2022 - 2023

Siuslaw School District 97J
Annual Open Enrollment
Benefits

Siuslaw School District 97J Annual Open Enrollment

OEBB Open Enrollment Period

August 15, 2022 – September 15, 2022

Open Enrollment is Mandatory for the 2022-23 year!

You need to log in to OEBBenroll.com during this open enrollment to:

- Select your medical, dental, and vision plans – or to decline coverage. *(Your current medical, dental and vision elections will NOT roll-over into 2022 – 2023. Please note: District office staff cannot enroll for you.)*
- Add or delete dependents
- Select "optional" AD&D or Long-Term Care Insurance. (*If you already have the "optional" AD&D plan, this plan will automatically roll-over to the new plan year. If you wish to increase/decrease amount, add or delete plan, you will need to make changes during this open enrollment period.)*
- Once you enroll in medical, dental, and vision plans, do not forget to "**save**" your selections. *Once you save your selections, you can always go back into the website and change your plans up until the enrollment cutoff date.*
- 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 the district office know anytime you experience a QSC, even during Open Enrollment.

The information provided in this document is not intended to fully describe the benefits of each plan. In the case of a conflict between this information and the official plan documents, insurance policies, or the OEBB Oregon Administrative Rules, the official governing documents will prevail.

2022– 2023 Plan Changes

♦ $5.00 Surcharge on Double Coverage

- Only pertains to OEBB/OEBB, OEBB/PEBB
- Only charged to Active employees (no Early Retirees or Cobra)
- One $5.00 surcharge per month (even if double-covering more than one dependent)
- Mainly will affect spouse/partners double covered
- Children are not included unless they are also an OEBB or PEBB subscriber (if their job makes them eligible for OEBB/PEBB benefits)
- Any OEBB or PEBB subscriber double covering any other OEBB or PEBB member will pay $5.00/month. This charge will not be included in any insurance pool calculations or covered by district contributions.

Plan rates have changed. Please check the 2022 – 2023 rate sheet for new plan costs.

♦ 9 Medical Plans Available: *Including pharmacy benefit*

Moda Plan 2
Moda Plan 3
Moda Plan 4
Moda Plan 5
Moda Plan 6 (H.S.A. eligible)
Moda Plan 7 (H.S.A. eligible)

Kaiser Plan 1
Kaiser Plan 2A
Kaiser Plan 3 (H.S.A. eligible)

♦ 5 Dental Plans Available:

Delta Dental Premier Plan 1
Delta Dental "Incentive Exclusive" PPO
Delta Dental Exclusive PPO

Kaiser Dental
Willamette Dental

♦ 3 Vision Plans Available:

Moda "Pearl" Plan
VSP Choice Plan

Kaiser Vision

2022 - 2023 Medical, Dental and Vision Plans

Instructions: **Choose any combination of one Medical Plan, Dental Plan, and/or Vision Plan.**

Add together to determine monthly rate. ***Life package is not included in totals *

Choose one Medical plan	Deductible - Single/Family	Single	Employee & Spouse	Employee & Children	Family
Medical Plans					
Moda Plan 2 w/Pharmacy	*$800/$2700*	686.74	1510.83	1304.84	2128.93
Moda Plan 3 w/Pharmacy	*$1200/$3900*	644.28	1417.42	1224.17	1997.32
Moda Plan 4 w/Pharmacy	*$1600/$5100*	608.36	1338.39	1155.89	1885.94
Moda Plan 5 w/Pharmacy	*$2000/$6300*	561.97	1236.34	1067.77	1742.16
Moda Plan 6 (H.S.A. eligible)	*$1600/$3400*	573.23	1261.10	1089.16	1777.05
Moda Plan 7 (H.S.A. eligible)	*$2000/$4200*	535.00	1176.98	1016.52	1658.51
Kaiser Medical Plan 1	*$0/$0*	663.25	1459.17	1260.18	2056.10
Kaiser Medical Plan 2A	*$800/$2400*	549.26	1209.15	1043.54	1703.53
Kaiser Medical Plan 3 (H.S.A. eligible)	*$1600/$3200*	404.50	890.43	768.23	1254.20
Choose one Dental plan	Benefit Amt:				
Delta Dental Premier Plan 1	$2200/year	64.79	128.37	142.74	211.39
Delta Dental "Incentive Exclusive" PPO	$2300/year	56.17	111.28	123.74	183.24
(above "Incentive Exclusive" plan has no out-of-network benefit. Check website for approved providers.)					
Delta Dental "Exclusive" PPO	$1500/year	37.86	74.98	83.38	123.49
(above "Exclusive" plan has no out-of-network benefit. Check website for approved providers.)					
Willamette Dental Plan	N/A	46.60	93.20	99.27	148.91
Kaiser Dental	$20 co-pay	73.07	160.77	138.84	226.53
	Benefit Amt:				
Choose one Vision Plan					
Moda "Pearl" Plan	$400/year	18.47	40.70	35.14	57.32
VSP Choice Plan	Exam $10/co-pay	8.05	17.71	15.29	24.94
Kaiser Vision Plan	$250/year	8.28	18.20	15.72	25.66

