Plan Design & Expenditure Committee

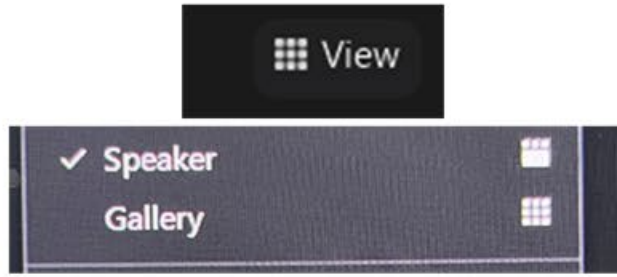
Thursday, December 5th, 2024
1 – 4pm

Universal Health Plan
Governance Board

Welcome Remarks – Chair Diaz

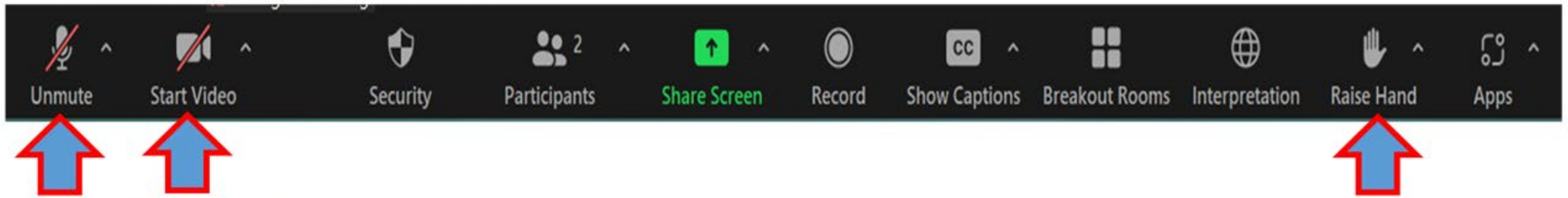
- Tech Check
- Roll Call Introductions
- Agenda Review

Tech Check / Zoom Navigation



- **In the upper right corner:**
  - Select “View”
    - Choose between Gallery or Speaker view at any time during meeting
      - Gallery – shows all participants at the same time
      - Speaker - shows active speaker

- **At the bottom of screen:**



  - Please stay muted when not speaking
  - Please start video, if you are able
    - Members of the public are invited to attend, but they are unable to connect audio or video. By having committee members on camera, it makes it easy to distinguish who committee members are
  - There is no meeting chat. Please select “Raise Hand” when you would like to speak

Agenda Review

- Introductions
- Update on Board Policy Changes
- Overview of Benefits
- Small Group Discussions of Benefits
- Next Committee Focus: Eligibility
- Committee Member Reflections / Feedback
- Public Comment

Update on Board Policy Changes

Committee Staff

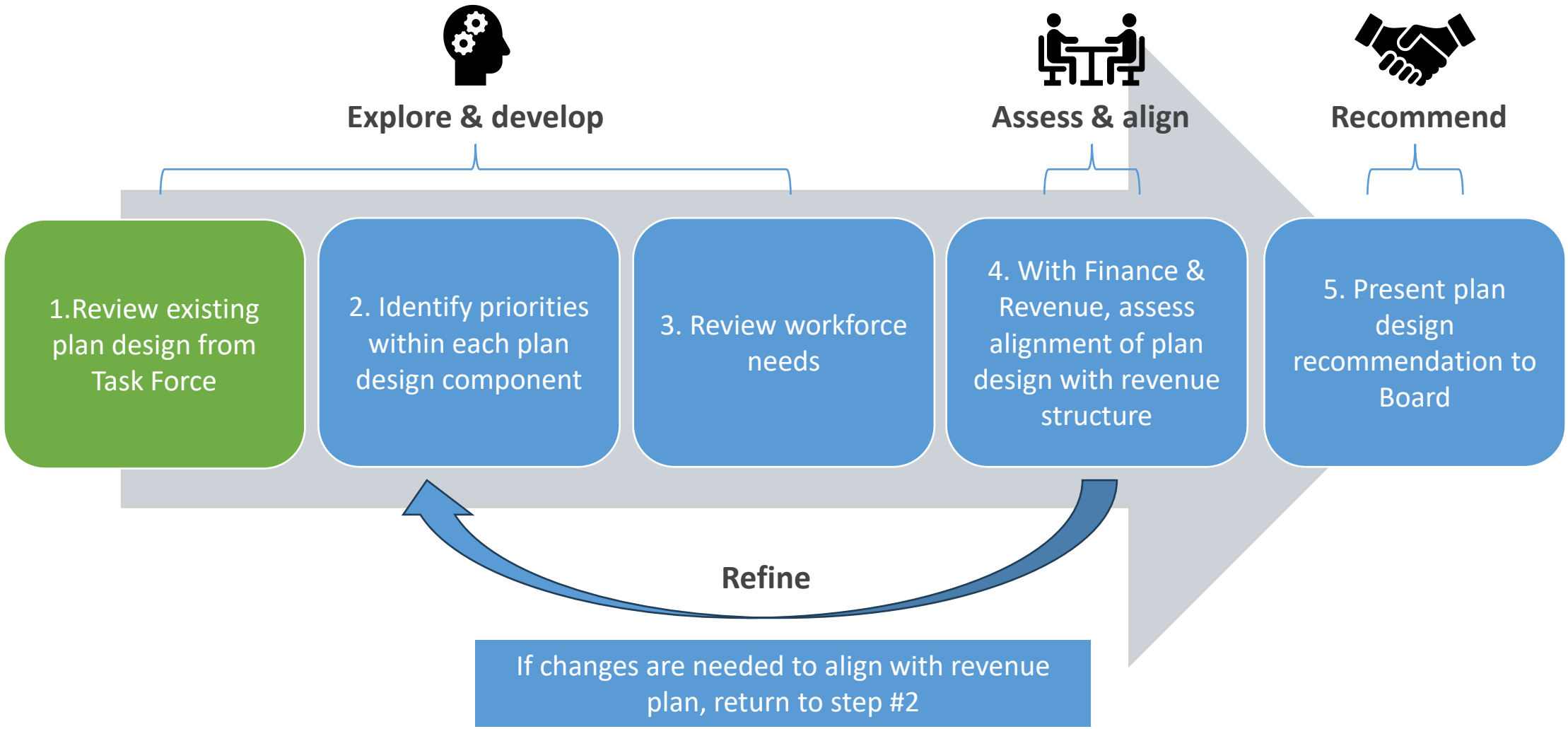
New Policy – Adopted Nov 21st

- The board and its committees hold a firm commitment to transparency and the preservation of public trust. The board also recognizes the importance to have some limited communication among members to facilitate the board's work and accomplish its deliverables as laid out in Senate Bill 1089. Communication among less than a quorum of the board is permitted, as long as it does not create a serial communication creating a quorum.
- A quorum of the members of the board will not, outside of meetings conducted in compliance with the Public Meetings Law, use a series of communications of any kind, directly or through intermediaries, for the purpose of deliberating, making recommendations, or deciding on any matter that is within the jurisdiction of the board. All board and committee members are encouraged to take the training offered by the Oregon Government Ethics Commission (OGEC) and to submit inquires to OGEC if unsure about compliance.

Review Committee Tasks & Timelines

Committee Staff

Universal Health Plan Design Components



Should the committee recommend changes to the Universal Health Plan Preliminary Structure with regard to benefits? If so, what changes?

The available levers to influence the cost and breadth of coverage through benefit design:

Reduce or change the covered benefits

Introduce cost sharing (copays, coinsurance and/or deductibles)

Restrict provider networks

Impose utilization management (prior authorization, visit limits, etc)

Plan Design & Expenditure Committee Workplan
2024-2025

November:
Committee
Orientation

December:
Review
Benefits

January:
Eligibility

February:
Provider
Reimbursement

March:
Cost
Containment
& Cost Sharing

April:
Workforce

May- June:

July:
Finance &
Revenue

Overview of Benefits

Anya Rader Wallack, Health Management Associates

Oregon Health Care: Benefits Overview

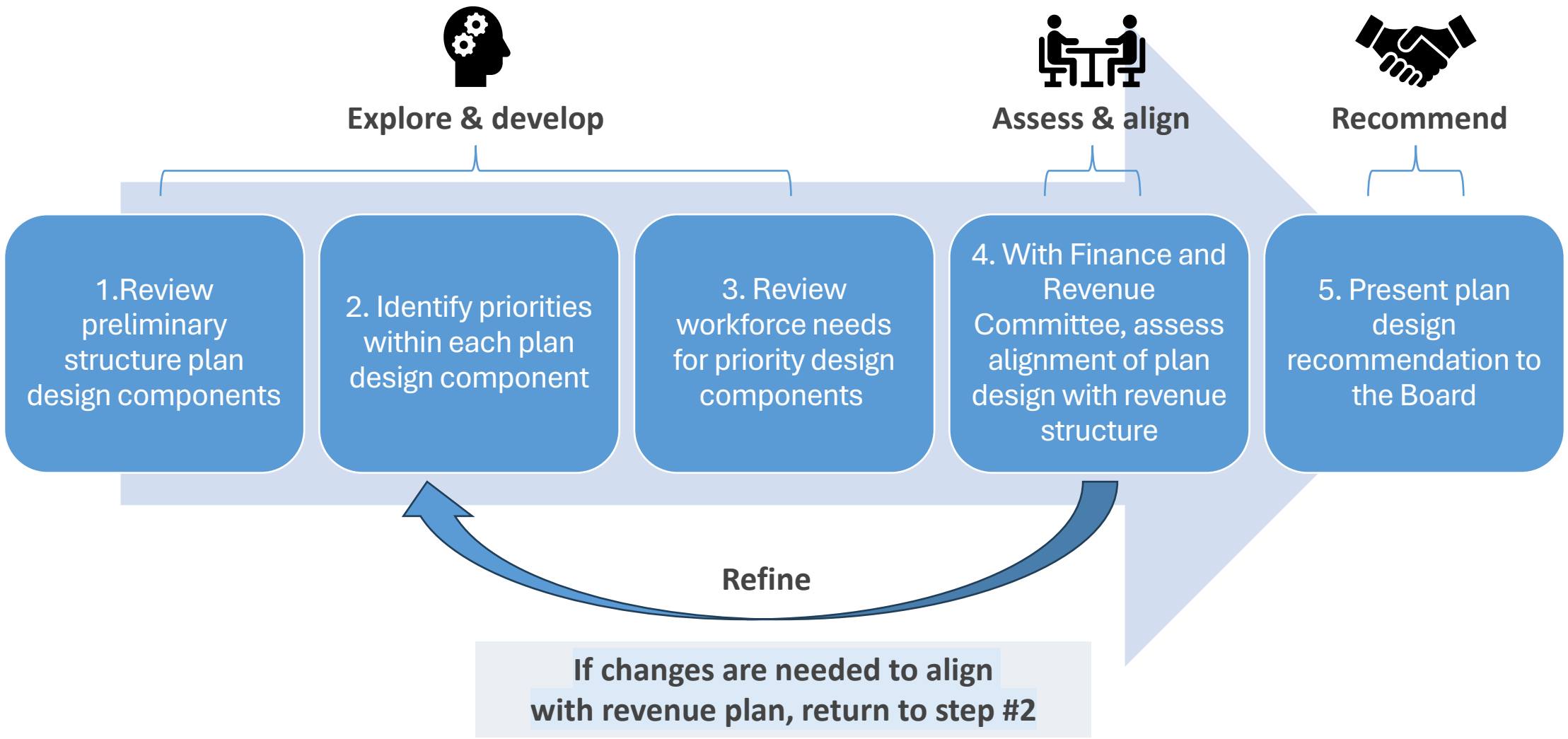
Plan Design & Expenditures Committee
December 5th, 2024

Universal Health Plan Governance Board

Recap: deliverables expected from this committee

- Final recommendations on Universal Health Plan benefits, eligibility, provider reimbursements, workforce and cost containment strategies
- Financial modeling and actuarial analysis of various plan options that include expenditures and savings

Building the Universal Health Plan Design Components



Three tools to reduce or contain the cost of coverage

- Covered people
- Covered benefits
- Provider payment

Three tools to reduce the cost of coverage: examples

- Covered population
  - Medicaid uses this (example: expand Medicaid or not?)
- Covered benefits and cost-sharing
  - Medicare uses this (example: cover prescription drugs or not?)
  - Commercial plans use this (example: tiered copays for drugs)
- Provider payment
  - Both Medicaid and Medicare use this (example: DRG payments for hospital care)

Today's focus: covered benefits

- What services are covered?
- What cost sharing is required of the people who are covered?
- How is utilization of services managed through limits on services or visits or prior authorization requirements?
- Is utilization of services managed through a restricted provider network?

Benefits recommended by the Joint Task Force on Universal Health Care (2022)

Plan recommendation: The Universal Health Plan is based on the benefits public employees get now. The benefits will be more generous than most current plans. The Plan will cover services offered now to people on Medicaid, Medicare, or Affordable Care Act plans. The Plan will increase funding for behavioral health services and benefits that exist today. This is because a portion of the money saved will be put towards the behavioral health system.

Benefits recommended by the Joint Task Force on Universal Health Care (2022), continued

The benefits covered by the Universal Health Plan will be equitable, comprehensive, inclusive, and will meet the needs of all people of Oregon. While the Task Force considered several options, it found that plans offered by Oregon's Public Employees' Benefit Board (PEBB) cover more benefit categories than the ACA's essential benefits (e.g., complementary care, adult dental, adult vision) or the Oregon Health Plan (e.g., infertility services). For this reason, the Task Force recommends PEBB plans as the basis for its benefits package.

Benefits recommended by the Joint Task Force on Universal Health Care (2022), continued

Plan recommendation: People who qualify for long-term care will continue to receive benefits and services through Medicaid and the Oregon Department of Human Services (DHS). The Plan will also cover some skilled nursing and home health care. The Plan's governance board will work with DHS to study how the Plan might further integrate long-term care in the future.

Essential Health Benefits

The Affordable Care Act requires non-grandfathered health insurance coverage in the individual and small group markets to cover at least the following benefit categories:

1. ambulatory patient services;
2. emergency services;
3. hospitalization;
4. maternity and newborn care;
5. mental health and substance use disorder services including behavioral health treatment;
6. prescription drugs;
7. rehabilitative and habilitative services and devices;
8. laboratory services;
9. preventive and wellness services and chronic disease management; and
10. pediatric services, including oral and vision care.

Background on benefit comparisons

Actuarial value

- The percentage of total average costs for covered benefits that a plan will cover
- Actual costs will vary
- Covered benefits will vary
- The price of a plan reflects the balance between costs covered by the insurance and costs covered out of pocket

The concept of actuarial value

$$AV = \text{Cost of covered benefits} \times \frac{\text{Cost sharing}}{\text{Premium}}$$

The reality of actuarial value (federal AV calculator)

User Inputs for Plan Parameters

Use Integrated Medical and Drug Deductible?	☑
Apply Inpatient Copay per Day?	☐
Apply Skilled Nursing Facility Copay per Day?	☐
Use Separate OOP Maximum for Medical and Drug Spending?	☐
Indicate if Plan Meets CSR Standard?	☐
Desired Metal Tier	

HSA/HRA Options		Narrow Network Options	
HSA/HRA Employer Contribution?	☐	Blended Network/POS Plan?	☐
Annual Contribution Amount:		1st Tier Utilization: 2nd Tier Utilization:	

	Tier 1 Plan Benefit Design			Tier 2 Plan Benefit Design		
	Medical	Drug	Combined	Medical	Drug	Combined
Deductible ($)						
Coinsurance (%, Insurer's Cost Share)						
OOP Maximum ($)						
OOP Maximum if Separate ($)						

Click Here for Important Instructions

Type of Benefit	Tier 1 Subject to Deductible?	Tier 1 Subject to Coinsurance?	Tier 1 Coinsurance, if different	Tier 1 Copay, if separate	Tier 2 Subject to Deductible?	Tier 2 Subject to Coinsurance?	Tier 2 Coinsurance, if different	Tier 2 Copay, if separate
Medical	☑ All	☑ All			☑ All	☑ All		
Emergency Room Services	☑	☑			☑	☑		
All Inpatient Hospital Services (inc. MHSA)	☑	☑			☑	☑		
Primary Care Visit to Treat an Injury or Illness (exc. Preventive, and X-rays)	☑	☑			☑	☑		
Specialist Visit	☑	☑			☑	☑		
Mental/Behavioral Health and Substance Abuse Disorder Outpatient Services	☑	☑			☑	☑		
Imaging (CT/PET Scans, MRIs)	☑	☑			☑	☑		
Rehabilitative Speech Therapy	☑	☑			☑	☑		
Rehabilitative Occupational and Rehabilitative Physical Therapy	☑	☑			☑	☑		
Preventive Care/Screening/Immunization	☐	☐	100%	$0.00	☐	☐	100%	$0.00
Laboratory Outpatient and Professional Services	☑	☑			☑	☑		
X-rays and Diagnostic Imaging	☑	☑			☑	☑		
Skilled Nursing Facility	☑	☑			☑	☑		
Outpatient Facility Fee (e.g., Ambulatory Surgery Center)	☑	☑			☑	☑		
Outpatient Surgery Physician/Surgical Services	☑	☑			☑	☑		
Drugs	☑ All	☑ All			☑ All	☑ All		
Generics	☑	☑			☑	☑		
Preferred Brand Drugs	☑	☑			☑	☑		
Non-Preferred Brand Drugs	☑	☑			☑	☑		
Specialty Drugs (i.e. high-cost)	☑	☑			☑	☑		

Options for Additional Benefit Design Limits:

Set a Maximum on Specialty Rx Coinsurance Payments?	☐
Specialty Rx Coinsurance Maximum:	
Set a Maximum Number of Days for Charging an IP Copay?	☐
# Days (1-10):	
Begin Primary Care Cost-Sharing After a Set Number of Visits?	☐
# Visits (1-10):	
Begin Primary Care Deductible/Coinsurance After a Set Number of Copays?	☐
# Copays (1-10):	

Recap

- Plans trade off coverage for cost sharing/utilization management
- Small and non-group plans must cover the essential health benefits
- The Task Force chose PEBB, which is a relatively comprehensive/generous plan

Comparison of benefits: PEBB, OEBB, Medicare and Medicaid

Public Employees' Benefit Board (PEBB)

PEBB

https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le-698450_2%20mail.pdf

What do I contribute in monthly premiums?

