OREGON EDUCATORS
OEBB
BENEFIT BOARD

2015-16 Plan Year
Open Enrollment Guide

Mandatory enrollment begins August 15, 2015

Includes medical plans in the
Kaiser Permanente,
Moda Health Statewide,
Synergy, and **Summit Networks**

Some members may not have access to all plans shown in this summary.
Your personalized cover letter explains which plans are available to you.

It's not too late to lower your 2015-16 deductible!
OEBB Healthy Futures
See pages 32 - 36 for program changes and details

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.

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Welcome

What's NEW for 2015-16

This guide contains information to help you make the best decisions for you and your family for the upcoming plan year. Here are some highlights of what's new and important for Open Enrollment 2015, and the pages of this guide where you can learn more:

Mandatory Enrollment

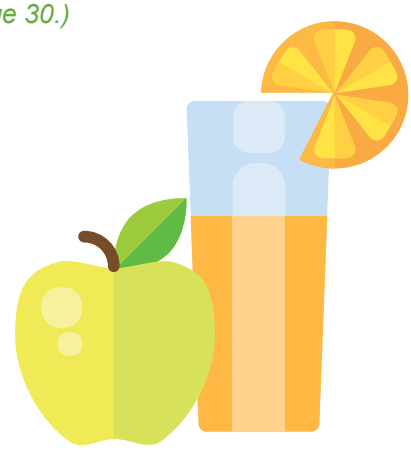
Everyone needs to log into MyOEBB and enroll in medical, dental and vision plans to have coverage for the plan year beginning October 1, 2015! *(See page 3.)*

Healthy Futures is CHANGING – Another Chance for Lower Deductible/Copays

Even if you didn't participate in Healthy Futures for 2014-15, you have a second chance to lower your deductible/copays this October – take action now and get rewarded right away! *(See page 32.)*

NEW "OEBB Fitness Rewards" Gym Membership Reimbursement Benefit

Starting October 1, 2015, you can get reimbursed for regular exercise at a qualifying fitness facility! *(See page 30.)*



Mandatory Open Enrollment

Make sure you're covered!

All OEBB medical, dental and vision plan elections, including elections to opt-out or waive coverage, will end September 30, 2015.

If you are eligible for OEBB benefits October 1, 2015 and beyond, you must log in to the MyOEBB enrollment system and make your health plan elections for the 2015-16 plan year. This includes enrolling yourself and any eligible dependents you wish to cover, as well as opting-out, waiving or declining any coverage you do not want.

Q: How do I log in and make my elections?

A: See Appendix A *(pages 46-52)* of this Enrollment Guide for complete instructions.

Q: When can I enroll?

A: Open Enrollment begins August 15, 2015 and continues through September 15, 2015 for most employing entities. Verify with your benefits administrator when your specific enrollment period ends.

Q: Why did the OEBB Board make this enrollment period mandatory?

A: There are a few reasons why mandatory enrollment is important this year:

1) With the changes to the Healthy Futures incentive program, it is important that all members learn about the changes and realize they still have an opportunity to lower their deductible/copays effective October 1, 2015. See *page 32* for more details.
2) It's just good practice to review your benefit elections every so often and ensure your coverage best meets your needs. OEBB's last mandatory Open Enrollment was in 2013, when the Healthy Futures program was implemented. Members who have not reviewed their plan options since then may have more appropriate options available to them now.
3) You should verify your personal information is all current, including your beneficiary designation and contact information, and confirm all dependents listed still meet the eligibility requirements.

Q: Do I need to re-enroll in optional plans like life insurance or long term care?

A: No. Current enrollments in "optional" types of coverage will roll forward into the 2015-16 plan year without needing to re-enroll, although you are welcome to change those elections during this time if you choose to do so. Medical, dental and vision are the only plan types that require active enrollment for 2015-16.

Q: What will happen if I do not log in and enroll in medical, dental and vision plans this Open Enrollment?

A: Some employing entities may choose to enroll you in a default plan if you fail to make your own elections. However, not all entities will do this. You may be left without healthcare coverage for the 2015-16 plan year, or you may be defaulted into a plan that doesn't fit your needs. To ensure you have the coverage you need and want, make sure you log into MyOEBB and make your selections.

Be sure to log in and choose the best options for you and your family.

More questions? Ask OEBB Member Services! Phone: 888-469-6322 | Email: oebb.benefits@oregon.gov

Checklist

Getting Ready to Enroll

Gathering some or all of the information below will help you complete the enrollment process quicker and give you more accurate results. Although some of these details may not be required, the more items you have readily available when you begin the process, the easier it should be.

The MyOEBB Plan Selection Process

Make sure your computer settings are compatible. The site is best viewed if you have:

- Internet Explorer 6.0 or higher with "Compatibility Mode" turned on
- Screen Resolution set at 1024*768
- Pop-ups enabled
- Full size computer or laptop (some functionality may not be available on a tablet or smartphone)

Your MyOEBB User Name and Password

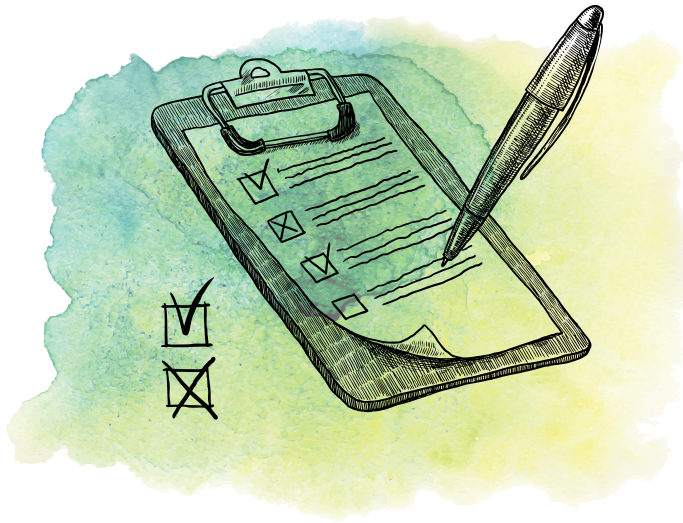
- **If you are a returning user** you will need to enter the MyOEBB User Name and Password you created for yourself in the past.
- **If you have forgotten your User Name and/or Password** click on the "I Forgot?" Button, or
- **If you are new to MyOEBB** click on the Register Here button.

  In either of these last two cases you will need the following information:

  - First name as it appears on your Pay Check
  - Last name as it appears on your Pay Check
  - Date of birth
  - One of the following ID numbers:
    - Social Security number
    - E-Number (OEBB Benefit Number that begins with the letter "E")

Other Information or Documents You May Need

- Birth dates and Social Security Numbers of eligible family members you want on your benefit plans
- Available Plan Choices for healthcare benefits and optional benefits (these are listed on your Welcome Letter)
- Affidavit Forms (if applicable) for certain dependents
- Other Group Coverage Information (if applicable)



The Informed Enrollment Plan Comparison Tool in MyOEBB

- **Know your Employer Contribution.** This is the amount your employer will pay toward your benefits for the 2015-16 plan year. This can be either a flat dollar amount or a percentage.
- **List of expected major medical services** you or your family members may need this year that you haven't needed in the past.
- **Explanation of Benefits (EOBs)** or records of healthcare services used in the past year can be helpful in estimating expenses for the coming year. These are not required.

The Online Health Assessment

Health Assessments should be completed each year for Healthy Futures participation (see *page 33*) and/or for "OEBB Fitness Rewards" reimbursement (see *page 30*).

Note: The following items are all optional. The more of these you can provide, the more detailed and accurate your health assessment will be, but you can still complete your health assessment even if you have none of these.

- Current height, weight, and waist size in inches
- Recent blood pressure
- Recent lab results (within the past five years)
  - Cholesterol (LDL, HDL, and Triglycerides)
  - Fasting and/or non-fasting glucose level
- Dates of most recent preventive screenings and vaccinations

Plan Selection Reminders

12-month Waiting Period when enrolling in Dental and/or Vision Coverage during an Open Enrollment period

If you didn't enroll yourself or a dependent in dental and/or vision coverage when initially eligible, then choose to enroll during an Open Enrollment period, you or your dependent will be considered a "late enrollee" and will be subject to a 12-month waiting period on all dental and vision plans, meaning only diagnostic and preventive care on the dental plans and routine eye exams on the vision plans will be covered for the first full 12 months of coverage.

Why is this waiting period in place? Dental and vision services tend to be less urgent than medical services, which leads to "adverse selection", meaning people who know they need costly services are most likely to enroll. The uninsured have greater leeway to postpone needed services until they attain insurance to cover them. If left unregulated, this can cost the plan more in claims than the premiums it brings in. The waiting period helps control costs, maintaining a balance between premiums coming in and claims paid out.

New to Willamette Dental Group or Kaiser Permanente?

Willamette Dental Group and Kaiser Permanente both require you to use their facilities and providers to have services covered. If you are currently covered by a different carrier and switching to one of these plans, be aware that you will need to change providers.

Are you currently enrolled in an incentive dental plan?

Moda Health/ODS Dental Plans 1, 2 and 3 are "incentive plans," meaning as long as you visit the dentist at least once during the year the level of benefit for certain services will increase the following year (up to a maximum of 100 percent). If you switch to one of the other "non-incentive" plans (Kaiser Dental Plan 8, Willamette Dental Group Plan 8, and Moda Health/ODS Dental Plans 4 and 6), you will not retain any higher benefit level you previously earned. If you switch back to an incentive plan in the future, your benefit will start over at 70 percent.

Thinking about covering your grandchild?

Grandchildren are only eligible when the eligible employee is the court-ordered legal guardian or adoptive parent of the grandchild. See *page 8* for complete dependent eligibility rules.

Adding voluntary short-term disability coverage?

If your coverage is voluntary and you apply more than 31 days after first becoming eligible, the late enrollment penalty applies. That means the benefit waiting period is 60 days for a disability caused by physical disease, pregnancy, or mental disorder for the first 12 months you are insured under the OEBB short-term disability plan.

Adding voluntary long-term disability coverage?

If your coverage is voluntary and you apply more than 31 days after first becoming eligible to apply, satisfactory evidence of insurability is required. You will need to complete and submit a Medical History Statement. In some cases, The Standard may request additional medical information or a physical exam. Coverage will not become effective until the first of the month following The Standard's approval.

Adding voluntary long-term care coverage?

If your coverage is voluntary and you apply more than 31 days after first becoming eligible to apply, satisfactory evidence of insurability is required. You will need to complete and submit a Medical History Statement. In some cases, Unum may request additional medical information or a physical exam. Coverage will not become effective until the first of the month following Unum's approval.

Online Resources

The OEBB website is a great place to start when looking for information about your benefit plans.

Home Page:	www.oregon.gov/oha/OEBB
Plan Handbooks:	www.oregon.gov/OHA/OEBB/pages/handbooks.aspx
Login to the MyOEBB Enrollment System:	To enroll or change your benefit elections: https://myoebb.org/oebb/!pb.main Forgot your User Name or Password? Click on the "I Forgot?" button. **Please note:** The MyOEBB system must be taken down for file processing and invoicing on the last day of each month, beginning at 8 p.m. and it remains down until approximately 9 a.m. the following day. **During this Open Enrollment period, the system will not be available between 8 p.m. Monday, August 31st and approximately 9 a.m. Tuesday, September 1st.** *Please plan your enrollment activities accordingly.*
Mid-Year Change Events:	Outside of the Open Enrollment period, certain life events will allow you to make changes to your benefit elections as long as you request the change within the specified time period (usually 31 days). Check the Qualifying Status Change (QSC) Matrix to see if your event qualifies: www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx
Find a doctor or dentist:	The "Plans Offered" page of the OEBB site contains links to each carrier's website as well as direct links to search for providers in their respective networks: www.oregon.gov/oha/OEBB/Pages/Plans-Offered.aspx
Medicare Notice of Creditable Coverage and other Required Notices:	For the 2015-16 plan year, all OEBB plans are considered "creditable coverage" for Medicare purposes. The notice required by Medicare to avoid late-enrollment penalties can be found here: www.oregon.gov/oha/OEBB/Pages/Required-Notices.aspx
OEBB Forms:	www.oregon.gov/oha/OEBB/Pages/forms.aspx

Enrollment Guides and Tools

Truven Informed Enrollment Tool – Helps You Compare Plan Expenses

When you log into the MyOEBB enrollment system, you'll find a link to the Truven Informed Enrollment Tool. This tool can help you compare the specific plans available to you by estimating the out-of-pocket costs for predicted healthcare needs under each plan as well as the monthly insurance premium, and employer contributions toward those premiums. In just a few minutes, this tool provides a report illustrating which plan is predicted to cost you the least out-of-pocket overall given your expected healthcare needs. For a step-by-step guide through this tool, see *Appendix B, pages 53 - 56*.