Log into your OEBB account to view your current plan choices under the benefit tab.
https://www.myoebb.org
The district office cannot help with OEBB log-in information. Click on the "Forgot User Name or Password" on the OEBB website.

NOTES:

*** Check OEBB website for plan information**
*** District Insurance Contribution is determined by Union Contract.**
*** Insurance Pools are calculated once everyone has enrolled. No changes to Pool afterwards.**
*** For those choosing Medical Plan 6, Medical Plan 7 or Kaiser Plan 3 H.S.A. Plan, see Union Contract for district monthly contribution onto your American Fidelity H.S.A Debit Card.**
*** An Employee Assistance Program is available for the 2022-2023 plan year for all employees**

Medical Plans - Moda

Most medical facilities in Lane County accept Moda insurance, but some are not in-network; always verify with your provider before the time of service.

All OEBB Moda Medical Plans will continue to use the Connexus network. Employees will have the option of coordinated or non-coordinated care. Choosing coordinated care means you will receive enhanced benefits, like a lower deductible, a lower out-of-pocket maximum, and lower costs for office visits, specialist visits, and alternative care visits. Moda does have coverage out-of-network, but your benefit will be subject to all out-of-network conditions. For complete information on coverage, see the specific plan handbooks and summaries.

- If you and/or your family members choose coordinated care, you must choose a primary care provider or "PCP 360" who will be accountable for your health. Each covered family member can choose if they want coordinated care, and if so, their own PCP 360.
- Employees can choose their PCP 360 in one of two ways:
  - Online- log into MyModa
  - Call Moda Customer Service: 866-923-0409
- Moda members who already have a PCP 360 selected only need to contact Moda if they want to update their PCP 360 selection. Otherwise, their PCP 360 selection will carry forward.
- Employees who choose their PCP 360 at any other point during the year will begin receiving the coordinated care enhanced benefit the first of the month of the date they choose their PCP 360 with Moda.

Medical Plans – Kaiser

Kaiser plans are available in our area. Kaiser Permanente places a strong emphasis on integrated care, and in most cases, you will need a referral from your primary care physician before you will be able to see a specialist. Kaiser Permanente uses a Provider Network that combines care coverage featuring physician directed care, primary care access, tele-health services, video and phone visits with Kaiser Permanente providers, and a mobile app. Through collaboration with PeaceHealth, Kaiser Permanente members will have access to Kaiser Permanente facilities and providers across the U.S., along with many existing health care providers in Lane County.

To get started, visit: kp.org/locations to choose a Kaiser Permanente doctor or see if your PeaceHealth doctor is in their network.

Dental Plans

Delta Dental *Premier Plan 1*, and *Exclusive PPO Incentive Plan* are incentive plans, with benefits starting at 70% for your first plan year of coverage. Thereafter, benefit payments increase by 10% each plan year (up to a maximum benefit of 100%) provided the individual has visited the dentist at least once during the previous plan year. Failure to do so will cause a 10% reduction in benefit payment the following plan year, although payment will never fall below 70%.

Note: All benefit eligible employees are allowed to waive dental coverage during Open Enrollment. However, dental benefits are subject to 12-month waiting period restrictions for members who previously waived dental coverage for themselves and/or a dependent and re-enroll in the future. The "waiting period" restrictions only allow an exam and cleaning, with no other preventive/diagnostic, basic, major or orthodontia benefits for the first 12 months of coverage.

Willamette Dental – You must go to a Willamette Dental Office in Eugene or Springfield for services.

Kaiser Dental – You must go to a Kaiser facility to obtain services.

Vision Plans

Check provider website for list of plan providers for either Moda Vision, VSP Vision, or Kaiser Vision.

