20%
Implants	30% - 0% ²	50%	50%	20%
Onlays	30% - 0% ²	30%	50%	20%
Prosthetic services				
Dentures and partial dentures	30% - 0% ²	50%	50%	20%
Bridges	30% - 0% ²	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. Covered emergencies consist of problem focused exam, palliative treatment and X-rays. All other services are considered non-covered.

5 \$250 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.

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).

Getting care in Lane County

Members in Lane County can get routine eye exams at Oregon Eye Associates or PeaceHealth Eye Care and Optical Shop.

To make an appointment, please contact:

Oregon Eye Associates541-484-3937

PeaceHealth Eye Care

and Optical Shop458-205-6257

2019-2020 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%

¹Must be enrolled in a Kaiser Permanente medical plan to enroll in the Kaiser Permanente vision plan.

²Once 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.

2019–20 Vision plan benefit table

	Opal	Pearl	Quartz
Benefit maximum	\$600	\$400	\$250
	What you pay		
Eye examinations (including refraction) <i>Frequency: Once per plan year</i>		0% ¹	
Lenses ² <i>Frequency: Contacts (including disposable contacts) or one pair of lenses per plan year</i>		0% ¹	
Frames <i>Frequency: One pair per plan year for members under 17 years old. One pair every two plan years for members 17 and older.</i>		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/members and refer to your Member Handbook.

Vision Benefits: VSP®



VSP Choice Plus Plan

VSP Provider Network: VSP Choice

VSP Choice Plan®

VSP Provider Network: VSP Choice

Benefit	Description	Copay
Your Coverage with a VSP Choice Network Provider		
WellVision® Exam	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> \$300 allowance for a wide selection of frames \$350 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	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children Every 12 months 	Included in Prescription Glasses
Lens Enhancements	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> \$300 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts Every 12 months 	\$20
Diabetic Eyecare Plus Program SM	<ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> 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 <ul style="list-style-type: none"> No more than a \$39 copay on routine retinal screening as an enhancement to a WellVision Exam 	
	Laser Vision Correction <ul style="list-style-type: none"> Average 15% off the price or 5% off the promotional price; discounts only available from contracted facilities 	

Benefit	Description	Copay
Your Coverage with a VSP Choice Network Provider		
WellVision® Exam	<ul style="list-style-type: none"> 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	<ul style="list-style-type: none"> \$150 allowance for a wide selection of frames \$200 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	<ul style="list-style-type: none"> Single vision, lined bifocal, and lined trifocal lenses Polycarbonate lenses for dependent children Every 12 months 	Included in Prescription Glasses
Lens Enhancements	<ul style="list-style-type: none"> 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)	<ul style="list-style-type: none"> \$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	<ul style="list-style-type: none"> \$150 allowance for ready-made non-prescription sunglasses instead of prescription glasses or contacts Every 12 months 	\$20

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.

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VSP, VSP Choice Plan, and WellVision Exam are registered trademarks, and VSP Diabetic Eyecare Plus Program is a service mark of Vision Service Plan. All other company names and brands are trademarks or registered trademarks of their respective owners. 20716 VCEE

Optional Benefits

The Standard
(Life & Disability Insurance)

Unum (Long Term Care)

Reliant Behavioral Health
(EAP)

Life and AD&D Insurance: The Standard

The Standard

Visit The Standard's OEBB microsite at standard.com/mybenefits/oebb/ to access product information, a needs estimator and our Decision Support Tool, which can help you assess your specific coverage needs.

Optional Life Insurance

Eligible employees may elect Optional Life 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 employee coverage elected when first eligible is \$200,000. Any amount requested in excess of the Guarantee Issue amount will be subject to medical underwriting approval. For members who have already elected Optional Life coverage, you may increase coverage by \$20,000 during the annual enrollment period (not to exceed the Guarantee Issue amount) without providing evidence of insurability. The Guaranteed Issue amount for spouse/partner coverage when first eligible is \$30,000. Any amount requested in excess of the guarantee issue amount will be subject to medical underwriting approval.

For your convenience, Life insurance from The Standard also includes helpful life planning and travel assistance tools.

- **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.
- **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.

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

Short and Long Term Disability Insurance: The Standard

Disability Insurance

Short Term Disability (STD) and Long Term Disability (LTD) 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 insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered non-occupational illness or injury. This benefit is an 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 insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit is an income replacement insurance. The 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



Long Term Care Insurance: Unum



Unum

OEGB offers **Long Term Care Insurance** through Unum as a valuable benefit option for participating employers to offer OEGB 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/OEGB

Employee Assistance Program: Reliant Behavioral Health



Reliant Behavioral Health

OEGB 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
- Telephone Counseling
- Online Consultations

Other Available Services

- Childcare Services Referral Assistance
- Adult and Eldercare Services Referral Assistance
- Discounted Legal Services
- Financial Services
- Discounted Mediation Services
- Home Ownership Program
- Online Legal Forms (e.g., Will; Living Trust; Power of Attorney, etc.)
- Identity Theft Recovery Assistance

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

Enroll starting August 15th at **OEBBenroll.com**

Plan Ahead!

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



Need Help?

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 2 (Labor Day),
and Saturday and Sunday,
September 14 and 15.