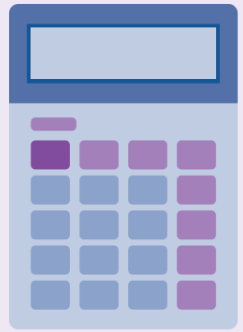
Your employer pays a large portion of the monthly premium costs for your core benefits (medical, dental, vision). Many employees only pay 1% to 5% of those monthly costs, depending on::

- your agency or university employer
- the plan you choose
- where you live
- your work status (full-time or part-time)

Note: Part-time employees may pay more depending on hours worked. Contact your payroll office for a more accurate estimate.

Use the Premium Estimator Tool to see what you may pay each month.

pebbpremiumestimator.com



Full-time and part-time medical plans

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Full-time and part-time		Full-time and part-time		Full-time and part-time		Full-time and part-time	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Standard deductible[2]	$250/individual, $750/family	$0	$250/individual, $750/family	$500/individual, $1,500/family	$250/individual $750/family	$500/individual, $1,500/family	$250/individual $750/family	$500/individual, $1,500/family
Additional non-HEM participant deductible applies to all services unless otherwise noted	$100/individual, $300/family	$100/individual, $300/family	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket max (some deductibles, copays, services don't apply)	$1,500/individual, $4,500/family	$600/individual, $1,200/family	$1,500/individual, $4,500/family	$4,000/individual, $12,000/family	$1,900/individual, $5,700 family	$4,800/individual, $14,400/family	$1,500/individual, $4,500/family	$4,000/individual, $12,000/family
Primary care visit	$5, deductible waived	$5	$10[13] first four visits, deductible waived	30%	15% or 10%[3] first four visits, deductible waived	30%	$10 first four visits, deductible waived	30%

PEBB

Full-time and part-time medical plans – continued

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Full-time and part-time		Full-time and part-time		Full-time and part-time		Full-time and part-time	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Chronic care visit[4]	$5, deductible waived	$5	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Specialty care visit	$5 with referral, deductible waived	$5 with referral	$10	30%	15%	30%	$10	30%
Outpatient mental health care	$5, deductible waived	$5	$10, deductible waived	30%	15%, deductible waived	30%	$10 deductible waived	30%
Substance Use Disorder Treatment	$0, deductible waived	$0	$0, deductible waived	30% outpatient, 40% inpatient	0%, deductible waived	30%	$0, deductible waived	30%
Maternity prenatal and postnatal services	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived prenatal, 15% postnatal	30%	$0, deductible waived	30%
Maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	$0, deductible waived	30%	15%	30%	$0, deductible waived	30%
Delivery facility charges	Included with maternity services and professional delivery	Included with maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges
Doula services	$0, deductible waived; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/ pregnancy, plus 1 labor and delivery visit
Fertility services	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook

PEBB

Full-time and part-time medical plans – continued

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Work status	Full-time and part-time		Full-time and part-time		Full-time and part-time		Full-time and part-time	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Preventive	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Lab and X-ray	$15, deductible waived	$0	$0, deductible waived	30%	15%	30%	$0, deductible waived	30%
Inpatient hospital per admission[11]	$50/day up to $250 max	$50/day, up to $250 max	$50/day, up to $250 max	$500 + 40%	15%	$500 + 40%	$50/day, up to $250 max	$500 + 40%
Outpatient surgery in a hospital setting[11]	15%	$5	$10	$100 + 40%	15%	$100 + 40%	$10	$100 + 40%
Urgent care	$25, deductible waived	$5	$25	$25	15%	15%	$25	$25
Emergency department[5]	$150	$150	$150	$150	$150 + 15%	$150 + 15%	$150	$150
Durable medical equipment	15%, deductible waived	$0	15%	30%	15%	30%	15%	30%
Insulin, diabetic supplies	$0, deductible waved	$0	$0, deductible waived[14]	$0, deductible waived[14]	0%, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived
Additional cost tier ($100[6] copay/$500[7] copay – does not apply to Kaiser)	$100, deductible waived for specialty scans and sleep studies	$100 for specialty scans and sleep studies only	$100[6]/$500[7]	$100[6] + 30%/ $500[7] + 30%	$100[6] + 15%/ $500[7] + 15%	$100[6] + 30%/ $500[7] + 30%	$100[6]/$500[7]	$100[6] + 30%/ $500[7] + 30%
Spinal manipulation and acupuncture[11]	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	30%; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	15%, up to 60 services/year max combined. Not applied to out-of-pocket max	30%, up to 60 services/year max combined. Not applied to out-of-pocket max	$10; Spinal manipulation: 20 visit annual limit. Acupuncture: 12 visit annual limit. Not applied to out-of-pocket max	30%; Spinal manipulation: 20 visit annual limit. Acupuncture: 12 visit annual limit. Not applied to out-of-pocket max

PEBB

Full-time and part-time medical plans – continued

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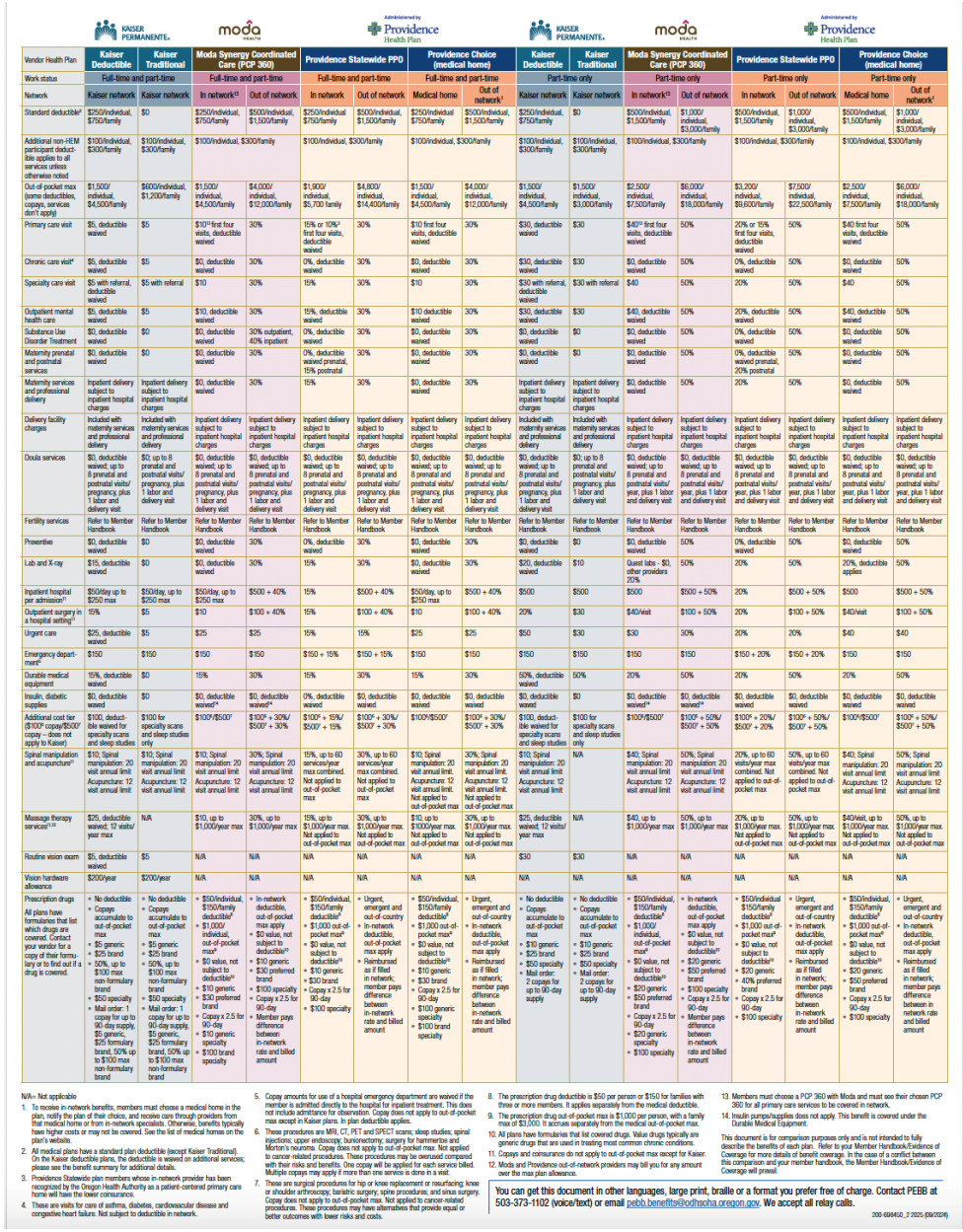
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Massage therapy services[11,12]	$25, deductible waived; 12 visits/ year max	N/A	$10, up to $1,000/ year max	30%, up to $1,000/year max	15%, up to $1,000/year max. Not applied to out-of-pocket max	30%, up to $1,000/year max. Not applied to out-of-pocket max	$10, up to $1000/ year max. Not applied to out-of-pocket max	30%, up to $1,000/year max. Not applied to out-of-pocket max
Routine vision exam	$5, deductible waived	$5	N/A	N/A	N/A	N/A	N/A	N/A
Vision hardware allowance	$200/year	$200/year	N/A	N/A	N/A	N/A	N/A	N/A
Prescription drugs All plans have formularies that list which drugs are covered. Contact your vendor for a copy of their formulary or to find out if a drug is covered.	•No deductible •Copays accumulate to out-of-pocket max •$5 generic •$25 brand •50%, up to $100 max non-formulary brand •$50 specialty •Mail order: 1 copay for up to 90-day supply, $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	•No deductible •Copays accumulate to out-of-pocket max •$5 generic •$25 brand •50%, up to $100 max non-formulary brand •$50 specialty •Mail order: 1 copay for up to 90-day supply, $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	•$50/individual, $150/family deductible[8] •$1,000/individual, out-of-pocket max[9] •$0 value, not subject to deductible[10] •$10 generic •$30 preferred brand •Copay x 2.5 for 90-day •$10 generic specialty •$100 brand specialty	•In-network deductible, out-of-pocket max apply •$0 value, not subject to deductible[10] •$10 generic •$30 preferred brand •$100 specialty •Copay x 2.5 for 90-day •Member pays difference between in-network rate and billed amount	•$50/individual, $150/family deductible[8] •$1,000 out-of-pocket max[9] •$0 value, not subject to deductible[10] •$10 generic • $30 brand • Copay x 2.5 for 90-day •$100 specialty	•Urgent, emergent and out-of-country •In-network deductible, out-of-pocket max apply •Reimbursed as if filled in network; member pays difference between in-network rate and billed amount	•$50/individual, $150/family deductible[8] •$1,000 out-of-pocket max[9] •$0 value, not subject to deductible[10] •$10 generic •$30 brand •Copay x 2.5 for 90-day •$100 generic specialty •$100 brand specialty	•Urgent, emergent and out-of-country •In-network deductible, out-of-pocket max apply •Reimbursed as if filled in network; member pays difference between in-network rate and billed amount