Employee Assistance Program (EAP)

This program is being offered to all staff members, and premium is paid by the district. Some of the benefits include:

- Up to six face-to-face or telephone counseling for each new issue, including family, relationship, stress and other common challenges.
- Online Peer Support Group
- Adult & Eldercare Services
- Child & Parenting Services
- 24-hour Crisis Consultation
- Financial help

Visit website: uprisehealth.com/members Access Code: OEBB

Phone: 866-750-1327

Avoid These Common Mistakes

- 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. Insurance Pools are calculated once everyone enrolls, so make your selections with this in mind.

- 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.

- 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. If your dependents live out of the area, make sure you provide their current mailing address.

- 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

- 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.

- Do not 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.

OEBB Contact Information:

Phone: 888-469-6322 www.OEBBinfo.com

Enroll at: www.OEBBenroll.com

Glossary of Insurance Terms

Health Savings Account - A Health Savings Account (HSA) is a tax-advantaged account created for or by individuals covered under high-deductible health plans (HDHPs) to save for qualified medical expenses. Contributions are made into the account by the individual or their employer and are limited to a maximum amount each year.

Who qualifies for an HSA? An eligible individual is anyone who:

- is covered under a High Deductible Health Plan (HDHP)
- is not covered by any other health plan that is not an HDHP
- is not currently enrolled in Medicare or TRICARE
- has not received medical benefits through the Department of Veterans Affairs (VA) during the preceding three months
- may not be claimed as a dependent on another person's tax return

Deductible – The amount you owe for health care services that your health plan covers before your health insurance begins to pay.

Coinsurance - The percentage of costs of a covered health care service you pay (20%, for example) after you have paid your deductible.

Let us say your health insurance plan's allowed amount for an office visit is $100 and your coinsurance is 20%.

- If you have paid your deductible: You pay 20% of $100, or $20. The insurance company pays the rest.
- If you have not met your deductible: You pay the full allowed amount, $100.

Out of Pocket Limit – The most you pay during the benefit year before your health plan begins to pay 100% of the allowed amount. This limit does not include your monthly premium, balance-billed charges, or non-covered services. *Moda plan members must check to see what applies to out-of-pocket limit and what applies to max-cost-share limit.

PCP 360 – Primary Care Physician who has contracted with Moda Health to deliver full-circle care, coordinating with other providers as needed.

PPO – For PPO plans, a medical care provider or facility that has agreed contractually to accept discounted fees as payment (with the member's coinsurance) for covered services from the plan.

Summary of Medical and Pharmacy Benefits 2022-23 Plan Year

Contents:

KAISER PERMANENTE® Plans

Please see Plan Handbook for details.

N/A

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network		Medical Plan 2A Kaiser Permanente Network		Medical Plan 2B Kaiser Permanente Network		Medical Plan 3 Kaiser Permanente Network *HSA Optional*	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Deductible per person	None	NA	$800	NA	$1,200	NA	$1,600[2]	NA
Maximum deductible per family	None	NA	$2,400	NA	$3,600	NA	$3,200[2]	NA
Out-of-pocket (OOP) maximum per person	$1,500	NA	$4,000	NA	$4,500	NA	$6,550[2]	NA
Out-of-pocket (OOP) maximum per family	$3,000	NA	$12,000	NA	$13,500	NA	$13,100[2]	NA
Preventive Care Services								
Routine adult, well-child and women's exams; annual obesity screening & immunizations.	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered
Office Visits and Virtual Care								
Primary care office visits	$20	Not Covered	$25[1]	Not Covered	$30[1]	Not Covered	20% after deductible	Not Covered
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	NA	NA	NA	NA	NA	NA	NA	NA
Incentive care office visits (Moda Plans only)	NA	NA	NA	NA	NA	NA	NA	NA
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0 after deductible	Not Covered
Specialist office visits	$30	Not Covered	$35[1]	Not Covered	$40[1]	Not Covered	20% after deductible	Not Covered
Urgent care	$35	See Plan Handbook	$40[1]	See Plan Handbook	$45[1]	See Plan Handbook	20% after deductible	See Plan Handbook
Mental Health and Chemical Dependency Services								
Mental health office visits	$20	Not Covered	$25[1]	Not Covered	$30[1]	Not Covered	20% after deductible	Not Covered
Mental health inpatient and residential services	$100 per day, up to $500 per admission max	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Chemical dependency services (inpatient, outpatient or residential)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	20% after deductible	Not Covered
Chemical dependency services (inpatient)	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	20% after deductible	Not Covered
Outpatient Services								
Outpatient surgery/facility care	$75	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Outpatient rehabilitation (physical, occupational & speech therapy)	$30 per visit	Not Covered	$35[1] per visit	Not Covered	$40[1] per visit	Not Covered	20% after deductible	Not Covered
Diagnostic Testing								
Labs, x-ray, and imaging	$20 per visit	Not Covered	$25[1] per visit	Not Covered	$30[1] per visit	Not Covered	20% after deductible	Not Covered
CT, MRI, PET scans	$20 per visit	Not Covered	$25[1] per visit	Not Covered	$30[1] per visit	Not Covered	20% after deductible	Not Covered
Alternative Care Services								
Acupuncture and Chiropractic[7]	$20 per service	Not Covered	$25[1] per service	Not Covered	$30[1] per service	Not Covered	20% after deductible	Not Covered
Naturopathic Office Visits	$20 per service	Not Covered	$25[1] per service	Not Covered	$30[1] per service	Not Covered	20% after deductible	Not Covered
Maternity Care								
Routine maternity care	$0	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered	$0[1]	Not Covered
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission max	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered	20% after deductible	Not Covered
Hospital Services								
Inpatient care/surgery	$100 per day, up to $500 per admission max	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook	20% after deductible	See Plan Handbook
Skilled nursing facility care	$0	NA	20% after deductible	NA	20% after deductible	NA	20% after deductible	NA