MyOEBB Enrollment Guide – Helps You Complete the Enrollment Process

This guide walks you step-by-step through the enrollment process, from logging in to selecting your plans, adding dependents, answering Healthy Futures questions, and more. You'll be sure you've completed all the required information and successfully saved your enrollments. *(See Appendix A, pages 46 - 52.)*

Coverage for Out-of-Area Dependents

Information and instructions for covering dependents who do not live with you, by carrier:

Kaiser Permanente

Students outside of the KPNW Service Area

When you travel or reside outside of the Kaiser Permanente Northwest (KPNW) service area, you are covered for urgent and emergency care. Urgent and emergency care visits are subject to your plan's copayments and/or coinsurance.

In addition, Kaiser has an out-of-area student benefit available for eligible dependents who are students residing outside of the KPNW service area. With the out-of-area student benefit, Kaiser will cover non-urgent medical needs such as routine, continuing, and follow-up care. The benefit is subject to a 20% coinsurance and the benefit limit is $1200 per calendar year. To qualify for this benefit, and verify if your dependent is eligible, you must fill out the out-of-area student benefit form. The form is available on Kaiser's website at kp.org/formsandpubs, or you can contact membership services to request the form or for more information about out-of-area benefits.

Non-Student Dependents outside of the KPNW Service Area

If your dependent is not a student and lives outside the KPNW service area, their coverage is limited to urgent and emergency care. For all other services, they would need to seek care from a KPNW provider.

Moda Health Statewide Plans

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

When a dependent has out-of-area status, Moda Health will extend plan benefits for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by in-network physicians or providers.

Members are encouraged to see a Moda Health Travel network provider in order to avoid balance billing for amounts above the maximum plan allowance. Fees charged by non-Travel Network out-of-area providers of care will be reimbursed at the maximum plan allowance for those services.

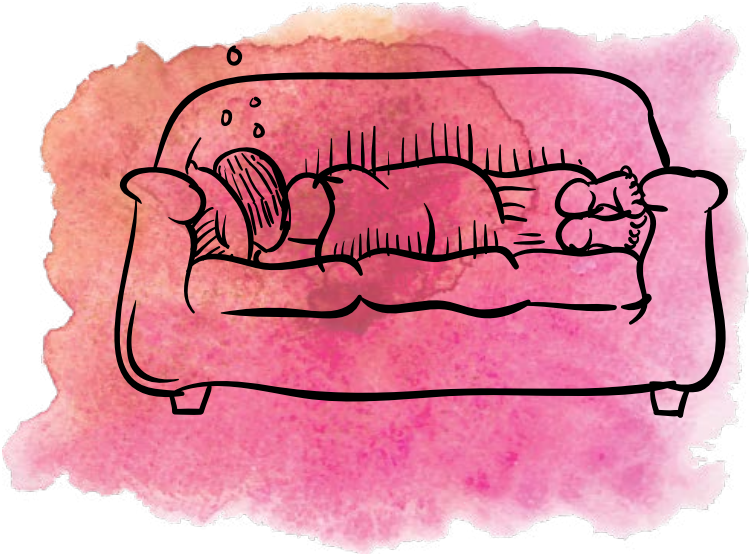
Moda Health Synergy/Summit Plans

For the Summit and Synergy networks, the dependent's out-of-area address must be updated in the MyOEBB system and that dependent must elect a Moda Medical Home to use for primary care when they are in the service area. When seeking services outside of the area, members must use the Moda Travel Network to receive in-network benefits.

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

Willamette Dental Group

Members can access care at any one of the 52 Willamette Dental Group offices located throughout Oregon, Washington and Idaho. Dependents residing outside of the Willamette Dental Group service area will not have coverage for any dental care with a non-Willamette Dental Group provider, unless they have a dental emergency. If you are traveling or reside 50 miles or more from a Willamette Dental Group office, you may obtain emergency dental treatment from any licensed dentist. Emergency dental treatment may be eligible for reimbursement up to $100. Following the dental emergency, call the Willamette Dental Group Member Services Department at 855-433-6825, Option 3 or send an email to memberservices@willamettedental.com for assistance with reimbursement. Non-emergent services will only be covered when performed by a Willamette Dental Group provider.



Dependent Eligibility Requirements

Make Sure Everyone You Cover Meets One of These Definitions

Note: OEBB will require documentation to verify eligibility of all enrolled dependents at least once every three years. To learn which documents will satisfy this requirement, visit the Dependent Eligibility Verification page of the OEBB website:
www.oregon.gov/oha/OEBB/Pages/DEV-Audit-Info.aspx

Definition of "Child"

"Child" means and includes the following:

(a) An eligible employee's, spouse's, or domestic partner's biological son, daughter, stepson, or stepdaughter; adopted child, child placed for adoption, or legally placed child, who is 25 or younger on the first day of the month. An eligible employee must provide the required custody or legal documents to their Employing Entity showing proof of adoption, legal guardianship or other court order if enrolling a child for whom the employee, spouse, or domestic partner is not the biological parent. Grandchildren are only eligible when the eligible employee is the court-ordered legal guardian or adoptive parent of the grandchild.

Note: OEBB no longer accepts Affidavit of Dependency or notarized documents for the purpose of establishing eligibility of a child for whom the employee or spouse/domestic partner are not the biological parent. Legal guardianship must be confirmed by a court-prepared and -signed document.

(b) A person who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. There is no age limit for a dependent child who is incapable of self-sustaining employment because of a developmental disability, mental illness, or physical disability. When the dependent child is 26 years of age or older all the following requirements must be met:

  (A) The disability must have existed before attaining age 26.

  (B) The employee must provide evidence to the Employing Entity or OEBB that (1) the person had health plan coverage, group or individual, prior to attaining age 26, and (2) health plan coverage continued without a gap until the OEBB health plan effective date.

  (C) The person's attending physician must submit documentation of the disability to the eligible employee's OEBB health insurance plan for review and approval. If the person receives health plan approval, the health plan may review the person's health status at any time to determine continued OEBB coverage eligibility.

  (D) The person must not have terminated from OEBB health plan coverage after attaining the age of 26.

(c) Eligibility for coverage under this rule includes people who may not be dependents under federal or state tax law and may require an Educational Entity to adjust an Eligible Employee's income based on the imputed value of the benefit.

Definition of "Spouse"

"Spouse" means a person who is married under the laws of the State of Oregon or under the laws of any other state or country. The definition of spouse does not include a former spouse and a former spouse does not qualify as a dependent.

Definition of "Eligible Domestic Partner"

"Eligible Domestic partner," unless otherwise defined by a collective bargaining agreement or documented district policy in effect on January 31, 2008, means and includes the following:

(a) An unmarried individual of the same sex who has entered into a "Declaration of Domestic Partnership" with the eligible employee that is recognized under Oregon law; or

Dependent Eligibility Requirements (CONTINUED)

(b) An unmarried individual of the same or opposite sex who has entered into a partnership that meets the following criteria:

(A) Both are at least 18 years of age

(B) Are responsible for each other's welfare and are each other's sole domestic partners;

(C) Are not married to anyone and have not had a spouse or another domestic partner within the prior six months. If previously married, the six-month period starts on the final date of divorce;

(D) Share a close personal relationship and are not related by blood closer than would bar marriage in the State of Oregon;

(E) Have jointly shared the same regular and permanent residence for at least six months immediately preceding the date the Affidavit of Domestic Partnership is signed and submitted to the Employing Entity; and

(F) Are jointly financially responsible for basic living expenses defined as the cost of food, shelter and any other expenses of maintaining a household. Financial information must be provided if requested.

(G) The eligible employee and domestic partner must jointly complete and submit to the Employing Entity an Affidavit of Domestic Partnership form, within five business days of the electronic enrollment date or the date the Employing Entity received the enrollment/change form. If the affidavit is not received, coverage will terminate for the domestic partner retroactive to the effective date.

(c) The domestic partner must notify the Employing Entity within 31 days of meeting all criteria as defined in 111-010-0015 (15)(b) or obtaining the "Declaration of Domestic Partnership" which is recognized under Oregon law.

(d) Employing Entities must calculate and apply applicable imputed value tax for domestic partners covered under OEBB benefit plans.

Special Notes for Retirees

A "retiree" enrolled in an OEBB retiree insurance plan who becomes eligible for Medicare coverage may not continue on an OEBB medical or vision plan, unless they are eligible for Medicare as a result of end-stage renal disease. OEBB benefits end the last day of the month prior to the Medicare effective date. The retiree is responsible for reporting to their sponsoring Entity and to OEBB when the retiree is covered by Medicare within 31 days after the Medicare coverage effective date. Failure to report within this timeframe may be considered by OEBB to be intentional misrepresentation and OEBB may retroactively terminate OEBB coverage back to the last day of the month prior to the Medicare effective date.

Eligible dependents of "retirees" who were covered on an OEBB medical plan at the time of retirement and who are eligible for Medicare, or who become eligible for Medicare, may not continue coverage on an OEBB medical or vision plan unless it is stated in a collective bargaining agreement or documented district policy in effect on or before February 1, 2010, that they may continue on OEBB medical plans until the retiree becomes eligible for Medicare with the following exception: OEBB coverage must end for Medicare-eligible dependents of a retiree enrolled on a Kaiser Permanente medical plan.

More information specific to retirees and members planning for retirement can be found on *pages 42 - 43* of this booklet.

Changes and Reminders for 2015-16

Kaiser Permanente Plans – NEW Prescription Tiers

All Kaiser Plans will move to a four-tier pharmacy benefit, where all prescription medications will be classified into one of the following categories: Generic, Formulary Brand, Non-Formulary Brand, or Specialty. Each of these categories will be subject to a different member copay as illustrated in the table below. Note that the Out-of-Pocket Maximum of $1,100 per plan year for prescription copayments/coinsurance under these plans remains in place and unchanged.

Where Does Your Medication Fit Into the New Tiers?

Kaiser will be publishing their formulary prior to October 1, 2015; however, if you have any questions about the tier your current medication will be on, you can call Kaiser Membership Services at 1-800-813-2000.

Kaiser Rx Benefit 2015-16	Copay
Generic	$5
Formulary Brand	$25
Non-Formulary Brand	$45
Specialty	25% up to $100
Rx OOPM	$1,100

Moda Health Plans A-G – NEW Affordable Care Act (ACA) Maximum Cost Share

This plan year limit includes your pharmacy copays and coinsurances and your Additional Cost Tier (ACT) copays, as well as the eligible medical expenses that accrue toward your in-network medical out-of-pocket maximum. The medical maximum out-of-pocket will remain the same for plans A-G.

For additional information, call Moda Health Customer Service at 866-923-0409 or visit the Moda Health website at www.modahealth.com/oebb.