PEBB



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Standard deductible[2]	$250/individual, $750/family	$0	$250/individual, $750/family	$500/individual, $1,500/family	$250/individual $750/family	$500/individual, $1,500/family	$250/individual $750/family	$500/individual, $1,500/family
Additional non-HEM participant deductible applies to all services unless otherwise noted	$100/individual, $300/family	$100/individual, $300/family	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket max (some deductibles, copays, services don't apply)	$1,500/individual, $4,500/family	$600/individual, $1,200/family	$1,500/individual, $4,500/family	$4,000/individual, $12,000/family	$1,900/individual, $5,700 family	$4,800/individual, $14,400/family	$1,500/individual, $4,500/family	$4,000/individual, $12,000/family
Primary care visit	$5, deductible waived	$5	$10[12] first four visits, deductible waived	30%	15% or 10%[3] first four visits, deductible waived	30%	$10 first four visits, deductible waived	30%
Chronic care visit[4]	$5, deductible waived	$5	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Specialty care visit	$5 with referral, deductible waived	$5 with referral	$10	30%	15%	30%	$10	30%
Outpatient mental health care	$5, deductible waived	$5	$10, deductible waived	30%	15%, deductible waived	30%	$10 deductible waived	30%
Substance Use Disorder Treatment	$0, deductible waived	$0	$0, deductible waived	30% outpatient, 40% inpatient	0%, deductible waived	30%	$0, deductible waived	30%
Maternity prenatal and postnatal services	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived prenatal, 15% postnatal	30%	$0, deductible waived	30%
Maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	$0, deductible waived	30%	15%	30%	$0, deductible waived	30%
Delivery facility charges	Included with maternity services and professional delivery	Included with maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges
Doula services	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit
Fertility services	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook
Preventive	$0, deductible waived	$0	$0, deductible waived	30%	0%, deductible waived	30%	$0, deductible waived	30%
Lab and X-ray	$15, deductible waived	$0	$0, deductible waived	30%	15%	30%	$0, deductible waived	30%
Inpatient hospital per admission[11]	$50/day up to $250 max	$50/day, up to $250 max	$50/day, up to $250 max	$500 + 40%	15%	$500 + 40%	$50/day, up to $250 max	$500 + 40%
Outpatient surgery in a hospital setting[5]	15%	$5	$10	$100 + 40%	15%	$100 + 40%	$10	$100 + 40%
Urgent care	$25, deductible waived	$5	$25	$25	15%	15%	$25	$25
Emergency department[6]	$150	$150	$150	$150	$150 + 15%	$150 + 15%	$150	$150
Durable medical equipment	15%, deductible waived	$0	15%	30%	15%	30%	15%	30%
Insulin, diabetic supplies	$0, deductible waived	$0	$0, deductible waived[14]	$0, deductible waived[14]	0%, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived
Additional cost tier ($100[9] copay/$500[7] copay – does not apply to Kaiser)	$100, deductible waived for specialty scans and sleep studies	$100 for specialty scans and sleep studies only	$100[9]/$500[7]	$100[9] + 30%/$500[7] + 30%	$100[9] + 15%/$500[7] + 15%	$100[9] + 30%/$500[7] + 30%	$100[9]/$500[7]	$100[9] + 30%/$500[7] + 30%
Spinal manipulation and acupuncture[10]	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	30%; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	15%, up to 60 services/year max combined. Not applied to out-of-pocket max	30%, up to 60 services/year max combined. Not applied to out-of-pocket max	$10; Spinal manipulation: 20 visit annual limit. Acupuncture: 12 visit annual limit. Not applied to out-of-pocket max	30%; Spinal manipulation: 20 visit annual limit. Acupuncture: 12 visit annual limit. Not applied to out-of-pocket max
Massage therapy services[7,8]	$25, deductible waived; 12 visits/year max	N/A	$10, up to $1,000/year max	30%, up to $1,000/year max	15%, up to $1,000/year max. Not applied to out-of-pocket max	30%, up to $1,000/year max. Not applied to out-of-pocket max	$10; up to $1000/year max. Not applied to out-of-pocket max	30%, up to $1,000/year max. Not applied to out-of-pocket max
Routine vision exam	$5, deductible waived	$5	N/A	N/A	N/A	N/A	N/A	N/A
Vision hardware allowance	$200/year	$200/year	N/A	N/A	N/A	N/A	N/A	N/A
Prescription drugs All plans have formularies that list which drugs are covered. Contact your vendor for a copy of their formulary or to find out if a drug is covered.	• No deductible • Copays accumulate to out-of-pocket max • $5 generic • $25 brand • 50%, up to $100 max non-formulary brand • $50 specialty • Mail order: 1 copay for up to 90-day supply, $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	• No deductible • Copays accumulate to out-of-pocket max • $5 generic • $25 brand • 50%, up to $100 max non-formulary brand • $50 specialty • Mail order: 1 copay for up to 90-day supply, $5 generic, $25 formulary brand, 50% up to $100 max non-formulary brand	• $50/individual, $150/family deductible[9] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $0 value, not subject to deductible[10] • $10 generic • $30 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• In-network deductible, out-of-pocket max apply • $0 value, not subject to deductible[10] • $10 generic • $30 preferred brand • $100 specialty • Copay x 2.5 for 90-day • Member pays difference between in-network rate and billed amount	• $50/individual, $150/family deductible[9] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in-network rate and billed amount	• $50/individual, $150/family deductible[9] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $10 generic • $30 brand • Copay x 2.5 for 90-day • $100 generic specialty • $100 brand specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in-network rate and billed amount