KAISER PERMANENTE®

Plans – *continued*

N/A

No lifetime maximum on any medical plans.	Medical Plan 1 Kaiser Permanente Network		Medical Plan 2A Kaiser Permanente Network		Medical Plan 2B Kaiser Permanente Network		Medical Plan 3 Kaiser Permanente Network *HSA Optional*	
	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays	In-Network Member Pays	Out-of-Network Member Pays
Additional Cost Tier								
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	NA	NA	NA	NA	NA	NA	NA	NA
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[3], knee & shoulder arthroscopy, uncomplicated hernia repair	NA	NA	NA	NA	NA	NA	NA	NA
Emergency Services								
Emergency room (copay waived if admitted)	$100 per visit (waived if admitted)		20% after deductible		20% after deductible		20% after deductible	
Ambulance	$75		$100[1]		$100[1]		20% after deductible	
Other Covered Services								
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10%	Not Covered	10%[1]	Not Covered	10%[1]	Not Covered	20% after deductible	Not Covered
Durable medical equipment (DME)	20%	Not Covered	20%[1]	Not Covered	20%[1]	Not Covered	20% after deductible	Not Covered
Pharmacy Services								
Out-of-pocket (OOP) maximum	$1100 - Rx max also applies to Medical OOP Max		$1100 - Rx max also applies to Medical OOP Max		$1100 - Rx max also applies to Medical OOP Max		Rx applies toward plan OOP max	
Retail								
Value	NA	NA	NA	NA	NA	NA	$0[7]	NA
Generic (Kaiser Plans) / Select generic (Moda Plans)	$5 per 30-day supply	See Plan Handbook	$5 per 30-day supply	See Plan Handbook	$5 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred brand	$25 per 30-day supply	See Plan Handbook	$25 per 30-day supply	See Plan Handbook	$25 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$45 per 30-day supply if criteria met	See Plan Handbook	$45 per 30-day supply if criteria met	See Plan Handbook	$45 per 30-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Mail								
Value	NA	NA	NA	NA	NA	NA		
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook	$10 per 90-day supply	See Plan Handbook	$10 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred Brand	$50 per 90-day supply	See Plan Handbook	$50 per 90-day supply	See Plan Handbook	$50 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$90 per 90-day supply if criteria met	See Plan Handbook	$90 per 90-day supply if criteria met	See Plan Handbook	$90 per 90-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Specialty								
Generic (Moda Plans only)	NA	NA	NA	NA	NA	NA	NA	NA
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook

NA – Not applicable

After ded – After deductible

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

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

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

moda HEALTH **Plans 1–4**

N/A

Please see Plan Handbook for details.