Moda Synergy Plans – Additional Counties Included for 2015-16

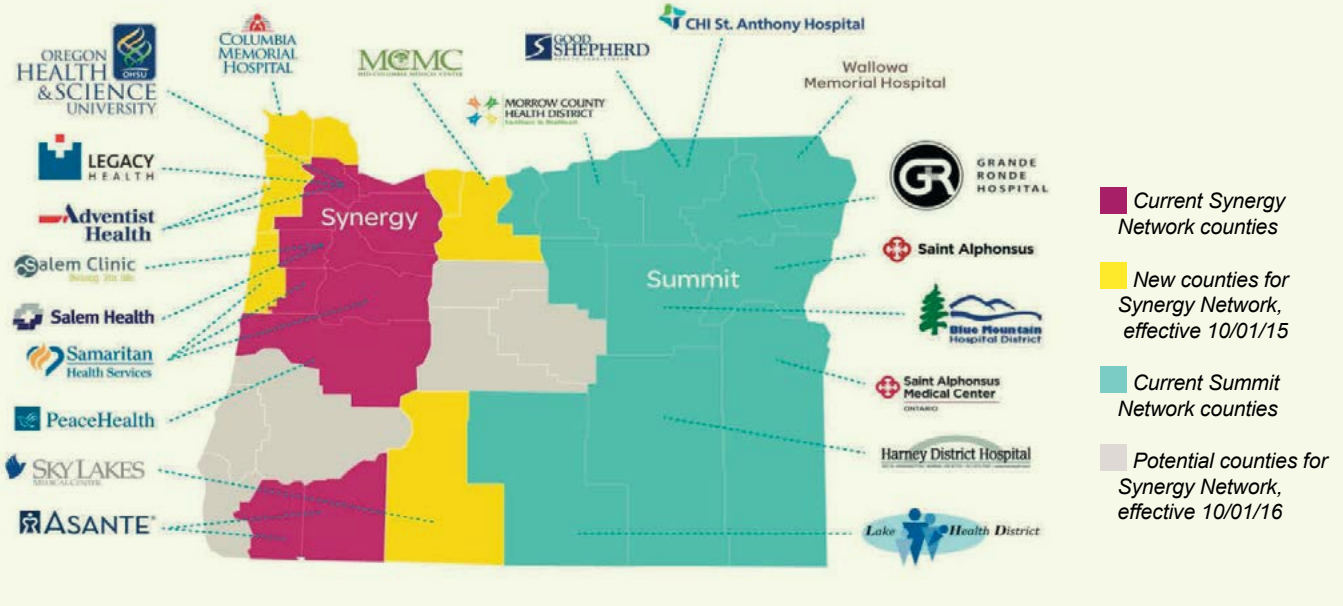
These counties will be added to the Synergy network area for 2015-16 plan year:

- Clatsop
- Columbia
- Hood River
- Lincoln
- Klamath
- Tillamook
- Wasco

Note: Each employer has the ability to limit the plans available to their members, so some OEBB members in these counties may not have a Synergy option available. Please refer to your personalized cover letter to determine the plans available to you.

Moda Health continues its efforts to make the Synergy/Summit plans available throughout Oregon in the future, but for 2015-16, these networks remain unavailable in Coos, Crook, Curry, Douglas, Deschutes, and Jefferson counties.

Map of Synergy and Summit Network Expansion for 2015-16



Moda Health Synergy and Summit Networks vs. Statewide Connexus Network

Moda's Synergy and Summit Network plans provide the same benefits as the traditional Moda Statewide plans, with lower premium costs and using a more limited network of providers.The Statewide plans use the Connexus Network (formerly known as the ODS Plus Network) which provides a large number of provider options across all of Oregon.

The Synergy and Summit plans are only available in certain areas, as illustrated by the map on the previous page. If you enroll in one of these plans, you will need to select a participating medical home from within that network to coordinate your care. You can choose a different medical home for each person on your plan, but each covered individual must receive their care from one of the providers within the special network to qualify for the in-network benefit. In return, you receive better coordinated and managed healthcare and lower premiums. To find out which providers are in these special networks, use the "Find Care" link on the Moda website: www.modahealth.com/oebb/members/providers.shtml

If you enroll in a Synergy or Summit medical plan, you and/or your covered dependents can elect or change your designated medical home by contacting Moda Health directly. You do not need to experience a qualifying status change (QSC) to change your medical home. To change your medical plan outside of the Open Enrollment period, you must experience a QSC. A full list of QSCs can be found online at: www.oregon.gov/oha/OEBB/pages/QSC-Matrix.aspx

If you have further questions about Moda Health medical plans, call Moda Member Services at 866-923-0409.

HSAs and OEBB Medical Plans

If you are interested in pairing a Health Savings Account (HSA) with your medical plan, you must enroll in either Kaiser Medical Plan 3 (where pairing with an HSA is allowed, but optional) or Moda Health Medical Plan H (where pairing with an HSA is required). These are the only two HSA-compliant medical plans OEBB offers. To learn more about HSAs, see *page 40*.

Choosing the Best Plan and Provider for You and Your Family

- If you enroll in a Kaiser medical plan, all your non-urgent medical services must be received within the Kaiser network. Kaiser highly encourages members to select a Kaiser primary care physician, and discuss your health status and care needs with them.
- If you enroll in a Moda Summit or Synergy plan, you must select a Moda Medical Home from within that plan's network for each covered individual and coordinate all non-urgent care through that medical home.
- If you enroll in a Moda Statewide plan, you don't have to identify your primary care provider and you have access to the more extensive Connexus Network to qualify for the in-network benefit level. However, in exchange for this wider selection of providers, you and/or your employer will pay a higher monthly premium for this coverage.
- OEBB provides a Plan Comparison Tool within the MyOEBB system to help you estimate and compare costs (monthly premiums and healthcare expenses combined) of the various plans available to you. Learn more about this tool on *pages 53 - 56*.

The Coordinated Care Model (CCM)

Through the coordinated care model, Oregonians are experiencing improved, more integrated care. With a focus on primary care and prevention, health plans using the coordinated care model are able to better manage chronic conditions and keep people healthy and out of the emergency department.

Key elements of the coordinated care model include:

- Best practices to manage and coordinate care;
- Shared responsibility for health;
- Performance is measured;
- Paying for outcomes and health;
- Transparency and clear information; and
- Maintain costs at a sustainable rate of growth.

OEBB works diligently to incorporate these elements into all OEBB medical plans, but they are particularly evident in the structure of the Moda Synergy and Summit plans as well as the healthcare delivery system inherent in the Kaiser plans.

Learn more about the Coordinated Care Model and Oregon's efforts in this area on the Oregon Health Policy Board website: www.oregon.gov/oha/OHPB/Pages/health-reform/ccos.aspx.

Medical Plans

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

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Medical Plans no lifetime maximum on any medical plans	**Med Plan 1** Kaiser (HMO)		**Med Plan 2** Kaiser (HMO)		**Med Plan 3** Kaiser (HMO)		**Med Plan A** Moda Health (PPO)		**Med Plan B** Moda Health (PPO)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
Deductible per person	None	See Plan Handbook	$200	See Plan Handbook	$1,500[2]	See Plan Handbook	$200		$350	
Maximum deductible per family	None	See Plan Handbook	$600	See Plan Handbook	$3,000[2]	See Plan Handbook	$600		$1,050	
Out-of-pocket (OOP) maximum per person	$1,500	See Plan Handbook	$3,400	See Plan Handbook	$5,000[2]	See Plan Handbook	$2,400	$4,800	$2,950	$5,900
Out-of-pocket (OOP) maximum per family	$3,000	See Plan Handbook	$6,800	See Plan Handbook	$10,000[2]	See Plan Handbook	$7,200	$14,400	$8,850	$17,700
Maximum cost share per person (Includes OOP, ACT, and Pharmacy)	NA	NA	NA	NA	NA	NA	$6,600	NA	$6,600	NA
Maximum cost share per family (Includes OOP, ACT, and Pharmacy)	NA	NA	NA	NA	NA	NA	$13,200	NA	$13,200	NA
Preventive Care Services										
Wellness Visit (Moda plans: ages 21 and over, must use Medical Home)	$0	NA	$0	NA	$0	NA	$0	Not covered	$0	Not covered
Includes routine adult, well-child and women's exams; annual obesity screening and immunizations. See Plan Handbook for additional Preventive Care Services.	$0	Not Covered	$0	Not Covered	$0	Not Covered	$0	50%	$0	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)										
Moda Medical Home incentive care	NA	NA	NA	NA	NA	NA	$10 copay[1]	50%	$10 copay[1]	50%
Incentive office visits and home visits	NA	NA	NA	NA	NA	NA	20%[1]	50%	20%[1]	50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

SHOW HIDE

Med Plan C Moda Health (PPO)		Med Plan D Moda Health (PPO)		Med Plan E Moda Health (PPO)		Med Plan F Moda Health (PPO)		Med Plan G Moda Health (PPO) Not HSA-Compliant		Med Plan H Moda Health (PPO) HSA Required	
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	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
$500		$750		$1,000		$1,250		$1,500		$1,500[2]	
$1,500		$2,250		$3,000		$3,750		$4,500		$3,000[2]	
$3,300	$6,600	$3,800	$7,600	$4,250	$8,500	$5,500	$11,000	$6,350	$12,700	$5,000[2]	
$9,900	$19,800	$11,400	$22,800	$12,700	$25,400	$12,700	$25,400	$12,700	$25,400	$10,000[2]	
$6,600	NA	$6,600	NA	$6,600	NA	$6,600	NA	$6,600	NA	NA	
$13,200	NA	$13,200	NA	$13,200	NA	$13,200	NA	$13,200	NA	NA	
$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered	$0	Not covered
$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	$0	50%
$10 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	$15 copay[1]	50%	20%	50%
20%[1]	50%	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%[1]	50%	20%	50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Medical Plans no lifetime maximum on any medical plans	**Med Plan 1** Kaiser (HMO)		**Med Plan 2** Kaiser (HMO)		**Med Plan 3** Kaiser (HMO)		**Med Plan A** Moda Health (PPO)		**Med Plan B** Moda Health (PPO)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
Professional Services										
Moda Medical Home primary care services	NA	NA	NA	NA	NA	NA	$20 copay[1]	50%	$20 copay[1]	50%
Primary care office visits	$20	Not Covered	$25[1]	Not Covered	20%	Not Covered	20%	50%	20%	50%
Specialist office visits	$30	Not Covered	$35[1]	Not Covered	20%	Not Covered	20%	50%	20%	50%
Mental health office visits	$20	Not Covered	$25[1]	Not Covered	20%	Not Covered	$20 copay[1]	50%	$20 copay[1]	50%
Mental health inpatient and residential services	$100 per day, up to $500 per admission maximum	Not Covered	20%	Not Covered	20%	Not Covered	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	$0	Not Covered	$0	Not Covered	20%	Not Covered	$0	50%	$0	50%
Alternative Care Services ($2,000 combined maximum)										
Acupuncture, Chiropractic & Naturopathic Services, labs, diagnostics, etc. Cost of lab, x-rays, supplies & procedures performed in Alternative Care Provider's office applies to Alternative Care Benefit Maximum	$20 per service	Not Covered	$25[1] per service	Not Covered	20%	Not Covered	20%	50%	20%	50%
Maternity Care										
Outpatient Materntity Care	$0	Not Covered	$0	Not Covered	$0	Not Covered	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	$100 per day, up to $500 per admission maximum	Not Covered	20%	Not Covered	20%	Not Covered	20%	50%	20%	50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Med Plan C Moda Health (PPO)		**Med Plan D** Moda Health (PPO)		**Med Plan E** Moda Health (PPO)		**Med Plan F** Moda Health (PPO)		**Med Plan G** Moda Health (PPO) Not HSA-Compliant		**Med Plan H** Moda Health (PPO) HSA Required	
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	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
$20 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	$30 copay[1]	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
$0	50%	$0	50%	$0	50%	$0	50%	$0	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Medical Plans no lifetime maximum on any medical plans	**Med Plan 1** Kaiser (HMO)		**Med Plan 2** Kaiser (HMO)		**Med Plan 3** Kaiser (HMO)		**Med Plan A** Moda Health (PPO)		**Med Plan B** Moda Health (PPO)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
Outpatient and Hospital Services										
Inpatient care/surgery	$100 per day, up to $500 per admission maximum	See Plan Handbook	20%	See Plan Handbook	20%	See Plan Handbook	20%	50%	20%	50%
Outpatient surgery/ facility care	$75	Not Covered	20%	Not Covered	20%	Not Covered	20%	50%	20%	50%
Skilled nursing facility care **Kaiser Plans:** 100 days per plan year **Moda Plans:** 60 days per plan year	$0	NA	20%	NA	20%	NA	20%	50%	20%	50%
Viscosupplementation	$30[5]	Not Covered	$35[1,5]	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Upper Endoscopies	$75	Not Covered	20%	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Sleep Studies	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
MRI, CT, PET imaging	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Lumbar Discographies	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Moda Plans Only: $100 Additional Cost Tier (ACT): spinal injections, tonsillectomies	NA	NA	NA	NA	NA	NA	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%
Moda Plans Only: $500 Additional Cost Tier (ACT): Spine surgery, knee & hip replacement[3], knee & shoulder arthroscopy, hernia repair	NA	NA	NA	NA	NA	NA	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Med Plan C Moda Health (PPO)		**Med Plan D** Moda Health (PPO)		**Med Plan E** Moda Health (PPO)		**Med Plan F** Moda Health (PPO)		**Med Plan G** Moda Health (PPO) Not HSA-Compliant		**Med Plan H** Moda Health (PPO) HSA Required	
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	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays		**Out-of-Network,** Member Pays
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	$100 copay + 20%	$100 copay + 50%	20%	50%
$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	$500 copay + 20%	$500 copay + 50%	20%	50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Medical Plans no lifetime maximum on any medical plans	**Med Plan 1** Kaiser (HMO)		**Med Plan 2** Kaiser (HMO)		**Med Plan 3** Kaiser (HMO)		**Med Plan A** Moda Health (PPO)		**Med Plan B** Moda Health (PPO)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
Outpatient and Hospital Services (continued)										
Outpatient Rehabilitation (physical, occupational & speech therapy) **Kaiser Plans:** Maximum 20 visits per therapy per Plan Year **Moda Plans:** 30 days per plan year / 60 for spinal or head injury	$30 per visit	Not Covered	$35[1] per visit	Not Covered	20%	Not Covered	20%	50%	20%	50%
Outpatient diagnostic lab and X-ray	$20 per visit	Not Covered	$25[1] per visit	Not Covered	20%	Not Covered	20%	50%	20%	50%
Emergency and Urgent Care										
Urgent care visit	$35	See Plan Handbook	$40[1]	See Plan Handbook	20%	See Plan Handbook	$50[1]		$50[1]	
Emergency room (copay waived if admitted)	$100 per visit (waived if admitted)		20%		20%		$100 copay + 20%		$100 copay + 20%	
Ambulance	$75		$100[1]		20%		20%		20%	
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	20%	Not Covered	10%	50%	10%	50%
Durable Medical Equipment	20%	Not Covered	20%[1]	Not Covered	20%	Not Covered	20%	50%	20%	50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Med Plan C Moda Health (PPO)		**Med Plan D** Moda Health (PPO)		**Med Plan E** Moda Health (PPO)		**Med Plan F** Moda Health (PPO)		**Med Plan G** Moda Health (PPO) Not HSA-Compliant		**Med Plan H** Moda Health (PPO) HSA Required	
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	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%
$50[1]		$50[1]		$50[1]		$50[1]		$50[1]		20%	
$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		$100 copay + 20%		20%	
20%		20%		20%		20%		20%		20%	
10%	50%	10%	50%	10%	50%	10%	50%	10%	50%	20%	50%
20%	50%	20%	50%	20%	50%	20%	50%	20%	50%	20%	50%