Vendor Health Plan	Kaiser Deductible	Kaiser Traditional	Moda Synergy Coordinated Care (PCP 360)		Providence Statewide PPO		Providence Choice (medical home)	
Work status	Part-time only		Part-time only		Part-time only		Part-time only	
Network	Kaiser network	Kaiser network	In network[13]	Out of network	In network	Out of network	Medical home	Out of network[1]
Standard deductible[2]	$250/individual, $750/family	$0	$500/individual, $1,500/family	$1,000/individual, $3,000/family	$500/individual, $1,500/family	$1,000/individual, $3,000/family	$500/individual, $1,500/family	$1,000/individual, $3,000/family
Additional non-HEM participant deductible applies to all services unless otherwise noted	$100/individual, $300/family	$100/individual, $300/family	$100/individual, $300/family		$100/individual, $300/family		$100/individual, $300/family	
Out-of-pocket max (some deductibles, copays, services don't apply)	$1,500/individual, $4,500/family	$1,500/individual, $3,000/family	$2,500/individual, $7,500/family	$6,000/individual, $18,000/family	$3,200/individual, $9,600/family	$7,500/individual, $22,500/family	$2,500/individual, $7,500/family	$6,000/individual, $18,000/family
Primary care visit	$30, deductible waived	$30	$40[12] first four visits, deductible waived	50%	20% or 15% first four visits, deductible waived	50%	$40 first four visits, deductible waived	50%
Chronic care visit[4]	$30, deductible waived	$30	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Specialty care visit	$30 with referral, deductible waived	$30 with referral	$40	50%	20%	50%	$40	50%
Outpatient mental health care	$30, deductible waived	$30	$40, deductible waived	50%	20%, deductible waived	50%	$40, deductible waived	50%
Substance Use Disorder Treatment	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Maternity prenatal and postnatal services	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived prenatal, 20% postnatal	50%	$0, deductible waived	50%
Maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	$0, deductible waived	50%	20%	50%	$0, deductible waived	50%
Delivery facility charges	Included with maternity services and professional delivery	Included with maternity services and professional delivery	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges	Inpatient delivery subject to inpatient hospital charges
Doula services	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit	$0, deductible waived; up to 8 prenatal and postnatal visits/pregnancy, plus 1 labor and delivery visit
Fertility services	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook	Refer to Member Handbook
Preventive	$0, deductible waived	$0	$0, deductible waived	50%	0%, deductible waived	50%	$0, deductible waived	50%
Lab and X-ray	$20, deductible waived	$10	Quest labs - $0, other providers 20%	50%	20%	50%	20%, deductible applies	50%
Inpatient hospital per admission[11]	$500	$500 + 50%	$500	$500 + 50%	20%	$500 + 50%	$500	$500 + 50%
Outpatient surgery in a hospital setting[5]	20%	$30	$40/visit	$100 + 50%	20%	$100 + 50%	$40/visit	$100 + 50%
Urgent care	$50	$30	$30	30%	20%	20%	$40	$40
Emergency department[6]	$150	$150	$150	$150	$150 + 20%	$150 + 20%	$150	$150
Durable medical equipment	50%, deductible waived	50%	20%	50%	20%	50%	20%	50%
Insulin, diabetic supplies	$0, deductible waived	$0	$0, deductible waived[14]	$0, deductible waived[14]	$0, deductible waived	$0, deductible waived	$0, deductible waived	$0, deductible waived
Additional cost tier ($100[9] copay/$500[7] copay – does not apply to Kaiser)	$100, deductible waived for specialty scans and sleep studies only	$100 for specialty scans and sleep studies only	$100[9]/$500[7]	$100[9] + 50%/$500[7] + 50%	$100[9] + 20%/$500[7] + 20%	$100[9] + 50%/$500[7] + 50%	$100[9]/$500[7]	$100[9] + 50%/$500[7] + 50%
Spinal manipulation and acupuncture[10]	$10; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	N/A	$40; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	50%; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	20%, up to 60 visits/year max combined. Not applied to out-of-pocket max	50%, up to 60 visits/year max combined. Not applied to out-of-pocket max	$40; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit	50%; Spinal manipulation: 20 visit annual limit Acupuncture: 12 visit annual limit
Massage therapy services[7,8]	$25, deductible waived; 12 visits/year max	N/A	$40, up to $1,000/year max	50%, up to $1,000/year max	30%, up to $1,000/year max. Not applied to out-of-pocket max	50%, up to $1,000/year max. Not applied to out-of-pocket max	$40/visit, up to $1,000/year max. Not applied to out-of-pocket max	50%, up to $1,000/year max. Not applied to out-of-pocket max
Routine vision exam	$30	$30	N/A	N/A	N/A	N/A	N/A	N/A
Vision hardware allowance	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Prescription drugs All plans have formularies that list which drugs are covered. Contact your vendor for a copy of their formulary or to find out if a drug is covered.	• No deductible • Copays accumulate to out-of-pocket max • $10 generic • $25 brand • $50 specialty • Mail order: 2 copays for up to 90-day supply	• No deductible • Copays accumulate to out-of-pocket max • $10 generic • $25 brand • $50 specialty • Mail order: 2 copays for up to 90-day supply	• $50/individual, $150/family deductible[9] • $1,000/individual, out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $250 generic specialty • $100 specialty	• In-network deductible, out-of-pocket max apply • $0 value, not subject to deductible[10] • $20 generic • $50 preferred brand • $100 specialty • Copay x 2.5 for 90-day • Member pays difference between in-network rate and billed amount	• $50/individual, $150/family deductible[9] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • 40% preferred brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in-network rate and billed amount	• $50/individual, $150/family deductible[9] • $1,000 out-of-pocket max[9] • $0 value, not subject to deductible[10] • $20 generic • $50 preferred brand • Copay x 2.5 for 90-day • $100 specialty	• Urgent, emergent and out-of-country • In-network deductible, out-of-pocket max apply • Reimbursed as if filled in network; member pays difference between in-network rate and billed amount

N/A= Not applicable

1. To receive in-network benefits, members must choose a medical home in the plan, notify the plan of their choice, and receive care through providers from that medical home or from in-network specialists. Otherwise, benefits typically have higher costs or may not be covered. See the list of medical homes on the plan's website.
2. All medical plans have a standard plan deductible (except Kaiser Traditional). On the Kaiser deductible plans, the deductible is waived on additional services; please see the benefit summary for additional details.
3. Providence Statewide plan members whose in-network provider has been recognized by the Oregon Health Authority as a patient-centered primary care home will have the lower coinsurance.
4. These are visits for care of asthma, diabetes, cardiovascular disease and congestive heart failure. Not subject to deductible in network.
5. Copay amounts for use of a hospital emergency department are waived if the member is admitted directly to the hospital for inpatient treatment. This does not include admittance for observation. Copay does not apply to out-of-pocket max except in Kaiser plans. In plan deductible applies.
6. These procedures are MRI, CT, PET and SPECT scans; sleep studies; spinal injections; upper endoscopy; bunionectomy; surgery for hammertoe and Morton's neuroma. Copay does not apply to out-of-pocket max. Not applied to cancer-related procedures. These procedures may be overused compared with their risks and benefits. One copay will be applied for each service billed. Multiple copays may apply if more than one service is done in a visit.
7. These are surgical procedures for hip or knee replacement or resurfacing; knee or shoulder arthroscopy; bariatric surgery; spine procedures; and sinus surgery. Copay does not apply to out-of-pocket max. Not applied to cancer-related procedures. These procedures may have alternatives that provide equal or better outcomes with lower risks and costs.
8. The prescription drug deductible is $50 per person or $150 for families with three or more members. It applies separately from the medical deductible.
9. The prescription drug out-of-pocket max is $1,000 per person, with a family max of $3,000. It accrues separately from the medical out-of-pocket max.
10. All plans have formularies that list covered drugs. Value drugs typically are generic drugs that are used in treating most common chronic conditions.
11. Copays and coinsurance do not apply to out-of-pocket max except for Kaiser.
12. Moda and Providence out-of-network providers may bill you for any amount over the max plan allowance.
13. Members must choose a PCP 360 with Moda and must see their chosen PCP 360 for all primary care services to be covered in network.
14. Insulin pumps/supplies does not apply. This benefit is covered under the Durable Medical Equipment.

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

You can get this document in other languages, large print, braille or a format you prefer free of charge. Contact PEBB at 503-373-1102 (voice/text) or email pebb.benefits@odhsoha.oregon.gov. We accept all relay calls.

200-699450_2 2025 (09/2024)