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan Year Costs[6]	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	$400	$500	$800	$800	$900	$1,600	$1,200	$1,300	$2,400	$1,600	$1,700	$3,200
Maximum deductible per family	$1,500	$1,500	$2,400	$2,700	$2,700	$4,800	$3,900	$3,900	$7,200	$5,100	$5,100	$9,600
Out-of-pocket (OOP) maximum per person[3]	$2,850	$3,250	$6,000	$3,850	$4,250	$8,000	$4,850	$5,250	$10,000	$6,700	$7,100	$13,700
Out-of-pocket (OOP) maximum per family[3]	$9,750	$9,750	$18,000	$12,750	$12,750	$24,000	$15,750	$15,750	$27,400	$15,800	$15,800	$27,400
Preventive Care Services												
Routine adult, well-child and women's exams; annual obesity screening & immunizations.	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office Visits and Virtual Care												
Primary care office visits	$20[1,5]	20% after ded	50% after ded	$20[1,5]	20% after ded	50% after ded	$25[1,5]	25% after deductible	50% after ded	$25[1,5]	25% after deductible	50% after ded
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$40[1]	NA	50% after ded	$40[1]	NA	50% after ded	$50[1]	NA	50% after ded	$50[1]	NA	50% after ded
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0[1,9]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered
Specialist office visits	$40[1]	20% after ded	50% after ded	$40[1]	20% after ded	50% after ded	$50[1]	25% after deductible	50% after ded	$50[1]	25% after deductible	50% after ded
Urgent care	$40[1]	20% after ded	20% after ded	$40[1]	20% after ded	20% after ded	$50[1]	25% after deductible	25% after deductible	$50[1]	25% after deductible	25% after deductible
Mental Health and Chemical Dependency Services												
Mental health office visits	$20[1]	$20[1]	50% after deductible	$20[1]	$20[1]	50% after deductible	$25[1]	$25[1]	50% after deductible	$25[1]	$25[1]	50% after deductible
Mental health inpatient and residential services	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	25% after ded	25% after ded	50% after ded	25% after deductible	25% after deductible	50% after ded
Chemical dependency services (outpatient or residential)	$20[1]	$20[1]	50% after deductible	$20[1]	$20[1]	50% after deductible	$25[1]	$25[1]	50% after deductible	$25[1]	$25[1]	50% after deductible
Chemical dependency services (inpatient)	20%	20%	20% after deductible	20%	20%	50%	25%	25%	50%	25%	25%	50%
Outpatient Services												
Outpatient surgery/facility care	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	25% after deductible	25% after deductible	50% after ded	25% after deductible	25% after deductible	50% after ded
Outpatient rehabilitation (physical, occupational & speech therapy)	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible
Tests (outpatient)												
Labs, x-ray, and imaging	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	25% after deductible	25% after deductible	50% after ded	25% after deductible	25% after deductible	50% after ded
CT, MRI, PET scans	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible
Alternative Care Services[7]												
Acupuncture and Chiropractic[7]	$20[1]	20% after deductible	20% after deductible	$20	20% after deductible	50% after deductible	$25[1]	25% after deductible	50% after deductible	$25[1]	25% after deductible	50% after deductible
Naturopathic office visits	$40[1]	20% after deductible	50% after deductible	$40[1]	20% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible	$50[1]	25% after deductible	50% after deductible
Maternity Care												
Routine maternity care	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	25% after deductible	25% after deductible	50% after ded	25% after deductible	25% after deductible	50% after ded
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	25% after deductible	25% after deductible	50% after ded	25% after deductible	25% after deductible	50% after ded
Hospital Services												
Inpatient care/surgery	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	25% after ded	25% after ded	50% after ded	25% after deductible	25% after deductible	50% after ded
Skilled nursing facility care	20% after deductible	20% after deductible	50% after deductible	20% after deductible	20% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible	25% after deductible	25% after deductible	50% after deductible