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Medical Plans no lifetime maximum on any medical plans	**Med Plan 1** Kaiser (HMO)		**Med Plan 2** Kaiser (HMO)		**Med Plan 3** Kaiser (HMO)		**Med Plan A** Moda Health (PPO)		**Med Plan B** Moda Health (PPO)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
Weight Management (subscriber and covered dependents unless noted otherwise)										
Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply)	$0		$0		$0		$0		$0	
12 Health Coaching Sessions per Plan Year & Online Educational Resources	$0		$0		$0		$0		$0	
Bariatric Surgery (a.k.a., Gastric bypass, Roux-en-Y)[3] Subscribers only, not covered for dependents. Approved providers only - See Plan Handbook for specific criteria.	$500 + Inpatient Care costs		$500 + 20%		$500 + 20%		$500 copay + 20%	Not covered	$500 copay + 20%	Not covered
Tobacco Cessation Program (available to age 10 and over)										
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications	Four 30-minute phone calls (more if needed) to Kaiser Health Coaching at no charge. Prescription required for patches, gum & medications, all subject to Rx copays. See Plan Handbook for details.		Four 30-minute phone calls (more if needed) to Kaiser Health Coaching at no charge. Prescription required for patches, gum & medications, all subject to Rx copays. See Plan Handbook for details.		Four 30-minute phone calls (more if needed) to Kaiser Health Coaching at no charge. Prescription required for patches, gum & medications, all subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.	
Pharmacy Services										
Out of pocket maximum	$1,100 Rx max also applies to Medical OOP Max		$1,100 Rx max also applies to Medical OOP Max		Rx applies toward plan OOP max		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share	
Retail Pharmacy Services										
Value (Moda Plans Only)	NA	NA	NA	NA	NA	NA	$0 (up to 90-day supply)		$0 (up to 90-day supply)	
Generic (Kaiser plans) / Select generic (Moda Plans)	$5 per 30-day supply	See Plan Handbook	$5 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply	

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Med Plan C Moda Health (PPO)		**Med Plan D** Moda Health (PPO)		**Med Plan E** Moda Health (PPO)		**Med Plan F** Moda Health (PPO)		**Med Plan G** Moda Health (PPO) Not HSA-Compliant		**Med Plan H** Moda Health (PPO) HSA Required	
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	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
$0		$0		$0		$0		$0		$0	
$0		$0		$0		$0		$0		$0	
$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 copay + 20%	Not covered	$500 + 20%	Not covered
Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.		Unlimited calls to (max 5 calls from) Alere Wellbeing per Plan Year. Patches, gum & prescribed medications subject to Rx copays. See Plan Handbook for details.	
Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward Max Cost Share		Rx applies toward plan OOP max	
$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0 (up to 90-day supply)		$0[4]	
$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		$8 per 31-day supply $24 per 90-day supply		20%	

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Medical Plans no lifetime maximum on any medical plans	**Med Plan 1** Kaiser (HMO)		**Med Plan 2** Kaiser (HMO)		**Med Plan 3** Kaiser (HMO)		**Med Plan A** Moda Health (PPO)		**Med Plan B** Moda Health (PPO)	
Plan Year Costs - Deductibles and copayments apply to the plan year out-of-pocket maximum (OOP).	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
Retail Pharmacy Services (continued)										
Preferred Brand	$25 per 30-day supply	See Plan Handbook	$25 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $50 per 31-day supply		25% up to $50 per 31-day supply	
Non-preferred brand	$45 per 30-day supply if criteria met	See Plan Handbook	$45 per 30-day supply if criteria met	See Plan Handbook	20%	See Plan Handbook	50% up to $150 per 31-day supply		50% up to $150 per 31-day supply	
Mail Pharmacy Services										
Value (Moda Plans Only)	NA	NA	NA	NA	NA	NA	$0		$0	
Generic (Kaiser plans) / Select generic (Moda Plans)	$10 per 90-day supply	See Plan Handbook	$10 per 90-day supply	See Plan Handbook	20%	See Plan Handbook	$16		$16	
Preferred Brand	$50 per 90-day supply	See Plan Handbook	$50 per 90-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $100 per 90-day supply		25% up to $100 per 90-day supply	
Non-preferred brand	$90 per 90-day, supply if criteria met	See Plan Handbook	$90 per 90-day, supply if criteria met	See Plan Handbook	20%	See Plan Handbook	50% up to $300 per 90-day supply		50% up to $300 per 90-day supply	
Specialty Pharmacy Services										
Select generic	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	$16		$16	
Preferred	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	25% up to $100 per 31-day supply		25% up to $100 per 31-day supply	
Non-preferred brand	25% up to $100 per 30-day supply	See Plan Handbook	25% up to $100 per 30-day supply	See Plan Handbook	20%	See Plan Handbook	50% up to $300 per 31-day supply		50% up to $300 per 31-day supply	

NA = not applicable

* If enrolled in a Summit or Synergy plan, you must select a medical home for each individual on the plan and each individual must access services and coordinate care through their medical home in order to receive the "In-Network" benefit; all preventive, primary and incentive care office visits not accessed through the individual's medical home will be paid at the "Out-of-Network" benefit. If enrolled in a traditional Statewide (i.e., not Summit or Synergy) plan, all providers within the Connexus Network are considered "In-Network".

[1] Deductible Waived

[2] Individual Deductible and Out-of-Pocket Maximum apply to single coverage only. Family Deductible and Out-of-Pocket Maximum apply when two or more individuals are covered on the Plan. This Deductible must be met before benefits will be paid (except where 1 indicates Deductible Waived).

Medical Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

Med Plan C Moda Health (PPO)		**Med Plan D** Moda Health (PPO)		**Med Plan E** Moda Health (PPO)		**Med Plan F** Moda Health (PPO)		**Med Plan G** Moda Health (PPO) Not HSA-Compliant		**Med Plan H** Moda Health (PPO) HSA Required	
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	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays	**In-Network*,** Member Pays	**Out-of-Network,** Member Pays
25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		25% up to $50 per 31-day supply		20%	
50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		50% up to $150 per 31-day supply		20%	
$0		$0		$0		$0		$0		$0[4]	
$16		$16		$16		$16		$16		20%	
25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		25% up to $100 per 90-day supply		20%	
50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		50% up to $300 per 90-day supply		20%	
$16		$16		$16		$16		$16		20%	
25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		25% up to $100 per 31-day supply		20%	
50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		50% up to $300 per 31-day supply		20%	

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

[4] To remain HSA-compliant, medications for certain conditions are not included in the Plan H value tier. See Plan Handbook for details.

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

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.

Notes

Dental Plans

Changes and Reminders for 2015-16

The only change to OEBB dental plans for 2015-16 is the addition of a Chronic Condition Dental Management program on Willamette Dental Group Dental Plan 8. Members with chronic conditions can learn more about this program by contacting Willamette Dental Group directly.

Below are reminders of important things to consider when choosing dental coverage.

Incentive Plans vs. Non-Incentive Plans

Moda Health/ODS Dental Plans 1, 2 and 3 are "incentive plans," meaning as long as you visit the dentist at least once during the year the level of benefit for certain services will increase the following year (up to a maximum of 100 percent). If you switch to one of the other "non-incentive" plans (Kaiser Dental Plan 8, Willamette Dental Group Plan 8, and Moda Health/ODS Dental Plans 4 and 6), you will not retain any higher benefit level you previously earned. If you switch back to an incentive plan in the future, your benefit will start over at 70 percent.

Maximum Benefit on Plans 1 – 6

Moda Health/ODS Dental Plans 1 – 6 are structured with a benefit maximum (maximum possible amount the insurance will pay in a given plan year). If you anticipate needing costly dental work, note the benefit maximum on the plan you choose and be prepared to pay 100% of any remaining costs after reaching that benefit maximum.

Kaiser Dental Plan 8 and Willamette Dental Group Dental Plan 8 do not have a benefit maximum. The plan and the member will continue to share the costs of all covered services as shown in the summary of benefits for the entire plan year, regardless of the accrued amount paid by either party.

Provider Networks

Willamette Dental Group and Kaiser Permanente both require you to use their facilities and providers to have nonemergency services covered. If you are currently covered by a different carrier and change to one of these plans, you will need to change providers.

Late Enrollment Penalty/12-Month Waiting Period

If you didn't enroll yourself or a dependent in dental coverage when initially eligible, then choose to enroll during an Open Enrollment period, whoever is being added to coverage will be considered a "late enrollee." Late enrollees are subject to a 12-month waiting period on all dental plans, meaning only diagnostic and preventive care will be covered for the first full 12 months of coverage.

Why is this waiting period in place?

Dental coverage is most often totally voluntary. That combined with the fact that dental services can often be delayed, as they tend to be less urgent than medical services, opens the plans up to "adverse selection." Basically, if individuals only enroll once they know they need costly services, the premiums for these coverages would need to be much higher for everyone than they are today in order to bring in enough premiums to pay the claims. The waiting period helps control costs, maintaining a balance between premiums coming in and claims being paid out.