PEBB Summary

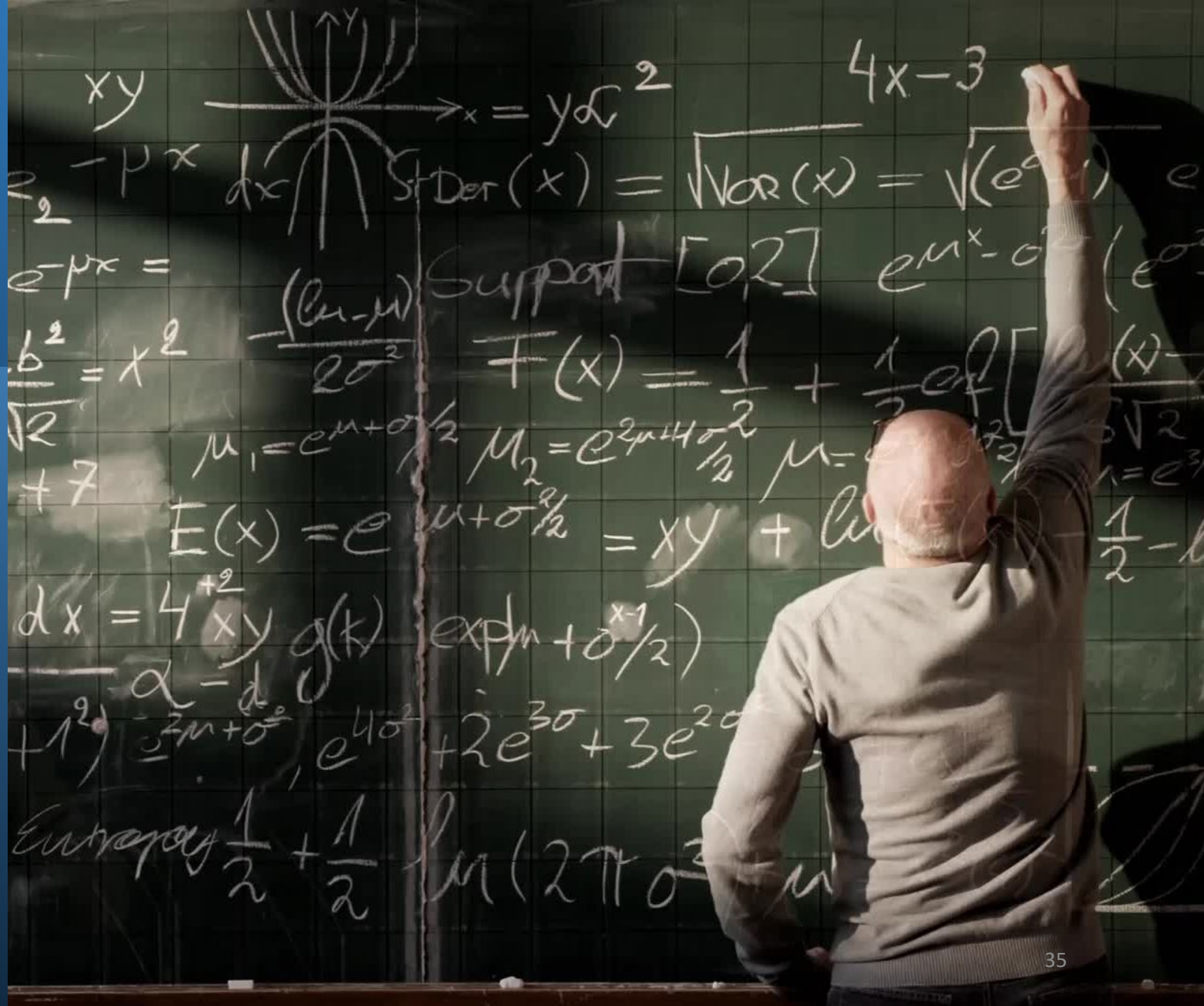
EXPANSIVE BENEFITS

MODERATE COST SHARING

INCREASED COST SHARING FOR OUT-OF-NETWORK SERVICES

TIERED PRESCRIPTION DRUG PLANS

Oregon Educators' Benefit Board (OEBB)



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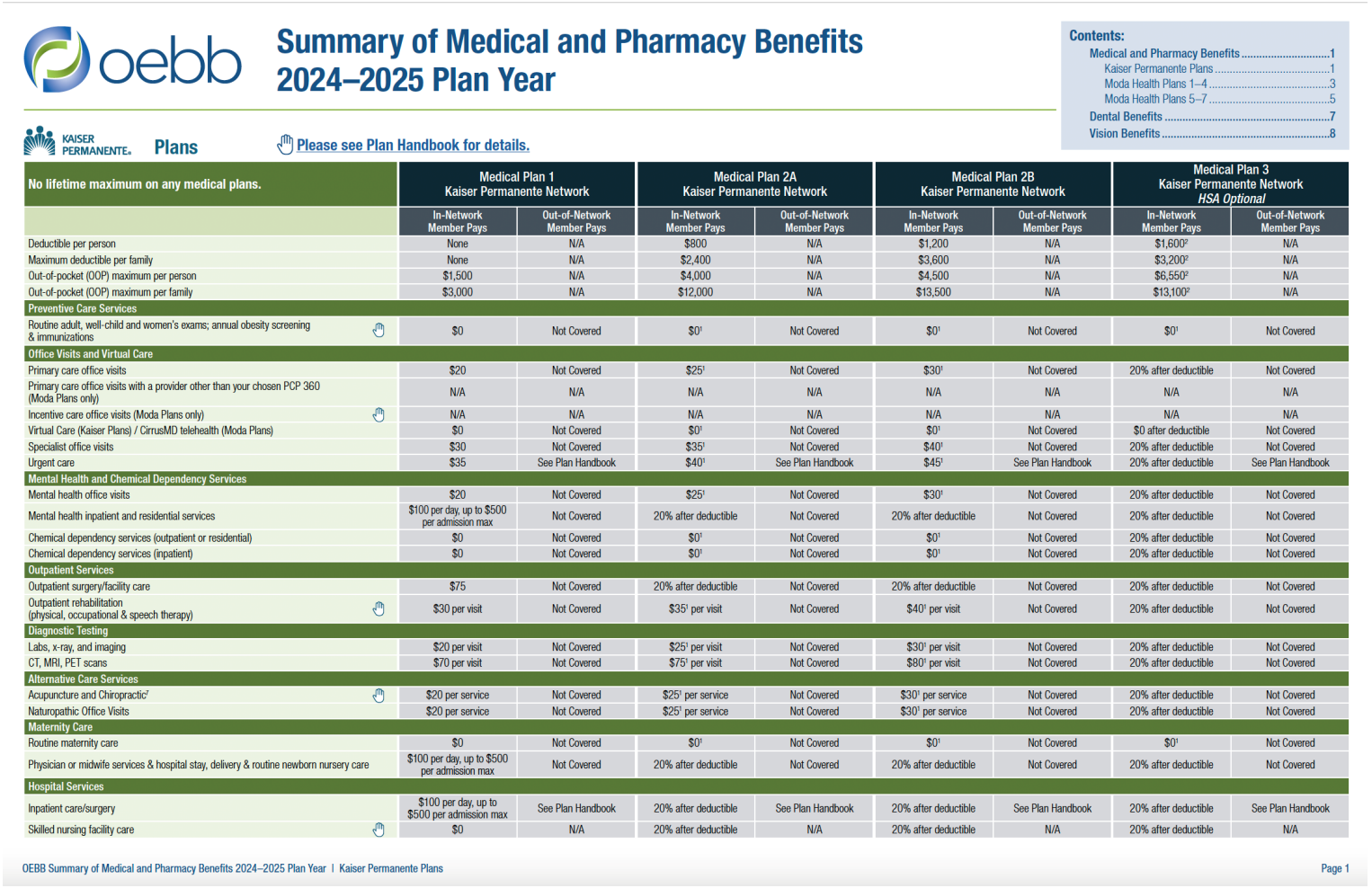
OEBB Summary of Benefits 2024-25 Plan Year



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Summary of Medical and Pharmacy Benefits 2024–2025 Plan Year

Contents:

KAISER PERMANENTE® Plans

Please see Plan Handbook for details.

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	N/A	$800	N/A	$1,200	N/A	$1,600[2]	N/A
Maximum deductible per family	None	N/A	$2,400	N/A	$3,600	N/A	$3,200[2]	N/A
Out-of-pocket (OOP) maximum per person	$1,500	N/A	$4,000	N/A	$4,500	N/A	$6,550[2]	N/A
Out-of-pocket (OOP) maximum per family	$3,000	N/A	$12,000	N/A	$13,500	N/A	$13,100[2]	N/A
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)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Incentive care office visits (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
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 (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	$70 per visit	Not Covered	$75[1] per visit	Not Covered	$80[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	N/A	20% after deductible	N/A	20% after deductible	N/A	20% after deductible	N/A

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KAISER PERMANENTE®

Plans – *continued*

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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[3], knee & shoulder arthroscopy, uncomplicated hernia repair	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Services								
Emergency room (copay waived if admitted)	$150 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	Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max	
Retail								
Value	N/A	N/A	N/A	N/A	N/A	N/A	$0[7]	N/A
Generic (Kaiser Plans) / Select generic (Moda Plans)	$10 per 30-day supply	See Plan Handbook	$10 per 30-day supply	See Plan Handbook	$10 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred brand	$30 per 30-day supply	See Plan Handbook	$30 per 30-day supply	See Plan Handbook	$30 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$50 per 30-day supply if criteria met	See Plan Handbook	$50 per 30-day supply if criteria met	See Plan Handbook	$50 per 30-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Mail								
Value	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Generic (Kaiser plans) / Select generic (Moda Plans)	$20 per 90-day supply	See Plan Handbook	$20 per 90-day supply	See Plan Handbook	$20 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred Brand	$60 per 90-day supply	See Plan Handbook	$60 per 90-day supply	See Plan Handbook	$60 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$100 per 90-day supply if criteria met	See Plan Handbook	$100 per 90-day supply if criteria met	See Plan Handbook	$100 per 90-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Specialty								
Generic (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook

N/A – Not applicable

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. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.