moda HEALTH

Plans 1–4 – *continued*

N/A

No lifetime maximum on any medical plans.	Medical Plan 1 Connexus Network			Medical Plan 2 Connexus Network			Medical Plan 3 Connexus Network			Medical Plan 4 Connexus Network		
Plan Year Costs[5]	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[6] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[5] Member Pays	Any Out-of-Network Services Member Pays
Additional Cost Tier												
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 20% after deductible	$100 copay + 20% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 20% after deductible	$500 copay + 20% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible
Emergency Services												
Emergency room (copay waived if admitted)	$100 copay + 20% after deductible			$100 copay + 20% after deductible			$100 copay + 25% after deductible			$100 copay + 25% after deductible		
Ambulance	20% after deductible			20% after deductible			25% after deductible			25% after deductible		
Other Covered Services												
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible	10% after deductible	10% after deductible	50% after deductible
Durable medical equipment (DME)	20% after ded	20% after ded	50% after ded	20% after ded	20% after ded	50% after ded	25% after deductible	25% after deductible	50% after ded	25% after deductible	25% after deductible	50% after ded
Pharmacy Services												
Out-of-pocket (OOP) maximum	Rx applies toward Max Cost Share			Rx applies toward Max Cost Share			Rx applies toward Max Cost Share			Rx applies toward Max Cost Share		
Retail												
Value	$4 per 31-day supply			$4 per 31-day supply			$4 per 31-day supply			$4 per 31-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply		See Plan Handbook	$12 per 31-day supply		See Plan Handbook	$12 per 31-day supply		See Plan Handbook	$12 per 31-day supply		See Plan Handbook
Preferred brand	25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply			25% up to $75 per 31-day supply		
Non-preferred brand[4]	50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply			50% up to $175 per 31-day supply		
Mail												
Value	$8 per 90-day supply			$8 per 90-day supply			$8 per 90-day supply			$8 per 90-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply		See Plan Handbook	$24 per 90-day supply		See Plan Handbook	$24 per 90-day supply		See Plan Handbook	$24 per 90-day supply		See Plan Handbook
Preferred brand	25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply			25% up to $150 per 90-day supply		
Non-preferred brand[4]	50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply			50% up to $450 per 90-day supply		
Specialty												
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed			$12 per 31-day supply or $36 per 90-day supply when allowed			$12 per 31-day supply or $36 per 90-day supply when allowed			$12 per 31-day supply or $36 per 90-day supply when allowed		
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		See Plan Handbook	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		See Plan Handbook	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		See Plan Handbook	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		See Plan Handbook
Non-preferred brand[4]	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.		

NA – Not applicable

After ded – After deductible

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

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

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

moda HEALTH

Plans 5–7

No lifetime maximum on any medical plans.

Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network *HDHP HSA Compliant*			Medical Plan 7 Connexus Network *HDHP HSA Compliant*		
	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[5] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[5] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[5] Member Pays	Any Out-of-Network Services Member Pays
Deductible per person	$2,000	$2,100	$4,000	$1,600[2]	$1,700[2]	$3,200[2]	$2,000[2]	$2,100[2]	$4,000[2]
Maximum deductible per family	$6,300	$6,300	$12,600	$3,400[2]	$3,400[2]	$6,400[2]	$4,200[2]	$4,200[2]	$8,000[2]
Out-of-pocket (OOP) maximum per person[3]	$6,800	$7,200	$13,700	$6,400[2]	$6,750[2]	$13,100[2]	$6,500[2]	$6,750[2]	$13,300[2]
Out-of-pocket (OOP) maximum per family[3]	$15,800	$15,800	$27,400	$13,500[2]	$13,500[2]	$26,200[2]	$13,500[2]	$13,500[2]	$26,600[2]
Preventive Care Services									
Routine adult, well-child and women's exams; annual obesity screening & immunizations.	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible	$0[1]	$0[1]	50% after deductible
Office Visits and Virtual Care									
Primary care office visits	$30[1,5]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$50[1]	NA	50% after deductible	15% after deductible	NA	50% after deductible	20% after deductible	NA	50% after deductible
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1,9]	$0[1,9]	Not covered	$0 after deductible	$0 after deductible	Not covered	$0 after deductible	$0 after deductible	Not covered
Specialist office visits	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Urgent care	$50[1]	25% after deductible	25% after deductible	15% after deductible	20% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Mental Health Services									
Mental health office visits	$30[1]	$30[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Mental health inpatient and residential services	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (outpatient or residential)	$30[1]	$30[1]	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Chemical dependency services (inpatient)	25%	25%	50%	20% after deductible	25% after deductible	50%	20% after deductible	25%	50%
Outpatient Services									
Outpatient surgery/facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Outpatient rehabilitation (physical, occupational & speech therapy)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Diagnostic Testing									
Labs, x-ray, and imaging	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
CT, MRI, PET scans	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Alternative Care Services									
Acupuncture and Chiropractic[7]	$30[1]	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Naturopathic Services	$50[1]	25% after deductible	50% after deductible	15% after deductible	20% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Maternity Care									
Outpatient maternity care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Hospital Services									
Inpatient care/surgery	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Skilled nursing facility care	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Additional Cost Tier									
Moda Plans Only: $100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET), spinal injections, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	$100 copay + 25% after deductible	$100 copay + 25% after deductible	$100 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25% after deductible	$500 copay + 25% after deductible	$500 copay + 50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible

Plans 5–7 – *continued*

No lifetime maximum on any medical plans.	Medical Plan 5 Connexus Network			Medical Plan 6 Connexus Network *HDHP HSA Compliant*			Medical Plan 7 Connexus Network *HDHP HSA Compliant*		
Plan Year Costs - Deductibles and copayments apply to the annual out-of-pocket maximum.	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[5] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[5] Member Pays	Any Out-of-Network Services Member Pays	In-Network Coordinated Care[5] Member Pays	In-Network Non-Coordinated Care[5] Member Pays	Any Out-of-Network Services Member Pays
Emergency Services									
Emergency room (copay waived if admitted)	$100 copay + 25% after deductible			20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Ambulance	25% after deductible			20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Other Covered Services									
Hearing aids: $4,000 maximum benefit every 48 months for adults, see handbook for State mandated benefit for children	10% after deductible	10% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Durable medical equipment (DME)	25% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible	20% after deductible	25% after deductible	50% after deductible
Pharmacy Services									
Out-of-pocket (OOP) maximum	Rx applies toward Max Cost Share			Rx applies toward plan OOP max			Rx applies toward plan OOP max		
Retail									
Value	$4 per 31-day supply			$4[1] per 31-day supply			$4[1] per 31-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply		See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Preferred brand	25% up to $75 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[5]	50% up to $175 per 31-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Mail									
Value	$8 per 90-day supply			$8[1] per 90-day supply			$8[1] per 90-day supply		
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply		See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Preferred brand	25% up to $150 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Non-preferred brand[4]	50% up to $450 per 90-day supply			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Specialty									
Generic (Moda Plans only)	$12 per 31-day supply or $36 per 90-day supply when allowed			20% after deductible	25% after deductible		20% after deductible	25% after deductible	
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook	20% after deductible	25% after deductible	See Plan Handbook
Non-preferred brand[4]	50% up to $500 per 31-day supply or $1,000 for 90-day supply when allowed.			20% after deductible	25% after deductible		20% after deductible	25% after deductible	

NA – Not applicable

After ded – After deductible

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply to single coverage only. Family deductible and family out of pocket maximum apply when two or more individuals are covered on the plan. This plan also includes an embedded per member out-of-pocket max, which is set at the individual OOP amount. Under this plan, deductible must be met before benefits will be paid (except where 1 indicates deductible waived).

3 For Moda plans, OOP maximum includes medical deductible, medical copayments, coinsurance, ACT copayments and pharmacy expenses.

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

5 To receive in-network coordinated care benefits, you must choose and use a PCP 360.

6 To receive in-network non-coordinated benefits, you must use Connexus providers.

7 For Kaiser plans, acupuncture care is limited to 12 visits per year and chiropractic is limited to 20 visits per year. For Moda plans, acupuncture care and spinal manipulation is limited to 12 combined visits per year. Office visits for acupuncture and chiropractors are subject to the specialist copay and coinsurances and not limited to the 12 combined visits per plan year.

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Summary of Dental Benefits 2022-23 Plan Year

Please see Plan Handbook for details.