Dental Plans

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

SHOW HIDE SHOW HIDE

Plan Option	Dental Plan 1 ♦	Dental Plan 2 ♦
Dental	**Moda Health/ODS**	**Moda Health/ODS**
Dental Office Visit Copayment	NA	NA
Benefit Maximum	$2,200	$1,500
Deductible	$50	$50
Plan Year Maximum	$2,200	$1,500
Preventive and Diagnostic Services* Deductible Waived for Preventive & Diagnostic Services on Moda Health/ODS Plans		
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	70% + 10% each Plan Year
Restorative Services*		
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	70% + 10% [1] each Plan Year
Simple Extraction*		
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year
Oral Surgery*		
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year
Periodontics*		
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year
Endodontics*		
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year
Major Restorative Services*		
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70% + 10% each Plan Year
Implants	70% + 10% each Plan Year	70% + 10% each Plan Year
Fixed and Removable Prosthetic Services*		
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	70% + 10% each Plan Year
Bridge retainers and pontics	70% + 10% each Plan Year	70% + 10% each Plan Year
Orthodontics* (All plans except Moda Health/ODS Dental Plan 6)		
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max

♦ Under incentive plans 1 - 3, benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year. Switching between incentive plans (1 - 3) and non-incentive plans (4, 6 and 8) will have an effect on benefit level.

† Kaiser Dental Plan 8 no longer requires enrollment in a Kaiser medical plan. Services must be provided by a contracted Kaiser provider in order for benefits to be payable. See handbook for details.

‡ Under Willamette Dental Group Plan 8, services must be provided by a Willamette Dental Group provider in order for benefits to be payable. See handbook for details.

* For Kaiser Permanente and Willamette Dental Group plans: Office visit copayment applies at each visit, in addition to any plan copayments for services.

** Pre-Orthodontic Service fee of $150 is credited toward the orthodontic benefit if patient accepts treatment plan.

Dental Plans (CONTINUED)

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

SHOW HIDE SHOW HIDE SHOW HIDE SHOW HIDE SHOW HIDE

Dental Plan 3 ♦	Dental Plan 4	Dental Plan 6	Dental Plan 8 †	Dental Plan 8 ‡
Moda Health/ODS	**Moda Health/ODS**	**Moda Health/ODS**	**Kaiser**	**Willamette Dental**
NA	NA	NA	$20*	$20[3]*
$1,500	$1,500	$1,200	NA	NA
$50	$50	$50	NA	NA
$1,500	$1,500	$1,200	NA	NA
70% + 10% each Plan Year	100%	100%	100%*	100%*
70% + 10% [1] each Plan Year	80% [1]	80% [1]	100% [2]*	100% [2]*
70% + 10% each Plan Year	80%	80%	100%*	100%*
70% + 10% each Plan Year	80%	80%	100%*	100%*
70% + 10% each Plan Year	80%	80%	100%*	100%*
70% + 10% each Plan Year	80%	80%	100%*	100%*
70% + 10% each Plan Year	80%	50%	100%*	100%*
50%	50%	50%	50%* (limit of 4 per lifetime)	See Certificate of Coverage for copays
50%	50%	50%	100%*	100%*
50%	50%	50%	100%*	100%*
80% to $1,800 lifetime max	80% to $1,800 lifetime max	NA	$1,500 copay + $20 per visit	$1,500 copay + $20 per visit**

[1] Posterior fillings paid to amalgam fee.

[2] Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and one-surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Kaiser Permanente or Willamette Dental Group directly for actual fees.

[3] The office visit copayment is waived for participants in the Chronic Condition Dental Management program for specific preventive services.

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.

Vision Plans

Reminders for 2015-16

There are no changes to OEBB vision plans for 2015-16. However, here are some reminders of important things to consider when choosing vision coverage.

Maximum Benefit on Plans 1 – 4

Moda Health Vision Plans 1 – 4 are structured with a benefit maximum (maximum possible amount the insurance will pay in a given plan year). If you anticipate needing vision services, note the benefit maximum on the plan you choose and be prepared to pay 100% of any remaining costs after the plan has paid that benefit maximum.

Kaiser Vision Plan 5 does not have an overall plan year benefit maximum. This plan has a specific allowance (maximum the plan will pay) for each type of service.

Note that all the vision plans have a "frequency schedule" for exams, lenses, and frames, meaning these services are only allowed once within a specified timeframe. See the Vision Plans Summary of Benefits on *page 29* for allowed amounts and frequency schedules.

Provider Networks

Kaiser Permanente requires you to use their facilities and providers to have nonemergency services covered. If you are currently covered by a different carrier and change to Kaiser Vision Plan 5, you will need to change providers.

Kaiser Vision Must Be Paired with Kaiser Medical

You must be enrolled in an OEBB Kaiser Medical Plan option in order to enroll in the Kaiser Vision Plan offered through OEBB.

You may enroll in a Moda vision plan with a Kaiser medical plan, but you cannot enroll in a Kaiser vision plan with a Moda medical plan, or if you opt-out or waive OEBB medical coverage.

Late Enrollment Penalty/12-Month Waiting Period

If you didn't enroll yourself or a dependent in vision coverage when initially eligible, then choose to enroll during an Open Enrollment period, whoever is being added to coverage will be considered a "late enrollee." Late enrollees are subject to a 12-month waiting period on all vision plans, meaning only routine eye exams will be covered for the first full 12 months of coverage – no lenses or frames.

Why is this waiting period in place?

Vision coverage is most often totally voluntary. That combined with the fact that vision services can often be delayed, as they tend to be less urgent than medical services, opens the plans up to "adverse selection." Basically, if individuals only enroll once they know they need costly services, the premiums for these coverages would need to be much higher for everyone than they are today in order to bring in enough premiums to pay the claims. The waiting period helps control costs, maintaining a balance between premiums coming in and claims being paid out.

Vision Plans

Summary of 2015-16 Benefits

Note: Some members may not have access to all plans shown in this summary. Your personalized cover letter explains which plans are available to you.

SHOW HIDE SHOW HIDE SHOW HIDE SHOW HIDE SHOW HIDE

Plan Option	Vision Plan 1	Vision Plan 2	Vision Plan 3	Vision Plan 4	Vision Plan 5**
Vision	**Moda Health**	**Moda Health**	**Moda Health**	**Moda Health**	**Kaiser**
Plan Year Maximum	$250*	$350*	$450*	$600*	See allowances
Routine Eye Exam	100%	100%	100%	100%	$5 office visit copay
Exam Frequency	**Once per Plan Year**	**Once per Plan Year**	**Once per Plan Year**	**Once per Plan Year**	**Once every 12 months**
Lenses	Either one pair of lenses or contacts	Either one pair of lenses or contacts	Either one pair of lenses or contacts	Either one pair of lenses or contacts	Either one pair of lenses or contacts
Single Vision	100%	100%	100%	100%	100% up to $58.50 per Plan Year
Bifocal	100%	100%	100%	100%	100% up to $86.00 per Plan Year
Lenticular	100%	100%	100%	100%	100% up to $86.00 per Plan Year
Trifocal	100%	100%	100%	100%	100% up to $109.00 per Plan Year
Contact Lenses	100%	100%	100%	100%	100% up to $192.50 per Plan Year
Lens Frequency	**Once per Plan Year**	**Once per Plan Year**	**Once per Plan Year**	**Once per Plan Year**	**Once every 12 months**
Frames	100%	100%	100%	100%	100% up to $75.00
Frame Frequency	**Under age 17:** Once per Plan Year	**Under age 17:** Once per Plan Year	**Under age 17:** Once per Plan Year	**Under age 17:** Once per Plan Year	**Under age 19:** No charge for one pair of standard frames and lenses every 12 months
	Age 17 and older: Once every two Plan Years	**Age 17 and older:** Once every two Plan Years	**Age 17 and older:** Once every two Plan Years	**Age 17 and older:** Once every two Plan Years	**Age 19 and older:** Once every 24 months

* Exam and hardware charges all apply to the Plan Year maximum on Moda Health Plans 1 - 4.

** Must be simultaneously enrolled in a Kaiser medical plan to be enrolled in Kaiser Vision Plan 5.

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.

NEW "OEBB Fitness Rewards"
Gym Membership Reimbursement Benefit

Get Reimbursed up to $15/month for Exercising at a Qualified Facility

Effective October 1, 2015, you can qualify for reimbursement (up to $15/month) of membership/participation fees paid to a qualifying fitness facility through OEBB's new "Fitness Rewards" program.

This program will offer reimbursement to members who meet the following criteria:

- Must be enrolled in an OEBB medical plan as either the primary subscriber (benefits-eligible employee or early retiree) or a covered spouse or domestic partner
- Must be 18 years old or older
- Must complete an annual online health assessment through your OEBB medical carrier
- Must submit the facility or instructor information to the OEBB Fitness Rewards program
- Must provide verification of exercise at a qualified facility of at least eight times within the calendar month

OEBB Fitness Rewards Benefit

OEBB Fitness Rewards program details including eligibility requirements, policies, forms, and processes can be found on the OEBB website:

www.oregon.gov/oha/OEBB/pages/OEBB-Fitness-Rewards.aspx

OEBB Fitness Rewards Q&A

Q: If I cover a spouse or domestic partner on my medical plan, do we both need to participate in "OEBB Fitness Rewards" to qualify for reimbursement? (In other words, is this a "both or neither" situation like Healthy Futures?)

A: No. For the purposes of the "OEBB Fitness Rewards" program, you and your spouse/partner are each registered and reimbursed individually. If your spouse/partner wants to participate and you don't, that is fine. They can register and submit for reimbursement without your participation, and vice versa. If you both participate, you could each get reimbursed up to $15/month.

Q: What do you mean by "up to" $15/month? Under what circumstances would my reimbursement be less than $15?

A: The program is truly meant to **reimburse** fees paid for gym membership or fitness class participation. Therefore, the program will only reimburse the actual amount paid up to the maximum amount of $15/month. If you pay $12/month for your gym membership and submit a request for reimbursement because you attended that gym eight times that month, the OEBB Fitness Rewards program would reimburse you the $12 you paid the gym for that month, not $15.

Q: How do I know if my gym or fitness facility qualifies?

A: OEBB Fitness Rewards policies and program details can be found on the OEBB website: www.oregon.gov/oha/OEBB/pages/OEBB-Fitness-Rewards.aspx. You can also contact OEBB Member Services by calling 1-888-469-6322 or sending an email to oebb.benefits@oregon.gov if you have additional questions.

NO COST Wellness Activities

OEBB offers a number of scientifically proven health-promoting activities at NO COST to qualifying members. See if you could benefit from any of the following programs!

Better Choices, Better Health® - Managing Chronic Conditions

Better Choices, Better Health is an online self-management course developed by Stanford University to assist people in dealing with problems associated with chronic medical conditions. Workshops are led by trained facilitators and include approximately 25 participants. You can participate in the six-week interactive workshop at your own pace from any computer. OEBB members and dependents age 18 or older enrolled in an OEBB medical plan can participate at NO COST.

Learn more or sign up now:
Restartliving.selfmanage.org/BetterHealth/SignUp?page=OEBB

MoodHelper - Depression Management

MoodHelper is an online program for adults to help manage depression. Going at your own pace, in the comfort of your own home, you can learn skills to overcome depression that have been effective for millions of people. OEBB members and dependents age 18 or older enrolled in an OEBB medical plan can participate at NO COST.

Learn more or get started now:
www.MoodHelper.org (Invitation Code: OEBB227)

Quit For Life® - Tobacco Cessation

The Quit For Life program has resources to help you quit tobacco. Your chances of quitting tobacco use will be eight times greater using the Quit For Life program than trying to quit on your own. Quit For Life is available at NO COST to anyone enrolled in an OEBB medical plan.

Call 1-866-QUIT-4-LIFE (1-866-784-8454)
or learn more online: QuitNow.net

Weight Watchers®

Weight Watchers is based on the philosophy that successful weight loss is achieved through the attainment of a series of realistic goals. The program incorporates healthy eating, physical activity, behavior modification, and for those who attend meetings, a supportive atmosphere. Anyone enrolled in an OEBB medical plan can enroll in their first 13-week session at NO COST (age restrictions may apply to children), either with AtWork Meetings, Community Meetings, or Online*Plus*. Those who maintain participation requirements could qualify for up to four 13- week sessions per plan year.

To learn more or enroll call 866-531-8170.
If you live in Lane, Douglas, Coos, Curry, Josephine, Jackson or Klamath County call 800-651-6000.