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KAISER PERMANENTE®

Plans – *continued*

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	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[3], knee & shoulder arthroscopy, uncomplicated hernia repair	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Emergency Services								
Emergency room (copay waived if admitted)	$150 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	Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max		Rx applies toward plan OOP max	
Retail								
Value	N/A	N/A	N/A	N/A	N/A	N/A	$0[7]	N/A
Generic (Kaiser Plans) / Select generic (Moda Plans)	$10 per 30-day supply	See Plan Handbook	$10 per 30-day supply	See Plan Handbook	$10 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred brand	$30 per 30-day supply	See Plan Handbook	$30 per 30-day supply	See Plan Handbook	$30 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$50 per 30-day supply if criteria met	See Plan Handbook	$50 per 30-day supply if criteria met	See Plan Handbook	$50 per 30-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Mail								
Value	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Generic (Kaiser plans) / Select generic (Moda Plans)	$20 per 90-day supply	See Plan Handbook	$20 per 90-day supply	See Plan Handbook	$20 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Preferred Brand	$60 per 90-day supply	See Plan Handbook	$60 per 90-day supply	See Plan Handbook	$60 per 90-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	$100 per 90-day supply if criteria met	See Plan Handbook	$100 per 90-day supply if criteria met	See Plan Handbook	$100 per 90-day supply if criteria met	See Plan Handbook	20% after deductible	See Plan Handbook
Specialty								
Generic (Moda Plans only)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook
Non-preferred brand[4]	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	25% up to $150 per 30-day supply	See Plan Handbook	20% after deductible	See Plan Handbook

N/A – Not applicable

1 Deductible waived.

2 Individual deductible and individual out of pocket maximum apply

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

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

This document is for comparison purposes only. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict

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moda HEALTH **Plans 1–4**

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[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[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 deductible	50% after deductible	$20[1,5]	20% after deductible	50% after deductible	$25[1,5]	25% after deductible	50% after deductible	$25[1,5]	25% after deductible	50% after deductible
Primary care office visits with a provider other than your chosen PCP 360 (Moda Plans only)	$40[1]	N/A	50% after deductible	$40[1]	N/A	50% after deductible	$50[1]	N/A	50% after deductible	$50[1]	N/A	50% after deductible
Incentive care office visits (Moda plans only)	$15[1]	20% after deductible	N/A	$15[1]	20% after deductible	N/A	$20[1]	25% after deductible	N/A	$20[1]	25% after deductible	N/A
Virtual Care (Kaiser Plans) / CirrusMD telehealth (Moda Plans)	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered	$0[1]	$0[1]	Not covered
Specialist 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
Urgent care	$40[1]	20% after deductible	20% after deductible	$40[1]	20% after deductible	20% after deductible	$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 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
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% 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
Outpatient Services												
Outpatient surgery/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
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 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
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	50% after deductible	$20[1]	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 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
Physician or midwife services & hospital stay, delivery & routine newborn nursery 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
Hospital Services												
Inpatient care/surgery	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
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

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moda HEALTH **Plans 1–4** *– continued*

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[6] 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 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
Pharmacy Services												
Out-of-pocket (OOP) maximum	Rx applies toward OOP Max			Rx applies toward OOP Max			Rx applies toward OOP Max			Rx applies toward OOP Max		
Retail												
Value	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook	$4 per 31-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply			$12 per 31-day supply		
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		See Plan Handbook	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook	$8 per 90-day supply		See Plan Handbook
Generic (Kaiser Plans) / Select generic (Moda Plans)	$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply			$24 per 90-day supply		
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		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook	$12 per 31-day supply or $36 per 90-day supply when allowed		See Plan Handbook
Select generic (Kaiser plans) / Preferred brand (Moda Plans)	25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed			25% up to $200 per 31-day supply or $400 for 90-day supply when allowed		
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		

N/A – Not applicable

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. It does not fully describe the benefits of each plan. Refer to the plan documents for more details. If there is a conflict between this comparison and the plan documents, the plan documents will prevail.

Commercial comparison, including PEBB (note this is from 2015)

Overview of Key Benefit Differences and Premium Impact of 2017 EHB Benchmark Options
Excluding pediatric dental and vision and habilitative services (see slides for additional background)
May 6, 2015 Meeting

WAKELY CONSULTING GROUP

	Small Group Plans			State Employee Plans			Federal Employee Plans		
	PacificSource[1]	Health Net	United	PEBB Statewide	PEBB Choice	Kaiser	BCBS Standard	BCBS Basic	GEHA
Home health	√	o	o	-	-	o	-	-	-
Acupuncture	NC	o	++	++	++	++	++	++	++
Spinal manipulation	NC	o	++	++	++	++	++	++	++
Abortion (elective)	√	o	o*	o	o	o	--	--	--
Infertility	NC	o	o	++	++	++	++	++	++
Bariatric Surgery	NC	o	o	++	++	++	++	++	++
TMJ	NC	++	++	++	++	++	++	++	++
Accidental Dental	√	o	o	o	o	--	o	o	o
Hospitalization for dental procedures	√	o	--	o	o	o	o	o	o
Private duty nursing	NC	++	o	o	o	o	o	o	o
Outpatient rehabilitation	√	+	o	+	+	o	+	+	+
Skilled nursing facility	√	+	o	+	+	+	+	+	-
Biofeedback	√	--	+	+	+	--	--	--	--
Cochlear implants	√	--	o	o	o	o	o	o	o
Hearing aids - adults	NC	o	++	++	++	++	++	++	++
Hearing aids - kids	√	o	o	+	+	o	o	o	+
Genetic testing	NC	++	++	++	++	++	++	++	++
Weight loss programs	NC	++	o	++	++	++	o*	o*	o*
Routine hearing exams - adults	NC	o	++	++	++	++	o	o	o
Routine hearing exams - kids	√	--	o	o	o	o	o	o	o
Growth hormone therapy	√	--	--	o	o	o	o*	o*	o
Estimated silver plan per member per month premium difference from baseline	**$0.00**	**$1.00 - $2.00**	**$2.00 - $3.00**	**$6.50 - $8.50**	**$6.50 - $8.50**	**$1.50 - $2.50**	**$5.00 - $6.50**	**$4.50 - $6.00**	**$5.00 - $6.50**
Difference as percent of silver premium (assuming pmpm of $420)	**0.0%**	**0.2% - 0.5%**	**0.5% - 0.7%**	**1.5% - 2.0%**	**1.5% - 2.0%**	**0.4% - 0.6%**	**1.2% - 1.5%**	**1.1% - 1.4%**	**1.2% - 1.5%**

[1] Baseline plan

Covered in baseline	√
Not covered in baseline	NC
Covered in plan but not baseline	++
Richer coverage than baseline	+
Similar to baseline	o
Less rich coverage than baseline	-
Not covered in plan	--
Unclear if covered, assumption noted	*

OEBB Summary

Expansive benefits

Moderate cost sharing

Increased cost sharing out of network

Options limited in some school districts

Tiered prescription drug benefits

Medicare

Original Medicare

This coverage includes:

- ✔ Part A – Hospital Insurance
- ✔ Part B – Medical Insurance
- ✖ Drugs
- ✖ Help with out-of-pocket costs
- ✔ Use of any doctor or hospital that takes Medicare, anywhere in the U.S.
- ✖ Vision, hearing, dental, and more

Total monthly premium
$185.00

Original Medicare

Part A premium: **Usually free**
Standard Part B premium: **$185.00**

- Covers 80% of the cost for most medical bills.
- You pay the remaining 20% of costs, after you meet your deductible.
- There's no yearly limit on what you pay out of pocket, unless you have supplemental coverage—like Medicare Supplement Insurance (Medigap), Medicaid, employer, retiree, or union coverage.
- You can choose to buy a Medicare Supplement Insurance (Medigap) policy to help pay your out-of-pocket costs that Medicare doesn't cover (like your 20% coinsurance).
- You can join a separate Medicare drug plan to get Medicare drug coverage (Part D).
- Can use any doctor or hospital that takes Medicare, anywhere in the U.S.

See savings programs that may lower your Medicare costs

Learn how Original Medicare works

Get the lowest price & avoid the penalty

If you don't buy a Medigap policy when you're first eligible, you may not be able to buy one later, or you may pay more. If you don't join a Medicare drug plan when you first get Medicare and then decide to join one later, you may pay a penalty for as long as you have Medicare drug coverage.