Dental	Premier Plan 1[1]	Premier Plan 5[1]	Premier Plan 6	Exclusive PPO – Incentive Plan[1]	Exclusive PPO Plan Ω	Kaiser Dental Plan	Willamette Dental Plan
Network	Delta Dental Premier	Delta Dental Premier	Delta Dental Premier	Incentive Plan would say: Limited Network Plan - Delta Dental PPO[2]	Incentive Plan would say: Limited Network Plan - Delta Dental PPO[2]	Limited Network Plan - Kaiser Permanente Facilities[2]	Limited Network Plan - Willamette Dental Group Facilities[2]
Dental Office Visit Copayment	NA	NA	NA	NA	NA	$20[3]	$20[3]
Benefit Maximum	$2,200	$1,700	$1,200	$2,300	$1,500	$4,000[4]	NA
Deductible	$50	$50	$50	$50	$50	NA	NA
Preventive & Diagnostic Services – Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans[6]							
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	70% + 10% each Plan Year[6]	100%	100%	100%	Preventative services will not accrue towards the plan benefit maximum. Same as Moda.	100%
Restorative Services							
Routine fillings, inlays and stainless steel crowns	70% + 10%[1] each Plan Year	70% + 10%[1] each Plan Year	80%[1]	70% + 10%[1] each Plan Year	90%[1]	100%[3]	100%[3]
Simple Extraction							
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100%[3]	100%[3]
Oral Surgery							
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$50 Copay[3]	$50 Copay[3]
Periodontics							
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	100%[3]	100%[3]
Endodontics							
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	70% + 10% each Plan Year	90%	$50 Copay[3]	$50 Copay[3]
Major Restorative Services							
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	70% + 10% each Plan Year	80%	$250 Copay[3]	$250 Copay[3]
Implants	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	50%[3] (limit of 4 per lifetime)	Implant surgery up to $1,500 calendar year maximum
Other covered services							
Occlusal guards (night guards)	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	50% up to $250 max, once every 5 years	90%, once every 5 years	100% once every 2 years
Athletic mouth guards	50%	50%	50%	50%	50%	90%	$100 Copay[3]
Nitrous Oxide	50%	50%	50%	50%	50%	$0 copay (Age 12 & Under) $25 copay (Age 13 & Up)	$15 Copay[3]
Fixed and Removable Prosthetic Services							
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	$100 Copay[3]	$100 Copay[3]
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	70% + 10% each Plan Year	80%	$250 Copay[3]	$250 Copay[3]
Orthodontics							
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NO ORTHO COVERAGE on this plan	80% to $1,800 lifetime max	80% to $1,800 lifetime max	$2,500 Copay + $20 per visit	$2,500 Copay + $20 per visit

Under Delta Dental Plans 1 and 5, and Exclusive PPO - Incentive Plan benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year.

2 Services performed by providers outside the limited network are not covered unless for a dental emergency.

3 Office visit copayment applies at each visit, in addition to any plan copayments for services.

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

5 Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit under the Willamette Dental Group plan.

6 Preventative services will not accrue towards the plan benefit maximum.

This document is for comparison purposes only and is not intended to fully describe the benefits of each plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

Summary of Vision Benefits 2022-23 Plan Year

Dental	Kaiser Vision Plan[1] Kaiser Permanente Facilities	Moda Opal Plan May use any licensed provider	Moda Pearl Plan May use any licensed provider	Moda Quartz Plan May use any licensed provider	VSP Choice Plus Plan VSP Choice Network	VSP Choice Plan VSP Choice Network
Plan Year Maximum	$250	$600*	$400	$250	N/A	N/A
Routine Eye Exam:						
Benefit:	Covered under the Kaiser Permanente medical plan (does not apply to the vision plan year maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	Plan pays 100% after $10 copay
Frequency:	As needed	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Lenses:						
Basic lens benefit:	**Under age 19:** No charge for one pair of standard frames and lenses or contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Polycarbonate lenses, scratch resistant and UV coatings covered in full	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. Scratch resistant and UV coatings covered in full
Lens enhancements:					$0 copay for standard progressive lenses $15 copay for anti-reflective coating or premium/custom progressive lenses	$0 copay for standard progressive lenses Discounts for polycarbonate, anti-reflective coating or premium/custom progressive lenses
Frequency:	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Frames / Contacts:						
Benefit:	**Under age 19:** No charge for one pair of standard frames and lenses or contacts **Age 19+:** Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Covered in full up to retail allowance of **$300;** 20% off amount over retail allowance for frames	Covered in full up to retail allowance of **$150;** 20% off amount over retail allowance for frames
Frequency:	**Frames or Contacts:** Once per Plan Year	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **or Contacts:** Up to the plan maximum	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **or Contacts:** Up to the plan maximum	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **or Contacts:** Up to the plan maximum	**Frames or Contacts:** Once every 12 months	**Frames or Contacts:** Once every 12 months
Non-Prescription Benefit						
Benefit:	$100 of your annual $250 allowance may be used toward non-prescription sunglasses and/or digital eye strain glasses.	Not Covered	Not Covered	Not Covered	OEBB members can use their frame allowance to pay for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts.	OEBB members can use their frame allowance to pay for ready-made non-prescription sunglasses or ready-made non-prescription blue light filtering glasses, in lieu of prescription glasses or contacts.

[1] Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

This document is for comparison purposes only and is not intended to fully describe the benefits of each Plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

You can get this document in other languages, large print, braille or a format you prefer. Contact OEBB Member Services at 888-4My-OEBB (888-469-6322) or email oebb.benefits@state.or.us. We accept all relay calls or you can dial 711.

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