Healthy Team Healthy U - Team-Based Wellness

Healthy Team Healthy U (HTHU) is an innovative program proven to help participants lead a healthier life by forming fun teams with coworkers or family members. Everyone learns together and helps each other succeed. You get the tools to improve your diet, be more physically active, have more energy, and enjoy better health.

OEBB members and dependents age 18 or older enrolled in an OEBB medical plan can participate at NO COST. Plus, participation counts as BOTH healthy activities for OEBB's Healthy Futures program!

Note: You must still complete your health assessment and other Healthy Futures requirements in order to qualify for the lower deductible/copays.

Learn more or sign up now: Oebb.hthu.com

Healthy Team Healthy U Videos

Introduction Video
oebb.healthyteam-secure.com/public/

Testimonials by OEBB Members
oebb.healthyteam-secure.com/public/learn-more

OEBB Healthy Futures

Spouse/Partner Participation

If you cover a spouse or domestic partner on your medical plan, you both need to complete the Healthy Futures requirements in order for either of you to receive the Healthy Futures incentive (lower deductible/copays). If only one of you participates, the program requirements have not been met and your family as a whole will not receive the incentive.

For ease of communication, the rest of this section will simply refer to "you" as a single person, but keep in mind, if you have a spouse or domestic partner covered on your medical plan, these references apply to you both.

2015-16 Changes and the Transition Process

Healthy Futures is improving! Thanks to upcoming changes, you get another chance to lower your 2015-16 deductible/copays AND you'll get faster rewards for your health-improvement efforts!

How This Year's Transition Will Work

Depending on your past participation, you will fall into one of these categories for the 2015-16 Open Enrollment period:

- **Group 1 –** Those Who Already Completed a Health Assessment (June 1, ***2014*** or later)
- **Group 2 –** Those Who Have Not Yet Completed a Health Assessment but Want to Participate
- **Group 3 –** Those Who Choose Not to Participate

Group 1 – Those Who Already Completed a Health Assessment (June 1, 2014 or later)

a) **Open Enrollment 2015 –** If you've completed the online health assessment between June 1, 2014 and July 31, 2015, the MyOEBB system will recognize that you've completed that step. It will ask if you have completed your two healthy actions and, if so, it will ask you to record your two actions. *See page 35 for details on reporting your actions.*

b) **Congratulations!**
You will have the reduced deductible/copays effective October 1, 2015 – September 30, 2016.

c) **Your Healthy Futures status is secure for 2015-16!**
You don't need to take any further action until Open Enrollment 2016.

Group 2 – Those Who Have Not Yet Completed a Health Assessment but Want to Participate

a) **Open Enrollment 2015** – If you have not completed the online health assessment (or if you completed it so recently that OEBB has not yet received record of it), the MyOEBB system will offer you another chance to participate. If you would like to earn the incentive (lower deductible/copays) for 2015-16, just ***agree to***:

1) Complete the health assessment no later than October 15, 2015 *(if you've just recently completed it, this part is already done!)*,
2) Take two healthy actions before August 15, ***2016***, and
3) Report your two healthy actions in the MyOEBB system during Open Enrollment 2016.

b) **Congratulations!** You will have the reduced deductible/copays effective October 1, 2015.

c) **Your Healthy Futures status depends on you completing your Health Assessment by October 15, 2015!** If you don't complete the Health Assessment by October 15, 2015, your deductible/copays will be changed back to the regular plan benefit amount ***retroactively effective October 1, 2015***. If this happens, you could be responsible for additional charges for services received and processed at the lower deductible/copay level since October 1, 2015. You will not have another chance to participate until Open Enrollment 2016.

For more details on completing the health assessment, see *page 33*.

For more information on healthy actions, see *page 34*.

For more details on reporting your healthy actions, see *page 35*.

Group 3 – Those Who Choose Not to Participate

a) **Open Enrollment 2015 –** If you have not completed the online health assessment, the MyOEBB system will offer you another chance to participate. If you choose not to participate, simply decline the opportunity in the system and you will advance to the plan selection process. You will have the normal deductible/copays effective October 1, 2015 – September 30, 2016.

b) **You will not have another opportunity to participate in Healthy Futures for 2015-16.** Even if you decide to complete a health assessment later in the plan year, you will need to wait until Open Enrollment 2016 for the next opportunity to participate in the Healthy Futures program.

Completing Your Health Assessment

To complete your health assessment, log into your medical carrier's website (Moda Health or Kaiser Permanente).

See the back cover of this Open Enrollment Guide for carrier websites and contact information.

If you cover a spouse/partner on your medical plan, make sure you each create/use your own distinct user name and password so the system recognizes you each as distinct individuals and registers you both as having completed the health assessment. If you both use the same logon, the system will think the same person has completed the assessment twice and you will not receive proper credit for this step.

Kaiser Members

Kaiser members can go to http://kp.org/tha and click “Start a Total Health Assessment now.” Log in to your account, or click “Register now” to create a new account, if needed. To create an account you will need your Member ID that is listed on your Kaiser Permanente medical card. Once you’re logged in, click on “Total Health Assessment” (look for the yellow sunflower at the top of the page). **For assistance, call Kaiser Permanente at 800-813-2000.**

Download PDF instructions for the Kaiser Permanente Health Assessment at: www.oregon.gov/oha/OEBB/Guides/KP-HAinfo.pdf

Moda Health Members

Moda Health members can go to www.modahealth.com/oebb and log in to your myModa account, or create a new account, if needed. To create an account you will need your Subscriber ID that is listed on your Moda Health medical card. Once you’re logged in, click on the "myHealth" tab, then click the "Momentum, powered by Moda Health" link near the middle of the page, and then click the "Visit Momentum now" button at the bottom of the screen. If you cover a spouse/partner on your medical plan, they need to complete their own health assessment as well. Their Subscriber ID will be the same as yours, but they will need to create a unique user ID and password. **For assistance, call Moda Health at 866-923-0409.**

Download PDF instructions for completing Moda’s Health Assessment at: www.modahealth.com/pdfs/oebb/wellness/8578473_how_to_login_to_momentum_poster_web_OEBB.pdf

What Counts as a Healthy Action?

The only requirements about what actions to take are:

1) If your health assessment indicates that **weight** is a health risk, one of your actions must be aimed at reducing that risk.
2) If your health assessment indicates that **tobacco use** is a health risk, one of your actions must be aimed at reducing that risk.

The options are limitless! *(See page 31 for some great NO COST suggestions.)* Choose an activity that interests/challenges you and addresses your personal health risks. If you don't exercise much, try scheduling a 15 - 30 minute walk each day. If you already exercise regularly, set a goal that stretches you to new achievements. Or if your stress level is high, try some new relaxation techniques or join a yoga class or meditation group.

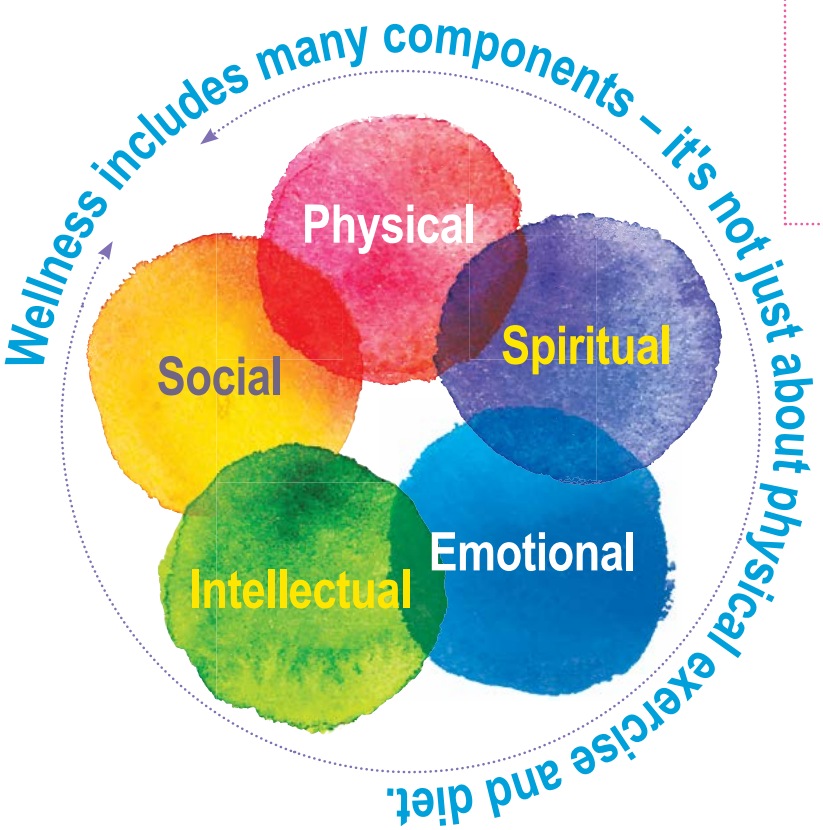
Each person's comfort zone is different, so just try to step slightly out of yours. You might be amazed by how a small change can improve your life!

Some examples of weight-related healthy actions are:

- Participate in Weight Watchers for at least one 13-week session
- Work with a health coach or dietitian available through your medical plan carrier to develop a plan for addressing your weight
- Work through the e-tools available on your medical carrier's website on weight management
- Participate in Healthy Team Healthy U (this counts as both wellness actions, regardless of your health risks!)

Some examples of tobacco-use-related healthy actions are:

- Participate in a tobacco cessation program (available through your medical plan carrier or through your healthcare provider)
- Work through the tobacco cessation e-tools on your medical carrier's website
- Participate in Healthy Team Healthy U (this counts as both of your wellness activities, regardless of your health risks!)



Reporting Your Healthy Actions

Open Enrollment is the time to report your healthy actions. If you've completed your online health assessment, the MyOEBB system will prompt you to report your two healthy actions. You can choose from a drop-down menu of popular activities (like those shown in the "NO COST Wellness Activities", on *page 31*), or you can type actions into free-form text fields. That's it!

Healthy Futures Q&A

Q: Do I have to participate in Healthy Futures?

A: No. Participation in Healthy Futures is optional, but you can reduce your deductible/copays if you do choose to participate and complete the program requirements. It's so easy, why pass up the opportunity to save money?

Q: What will happen if I select "NO -- I don't want to participate"?

A: Nothing. You will proceed to the plan selection process in the MyOEBB system and your medical plan options will all have the normal, non-incentivized deductible/copays. Once Open Enrollment ends, you will not have another opportunity to participate until the next Open Enrollment period the following year.

Q: What will happen if I select "YES -- I want to participate"?

A: You will be presented with an "attestation statement" where you will be asked to acknowledge that you understand and agree to the program requirements. If you decide you do not want to agree to these terms, you can back out and change your response to "No – I don't want to participate." If you do agree to the terms, you will receive the incentive (lower deductible/copays) effective October 1, 2015.

Q: What if I agree to the terms of the program, but then I miss a deadline?

A: Failure to complete the health assessment by October 15, 2015, after agreeing to do so will cause your deductible/copays to be adjusted back to the higher normal plan benefit amount, retroactively effective October 1, 2015. Failure to complete or report your two healthy actions during the 2016 Open Enrollment period will make you ineligible for the incentive (lower deductible/copays) for the 2016-17 plan year.

Q: What do you mean by "lower deductible/copays"? How much lower? And is it *both* my deductible AND my copays, or is it one or the other?

A: It depends on which plan you choose and how many individuals you cover.

In most cases (Kaiser Plan 2 and Moda Plans A – G), your individual deductible will be reduced by $100, up to $300 total for a family of three or more. Kaiser Plan 3 and Moda Plan H are HSA-Compliant and structured differently – on these plans, the individual deductible will be reduced to $1400, and the family deductible will be reduced to $2800.

Kaiser Plan 1 has no deductible; therefore, you will receive lower copays on certain services as a financially similar incentive. The details of the Kaiser Plan 1 incentive can be found online at: www.oregon.gov/oha/oebb/Documents/KP1incentive2015-16.pdf

Q: How do I notify OEBB that I completed my two actions?

A: You report your actions in the MyOEBB system during the Open Enrollment period.