Medicare Advantage

Compare Medicare Advantage Plans for 97035

Showing 7 of 7 plans available	AARP Medicare Advantage Extras from UHC OR-6 (HMO-POS)	AARP Medicare Advantage Essentials from UHC OR-4 (HMO-POS)	AARP Medicare Advantage from UHC OR-0002 (PPO)
	$0 Monthly premium Enroll · Save	$0 Monthly premium Enroll · Save	$0 Monthly premium Enroll · Save
Annual medical deductible This is the amount you have to pay before your plan starts paying its share of your medical costs	$0 In-network	$0 In-network	$0 In-network / $0 Out-of-network
Out-of-pocket maximum This is the most you pay for covered services from network providers during the year	$6,700 In-network	$4,500 In-network	$6,700 In-network / $10,100 combined in and out-of-network
Part B premium reduction A reduction to your Medicare Part B premium each month	✕ Not offered	✕ Not offered	✕ Not offered
Care while traveling Get network costs when you travel across the country	✓ Covered with the UnitedHealthcare Medicare National Network	✓ Covered with the UnitedHealthcare Medicare National Network	✓ Covered with the UnitedHealthcare Medicare National Network

Medicare Advantage

Prescription drug benefits

Your drugs	Add your drugs	Add your drugs	Add your drugs
Annual prescription deductible You pay the full cost of your drugs until you reach the annual deductible amount	$0 for Tiers 1-2 $340 for Tiers 3-5	$0 for Tiers 1-2 $255 for Tiers 3-5	$0 for Tiers 1-2 $420 for Tiers 3-5
Retail network pharmacy (30-day supply)			
Tier 1: Preferred Generic Drugs	$0 copay	$0 copay	$0 copay
Tier 2: Generic Drugs	$12 copay	$0 copay	$10 copay
Tier 3: Preferred Brand Drugs	$47 copay	$47 copay	$47 copay

Medicare Summary

Limited benefits

Heavy cost sharing

No network limits in original Medicare

More benefits, less cost sharing and network limits in Medicare Advantage

Medicaid

Medicaid

Summary of Benefits and Coverage: What this Plan Covers & What You Pay for Covered Services
Coverage Period: 01/01/2024-12/31/2024

Oregon Health Plan
Coverage for: Individual and Family | Plan Type: Coordinated Care Organization

The Summary of Benefits and Coverage (SBC) document will help you choose a health plan. The SBC shows you how you and the plan would share the cost for covered health care services. NOTE: Information about the cost of this plan (called the premium) will be provided separately. This is only a summary. For more information about your coverage, or to get a copy of the complete terms of coverage, go to https://www.oregon.gov/oha/HSD/OHP/Pages/Splash.aspx or call the Oregon Health Plan at 1-800-273-0557. For information for your CCO, please go here: https://www.oregon.gov/oha/hsd/ohp/pages/coordinated-care-organizations.aspx. For general definitions of common terms, such as allowed amount, balance billing, coinsurance, copayment, deductible, provider, or other underlined terms, see the Glossary. You can view the Glossary at http://www.healthcare.gov/sbc-glossary or call 1-800-273-0557 to request a copy.

Important Questions	Answers	Why This Matters:
What is the overall deductible?	$0	See the Common Medical Events chart below for services this plan covers.
Are there services covered before you meet your deductible?	Yes	All services covered by this plan are provided with no deductible. This plan covers some items and services even if you haven't yet met the deductible amount.
Are there other deductibles for specific services?	No	You don't have to meet deductibles for specific services.
What is the out-of-pocket limit for this plan?	Not Applicable	There is no out-of-pocket limit for this plan.
What is not included in the out-of-pocket limit?	Premiums and services this plan doesn't cover are not included in the out-of-pocket limit.	There is no out-of-pocket limit for this plan.
Will you pay less if you use a network provider?	Yes. See https://www.oregon.gov/oha/hsd/ohp/pages/find-providers.aspx or call 1-800-273-0557 for a list of network providers.	This plan uses a provider network. You will pay less if you use a provider in the plan's network. You will pay the most if you use an out-of-network provider, and you might receive a bill from a provider for the difference between the provider's charge and what your plan pays (balance billing). Check with your provider before you get services. Be aware, your network provider might use an out-of-network provider for some services (such as lab work). Check with your provider before you get services.
Do you need a referral to see a specialist?	Yes.	This plan will pay all of the costs to see a specialist for covered services but only if you have a referral before you see the specialist.

(HHS - OMB control number: 0938-1146/Expiration date: 05/31/2026)

Medicaid

All copayment and coinsurance costs shown in this chart are after your deductible has been met, if a deductible applies.

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	No charge	Not covered	None
	Specialist visit	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, the visit will not be covered by the plan.
	Preventive care/screening/ immunization	No charge	Not covered	You may have to pay for services that aren't preventive. Ask your provider if the services needed are preventive. Then check what your plan will pay for.
If you have a test	Diagnostic test (x-ray, blood work)	No charge	Not covered	None
	Imaging (CT/PET scans, MRIs)	No charge	Not covered	
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at https://www.oregon.gov/oha/hsd/ohp/pages/drug-coverage.aspx	Generic drugs (Tier 1)	No charge	Not covered	Covers up to a 30-day supply (retail subscription); 31-90 day supply (mail order prescription).Prior authorization required for certain drugs. If not received, you will be responsible for the expense.
	Preferred brand drugs (Tier 2)	No charge	Not covered	
	Non-preferred brand drugs (Tier 3)	No charge	Not covered	
	Specialty drugs (Tier 4)	No charge	Not covered	
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	No charge	Not covered	Preauthorization is required. If you don't get preauthorization, the service will not be covered by the plan.
	Physician/surgeon fees	No charge	Not covered	None
If you need immediate medical attention	Emergency room care	No charge	No charge	None
	Emergency medical transportation	No charge	No charge	

* For more information about limitations and exceptions, see the plan or policy document at www.oregon.gov/oha/HSD/OHP/Pages/Handbooks.aspx. Page 2 of 5

Medicaid

Common Medical Event	Services You May Need	What You Will Pay		Limitations, Exceptions, & Other Important Information
		Network Provider (You will pay the least)	Out-of-Network Provider (You will pay the most)	
	Urgent care	No charge	Not covered	
If you have a hospital stay	Facility fee (e.g., hospital room)	No charge	Not covered	None
	Physician/surgeon fees	No charge	Not covered	None
If you need mental health, behavioral health, or substance abuse services	Outpatient services	No charge	Not covered	None
	Inpatient services	No charge	Not covered	
If you are pregnant	Office visits	No charge	Not covered	Maternity care may include tests and services described elsewhere in the SBC (i.e., ultrasound).
	Childbirth/delivery professional services	No charge	Not covered	
	Childbirth/delivery facility services	No charge	Not covered	
If you need help recovering or have other special health needs	Home health care	No charge	Not covered	None
	Rehabilitation services	No charge	Not covered	None
	Habilitation services	No charge	Not covered	
	Skilled nursing care	No charge	Not covered	None
	Durable medical equipment	No charge	Not covered	None
	Hospice services	No charge	Not covered	None
If your child needs dental or eye care	Children's eye exam	No charge	Not covered	None
	Children's glasses	No charge	Not covered	None
	Children's dental check-up	No charge	Not covered	None

Excluded Services & Other Covered Services:

Services Your Plan Generally Does NOT Cover (Check your policy or plan document for more information and a list of any other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Non-emergency care when traveling outside the U.S.

Other Covered Services (Limitations may apply to these services. This isn't a complete list. Please see your plan document.)

- Acupuncture (if prescribed for rehabilitation purposes)
- Bariatric surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Private-duty nursing
- Routine eye care (Adult)
- Routine foot care

* For more information about limitations and exceptions, see the plan or policy document at www.oregon.gov/oha/HSD/OHP/Pages/Handbooks.aspx. Page 3 of 5

Medicaid Summary

Most expansive benefits (including long term services and supports)

No cost sharing

Network limits either de facto through managed care or due to low provider payment

Overall summary

	PEBB	OEBB	Medicare	Medicare Advantage	Medicaid
Covered services	Covers most everything except dental and vision.	Minor differences from PEBB	Covers hospital and medical bills. Does not cover drugs or dental.	Covers hospital and medical bills, drugs and sometimes other benefits (e.g., nutrition, fitness).	Covers everything, except cosmetic surgery and infertility treatment, including dental and long-term care.
Cost sharing	Modest cost sharing. Lower cost sharing in-network.	Minor differences from PEBB	20% coinsurance on most services.	Modest	No cost sharing.
Restricted provider networks	Yes with the option to pay more and got out of network.	Minor differences from PEBB	No	Yes	Generally no coverage outside of network.
Utilization management	Some	Minor differences from PEBB	Generally no	Yes	For hospitalizations and some surgery, for long term care.

Discussion

Small Group Discussion of Benefits

Small Groups

Breakout Group Instructions

- You'll be in groups of 5-6 people
- One staff member will be in each group
- Step one: Assign a note taker
- Step two: Assign someone to report out to full committee after discussion
- Step three: Discuss the following questions (next slide)

Breakout Group Discussion Questions

- Do you support PEBB as the baseline benefit plan?
  - If not, what would you change? Is there another benefits package you think the committee should adopt as a baseline?
- Are there benefits that still need a deeper dive by the committee?
- If there is room to add benefits, what would you add?
- If tradeoffs need to occur to fit within a budget, what would you propose to limit?

Discussion on Moving Forward

Is the committee ready to move to Eligibility or is there more discussion or information on benefits that is needed?

Next Meeting Topic: Eligibility

Committee Members

Next Topic: Eligibility

What questions do you have/ what information do you want to have a full discussion on eligibility?

Committee Member Reflections

Committee Members

Public Comment

Universal Health Plan
Governance Board

Thank you