Q: What if the actions I take don't work for me? (For example, if I try Weight Watchers but don't lose weight; or if I try a tobacco cessation program, but can't quit smoking?) Do I still get the incentive because I tried?

A: Yes! Taking two actions is just that … trying. You're not required to achieve results, although your chances are much better than if you didn't take action at all!

OEBB Healthy Futures (CONTINUED)

Q: I have an idea for a wellness activity that isn't on your list. How can I be sure it will count toward my Healthy Futures participation?

A: Any action that contributes to improving your health and well-being will count.

Q: What if I'm already very healthy and don't really have any health risks? How can I participate?

A: Congratulations! And thank you for taking such good care of yourself. Most people find that even if they are already quite healthy, the Health Assessment identifies one or two things they hadn't thought of, so you may still discover something you'd like to work on. Sometimes areas like stress management or emotional well-being are easy to overlook and could use some attention. If your Health Assessment confirms you're in perfect health, chances are good that you are already taking at least two actions to get and to stay that way. Just keep doing what you're doing and record two of your actions next year!

And don't forget to try to "step out of your comfort zone". If you already exercise regularly, perhaps you could increase the amount or intensity of your workouts, or participate in a group event if you usually exercise alone. There are always new and challenging things to try – have fun with it!

Q: What if I can't complete the requirements due to special circumstances?

A: The Oregon Educators Benefit Board (OEBB) will allow exemptions from the Healthy Futures' online health assessment and/or the two healthy activities requirements for members whose condition, disability or situation makes it unreasonably difficult or medically inadvisable. The complete policy and instructions explaining how to apply for exemption are available on the OEBB website: www.oregon.gov/oha/OEBB/Guides/Exemptions-from-OEBB-Healthy-Futures-Requirements-Policy.pdf

Notes

Optional Plans

Not all entities or employee groups offer all optional plans. For plan availability check with your employing entity or your personalized open enrollment cover letter.

Life Insurance

It's not easy to think about, but what if you suddenly died? Your family could be faced with house payments, unpaid bills, child care and other expenses just to maintain their current lifestyle. Could your family live without your income? Would your family be able to cover the medical expenses associated with a terminal illness or with burial and funeral expenses? To help protect your family, you may have the opportunity to apply for Optional Life insurance from The Standard.

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

If your entity is offering this benefit to your employment group for the first time this Open Enrollment, or if you are a new hire within your initial eligibility period, or with certain qualifying mid-year change events, Optional Life enrollment has a guarantee issue amount of $100,000 for employee and $30,000 for spouse/partner coverage. Any requested amount in excess of the guarantee issue amount or requested at a later date such as during an Open Enrollment period, will be subject to medical underwriting approval.

For more information about Optional Life:

The Standard
1-866-756-8115
www.standard.com/mybenefits/oebb/

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

Accidental Death & Dismemberment (AD&D) Insurance

The time you spend with your family is priceless, and you wouldn't trade those special moments together for anything in the world. But what would happen if you accidentally died or lost a limb? Would your family be financially prepared?

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

You may elect coverage for yourself or elect coverage for yourself and your spouse/domestic partner and/or eligible children:

- Employee in units of $10,000 from $10,000 up to a maximum of $500,000
- Spouse/Domestic Partner: Any multiple of $10,000 up to $500,000, but not to exceed the amount of the Employee coverage
- Children: Any multiple of $2,000 up to $10,000, but not to exceed the amount of Employee coverage

For more information about Optional AD&D:

The Standard
1-866-756-8115
www.standard.com/mybenefits/oebb/

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

Disability Insurance

Short Term Disability (STD) and Long Term Disability (LTD) insurance is designed to pay a benefit to you in the event you cannot work because of a covered illness, injury or pregnancy. This benefit replaces a portion of your income, thus helping you meet your financial commitments in time of need. Check with your employing entity for enrollment availability.

Short Term Disability (STD)

STD insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered non-occupational illness or injury. This benefit is an income replacement insurance. Weekly benefit amount, calendar day waiting period, and benefit duration will depend upon the plan selected by your employing entity for enrollment.

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

Long Term Disability (LTD)

LTD insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit is an income replacement insurance. Monthly benefit amount and calendar day waiting period will depend upon the plan selected by your employing entity.

For complete STD and LTD policy coverage and exclusions information:

The Standard
1-866-756-8115
www.standard.com/mybenefits/oebb/

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

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

Long Term Care Insurance

What is long term care?

Whether it's due to a motorcycle accident or a serious illness, it is the type of care you may need if you couldn't independently perform the basic activities of daily living: bathing, dressing, using the toilet, transferring from one location to another, continence and eating, or if you suffered severe cognitive impairment from a condition such as Alzheimer's disease.

Won't my other insurance pay for long term care?

Unfortunately, no.

- Medical insurance and Medicare are designed to pay for specific care for acute conditions — not for long term help with daily living.
- Medicaid only helps with long term care expenses after you have depleted virtually all of your assets.

The exact amount varies by state but usually leaves just a few thousand dollars in total assets. Only long term care insurance may cover those costs and allow you to maintain as much of your assets as possible.

Do I need to be in a nursing home to use my LTC insurance?

All Unum plans include a home health option. This allows you to use your benefit to pay for an aide to come to your home, so you can remain in your residence as long as possible. For an extra premium, some plans allow you to pay a family member or friend to take care of you.

Why buy now?

People often buy long term care insurance at an early age, because the younger you are, the more affordable the rates. In fact, 63% of the people who buy group LTC insurance are under age 55.

Additional help for caregivers

Even if you don't need long term care in the immediate future, you may be a caregiver for someone you love. Your plan includes LTC Connect® service, which gives you access to counselors who can help you find long term care providers in your area, a support group, or other assistance you may need. This service also provides discounts for medical equipment such as walkers, hearing aids, wheelchairs, and other related needs. Your parents, grandparents, siblings and children may also apply for this coverage by contacting Unum.

For more information about OEBB Long Term Care:

UNUM Life Insurance Company of America
1-800-227-4165 https://w3.unum.com/enroll/OEBB002/index.aspx

Optional Plans (CONTINUED)

Employee Assistance Program (EAP)

A free benefit to you if your employing entity offers this program. A full list of entities offering this benefit can be found on the OEBB website: www.oregon.gov/oha/OEBB/Pages/Employee-Assistance-Program.aspx

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

Confidential Counseling

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

Other Available Services:

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

For more information or to access EAP services contact:

RBH
the road to better health

Reliant Behavioral Health (RBH)
1-866-750-1327
www.MyRBH.com
Access Code: OEBB

Health Savings Accounts (HSAs)

OEBB offers Health Savings Accounts (HSAs) as a valuable benefit for participating employers to offer OEBB members. These accounts, paired with a qualified high-deductible health plan*, allow members to save money by paying lower medical insurance premiums and paying for qualifying healthcare expenses with pre-tax dollars. OEBB-participating employers are not required to offer these benefits, and they have the option to use a different vendor to provide these benefits if they so choose. If you are an OEBB member, please confirm with your employer whether these benefits are available to you and, if so, how to access them.

What is Health Savings Account (HSA)?

A Health Savings Account (HSA) is like a 401(k) for healthcare. Combined with your qualified high-deductible health plan*, an HSA gives you an easy, safe way to lower your healthcare costs today while saving money for future healthcare expenses.

**OEBB plans that qualify as a high-deductible health plan are Kaiser Medical Plan 3 and Moda Health Medical Plan H.*

Learn more about OEBB's HSAs through OEBB's preferred vendor (effective October 1, 2015):

WageWorks
everyone benefits

WageWorks
(866) 531-8170
www.wageworks.com/oebb

Flexible Spending Accounts (FSAs)

OEBB offers Flexible Spending Accounts (FSAs) as a valuable benefit for participating employers to offer OEBB members. These accounts allow members to save money by paying for qualifying expenses with pre-tax dollars. OEBB-participating employers are not required to offer any or all of these benefits, and they have the option to use a different vendor to provide these benefits if they so choose. If you are an OEBB member, please confirm with your employer which of these benefits are available to you and how to access them.

Types of Flexible Spending Accounts (FSAs) Offered by OEBB:

Healthcare Flexible Spending Account

A Healthcare Flexible Spending Account (FSA) is a pre-tax benefit account used to pay for eligible medical, dental, and vision care expenses that aren't covered by your insurance plan or elsewhere. These healthcare expenses can be incurred by you, your spouse/domestic partner, and/or your dependent children. It's a smart, simple way to save money while keeping you and your family healthy and protected.

HSA-Compatible Flexible Spending Account

If you're enrolled in a qualified high-deductible health plan* and have an HSA (Health Savings Account), you can maximize your savings with an HSA-Compatible FSA. This pre-tax benefit account helps you save on this plan year's eligible out-of-pocket dental and vision expenses while taking advantage of the long-term savings power of an HSA.

**OEBB plans that qualify as a high-deductible health plan are Kaiser Medical Plan 3 and Moda Health Medical Plan H.*

Dependent Care Flexible Spending Account

A Dependent Care Flexible Spending Account is a pre-tax benefit account used to pay for dependent care services, such as preschool, summer day camp, before or after school programs, and child or elder daycare. A Dependent Care FSA is a smart, simple way to save money while taking care of your loved ones so that you can continue to work.

Note: This type of account is NOT used to pay for healthcare expenses incurred by your dependents. Pre-tax savings for healthcare expenses, whether incurred by you or your dependents, would be put into a Health-care Flexible Savings Account as shown above.

New Commuter Savings Benefit

Effective October 1, 2015, OEBB is offering Commuter Benefits through WageWorks® as another valuable option for participating employers to offer OEBB members. OEBB-participating employers are not required to offer any or all of these benefits, and they have the option to use a different vendor to provide these benefits if they so choose. If you are an OEBB member, please confirm with your employer which of these benefits are available to you.

What are Commuter Benefits?

If employees take public transportation to work or pay for parking, Commuter Benefits save them money by paying transit and parking expenses with pre-tax dollars. The employer lowers its payroll taxes, and employees take home extra money each month.

Commuter Transit Account

A Commuter Transit Account is a pre-tax benefit account used to pay for public transit—including train, subway, bus, and ferry—as part of your daily commute to and from work. It's a great way to put extra money in your pocket each month and make your commute more convenient and affordable.

Commuter Parking Account

A Commuter Parking Account is a pre-tax benefit account used to pay for parking as part of your daily commute to and from work. It's a great way to put extra money in your pocket each month and make your commute more convenient and affordable.

Commuter Vanpool Account

A Commuter Vanpool Account is a pre-tax benefit account used to pay for vanpools as part of your daily commute to and from work. It's a great way to put extra money in your pocket each month and make your commute more convenient and affordable.

Bicycle Reimbursement Program

The Bicycle Reimbursement Program can help you save money while supporting your healthy, environmentally-friendly commute to and from work. Even if you bike to work only a few days a week, this program is a great way to put extra money in your pocket each month.

Learn more about OEBB's FSAs and Commuter Savings Benefits through OEBB's preferred vendor (effective October 1, 2015):

WageWorks
(866) 531-8170
www.wageworks.com/oebb

Early Retiree Information

Enrollment Changes Allowable during Open Enrollment

As an Early Retiree during Open Enrollment you can:

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

As a Reminder:

- Any coverage waived, declined, or canceled cannot be added back unless you are doing so because of losing other OEBB coverage
- Any eligible dependent removed from coverage cannot be added back unless the dependent experiences a Qualified Status Change (QSC) Event that would allow the enrollment in coverage

If you or an eligible dependent are experiencing a QSC event, you will need to contact your benefits administrator within 31 days of the qualifying event.

To View Your Current Enrollments:
https://myoebb.org/oebb/!pb.main

Rate Information:
www.oregon.gov/oha/OEBB/Pages/Plans-Offered.aspx

QSC Matrix:
www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

Becoming Eligible for Medicare during the Plan Year

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

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

The OEBB system will end coverage for Medicare eligibility gained due to turning 65 years old. You will need to notify your benefits administrator if gaining eligibility prior to turning age 65.

Medicare Enrollment Resources

You can enroll in Medicare up to three months in advance. The Senior Health Insurance Benefits Assistance (SHIBA) Program was created to assist with Medicare and Medicare plan selection questions. The SHIBA website is full of helpful Medicare information and certified counselors are available by phone at 1-800-722-4134.

Medicare website:
http://medicare.gov/

Medicare questions and plan selection assistance:
www.oregonshiba.org

PERS Health Insurance Program
(PERS offers Retiree and Medicare Plans):
https://www.pershealth.com/

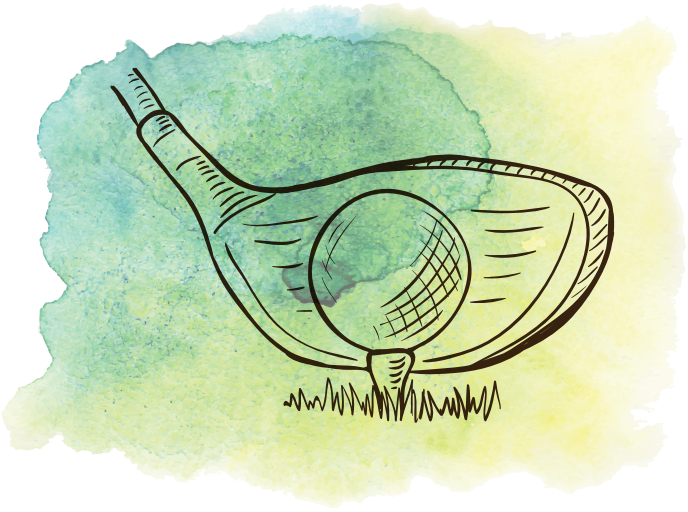
Additional Resources

Frequently Asked Questions (see Early Retiree categories):
www.oregon.gov/oha/OEBB/Pages/FAQs.aspx

Public Employees Retirement System (PERS):
www.oregon.gov/pers

Early Retiree Information (CONTINUED)

Resources for OEBB-Administered Self-Pay Early Retirees



This section is for retirees whose employing entity has transferred administration of their benefits to OEBB and who have signed, or will sign, an agreement with OEBB to deduct the monthly premium electronically from their financial institution.

The following forms are only for OEBB-Administered Self-Pay Early Retirees:

Self-Pay Early Retiree ACH Debit Authorization Form:
www.oregon.gov/oha/OEBB/Forms/Self-Pay-Early-Retiree-ACH-Debit-Authorization-Form.pdf

Self-Pay Early Retiree Change of Address Form:

- Printable Form
  www.oregon.gov/oha/OEBB/Forms/Self-Pay-Early-Retiree-Change-of-Address-Form.pdf
- Online Submission Form
  http://form.jotformpro.com/form/50765278296973

Self-Pay Early Retiree Terminate Benefits Form:

- Printable Form
  www.oregon.gov/oha/OEBB/Forms/Self-Pay-Early-Retiree-Terminate-Benefits-Form.pdf
- Online Submission Form
  http://form.jotformpro.com/form/50765030172952

Monthly Premiums

OEBB-Administered Self-Pay Early Retirees pay the full monthly premium for their plan selections. A separate rates document was included with your Open Enrollment materials. You can also find premium rates online at:
www.oregon.gov/oha/OEBB/Pages/Plans-Offered.aspx

Glossary of Terms

The terms defined below are commonly used in reference to OEBB plans. Some apply to health insurance in general and some are specific to OEBB plans.

ACA Maximum Cost Share

Effective October 1, 2015, this limits the amount a member could pay out-of-pocket for in-network medical and prescription services combined, including Additional Cost Tier (ACT) copayments. For OEBB plan offerings, this applies only to Moda Health Medical Plans A – G.

Additional Cost Tier (ACT)

Services in this tier require an additional copayment of $100 or $500. These copayments do not apply toward the deductible or the annual medical out-of-pocket maximum and are in addition to any other applicable copayment or coinsurance you must pay under your specific medical plan benefits. These copayments do apply toward the annual ACA Maximum Cost Share. Services in this tier have been shown to have alternatives that are often as safe or safer, less expensive and/or produce better health outcomes. The additional copayment serves as financial incentive for members to discuss other options with their doctor before proceeding.

COBRA

This acronym stands for the Consolidated Omnibus Budget Reconciliation Act, which is the federal law requiring employers to allow for continued coverage through a group health plan after losing eligibility in the group, on a self-pay basis. For OEBB members, COBRA coverage is guaranteed continuation of your previous OEBB coverage and administered by BenefitHelp Solutions (BHS). Regardless of your health status, COBRA law allows eligible parties losing OEBB coverage to continue that same coverage for at least 18 months. COBRA premiums are equal to the full OEBB premium plus two percent. Keep in mind, your employer may have been contributing toward your premium when you were eligible for OEBB coverage, so the amount you were paying may not have been the full premium amount. More information about COBRA and other options after loss of OEBB coverage can be found in the COBRA category FAQs on the OEBB website: www.oregon.gov/oha/OEBB/Pages/FAQs.aspx

Coinsurance

The cost of a covered service that is shared by the plan and you, typically expressed in percentages, once the deductible has been met. Example: 20 percent coinsurance = Member pays 20 percent, Plan pays 80 percent.

Copayment

A fixed dollar amount (e.g., $20) you pay to the provider at the time of service.

Deductible

The amount you pay for covered services before the plan begins to pay claims at a coinsurance level. Effective October 1, 2015, the deductible does apply toward the annual medical out-of-pocket maximum on all plans.

Note: The deductible is waived on a number of services. See the plan comparisons on pages 12 - 23 and 26 - 27 for more details.

Early Retiree

An individual who retires before the age of 65. In order to be eligible for OEBB benefits, an early retiree must not be eligible for Medicare and must be eligible to receive a service retirement allowance under PERS or a retirement benefit plan or system offered by an OEBB-participating organization. For more information specific to Early Retirees, see *pages 42 - 43* of this Enrollment Guide.

Employer Contribution

The amount your employer pays toward your benefits package or health insurance premium.

Formulary

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

Incentive Office Visit

A regularly scheduled visit with a healthcare provider to manage asthma, heart conditions, high cholesterol, high blood pressure, or diabetes. This is only applicable to OEBB Moda Health medical plans.

Maximum Benefit

The total amount payable by a plan per plan year. Examples: Alternative Care under OEBB medical plans and all Moda Health dental and vision plans.

Glossary of Terms (CONTINUED)

Medical Out-of-Pocket Maximum

The maximum you will have to pay "out of your pocket" for covered services in a plan year. Effective October 1, 2015, the out-of-pocket maximums include the deductible and any copayments for medical (non-pharmacy) services. Deductibles are calculated on an individual basis, but are limited to no more than three per family on the Moda Health plans and no more than two per family on the Kaiser Permanente plans. Under Kaiser Plan 3 and Moda Health Medical Plan H, the maximum amount is determined by the number of individuals covered on the plan (individual or family).

Moda Health Medical Home

A select group of healthcare providers who practice team-based medicine and have met the state's criteria to be certified as a Patient-Centered Primary Care Home and are participating in the Moda Health Connexus provider network. OEBB members enrolled in a Moda Health Statewide medical plan will receive a better benefit on certain services if they use one of these providers. Each individual enrolled in a Moda Health Synergy or Summit plan must select a Moda Health Medical Home to coordinate their care, and ensure that medical home is formally on record with Moda Health prior to utilizing services. You can search for a Moda Health Medical Home provider on the Moda Health website: www.modahealth.com/oebb/members/medical_home/find_provider.shtml

Pre-authorization (or Prior Authorization)

An insurance plan requirement that covered services be approved by the plan prior to the date of service. Only certain services require pre-authorization under the OEBB benefit plans. See your plan handbook for more details.

Primary Care Provider

Also referred to as General Practitioner, provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions not limited by cause, organ system, or diagnosis. Examples: Internist, Family Practice, ObGyn, Pediatrician, Nurse Practitioner.

Qualified Status Change (QSC)

A life event that allows a member to change their plan elections outside the annual Open Enrollment period. The QSC Matrix lists all the events that qualify as a QSC. The QSC Matrix is available online at: www.oregon.gov/oha/OEBB/Pages/QSC-Matrix.aspx

Specialist Provider

Provides services specific to a particular cause, organ system, or diagnosis on which they have chosen to focus their medical expertise. Examples: Allergist, Neurologist, Oncologist, Dermatologist.

Value Tier

A tier of medications under the Moda Health pharmacy benefit available at no cost to the member when used to manage asthma, heart conditions, high cholesterol, high blood pressure, diabetes, or osteoporosis. Under Moda Health Medical Plans A – G, some medications used to treat depression or pain/arthritis are also included in this tier.

Wellness Visit

A covered service under all OEBB medical plans. On the Moda Health Statewide plans, this service is only covered if provided by a Moda Health Medical Home provider. This is a visit with a physician focused on overall wellness rather than treating a specific condition. The visit could focus on drug/alcohol/tobacco use, exercise, weight, physical activity, nutrition, depression, or other wellness-related topics.

Appendix A – Guide to the MyOEBB Enrollment System

Welcome to MyOEBB!

Overview of the Open Enrollment Process

The Open Enrollment period is the only time of year you can make changes to your plan selections without a Qualified Status Change (QSC) event such as marriage, birth, or change of employment. The QSC Matrix (available on the OEBB website) provides a detailed list of all qualifying events, the changes each allows, and the timeframe allowed for requesting any desired changes (usually 31 days, although a few events allow more time). Contact the benefits administrator at your employing entity if you experience a QSC event.

Along with making your benefit selections for the upcoming plan year, Open Enrollment is also an excellent time to review and update your personal information, add or change dependent information, get information about plans, and more. See the Resource Tools menu on the left side of the MyOEBB screen for all your options.

Once you have saved your plan selections and the Open Enrollment period has ended, those selections will stay in effect until the next Open Enrollment period or until you make a change allowed by a QSC.

Checklist for Open Enrollment

- ✔ Your E Number or SSN
- ✔ Birth Dates of benefit eligible family members
- ✔ Plan Choices for Healthcare Benefits and Optional Benefits
- ✔ Affidavit Forms (if necessary) for certain dependents
- ✔ Other Group Coverage Information (if necessary)

Follow these steps to complete the Enrollment Process.

Log In or Register

Log in to the MyOEBB website:

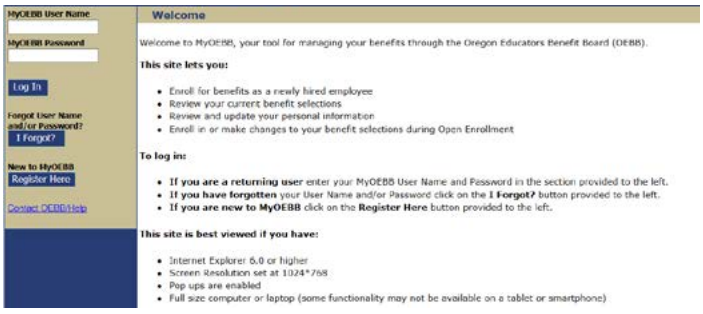
https://myoebb.org/oebb/!pb.main

If you are new to MyOEBB:

Click Register Here if you are new to MyOEBB. MyOEBB identifies your membership and leads you through setting up two security questions, a User Name, and Password.

As a new user, you will need to provide the following information to identify yourself:

- ✔ First name as it appears on your Pay Check
- ✔ Last name as it appears on your Pay Check
- ✔ Date of birth
- ✔ ID Type you wish to use to register.
  You may use your:
  - Social Security number, or
  - E-Number (OEBB Benefit Number that begins with the letter "E")



If you are a returning member to MyOEBB:

Note: If you have registered in the past with another employing entity, your user name and password stays the same.

Enter your MyOEBB User Name and MyOEBB Password: Click the Log In button.

If you have Forgot User Name and/or Password, click the I Forgot? button.

If you have forgotten your User Name and/or Password you will need the following information to identify yourself:

- ✔ First name as it appears on your Pay Check
- ✔ Last name as it appears on your Pay Check
- ✔ Date of birth
- ✔ Select types of ID you wish to use. You may use your:
  - Social Security number, or
  - E-Number (OEBB Benefit Number that begins with the letter "E")

If you have any difficulties with your log in, please contact your Employing Entity or contact OEBB at 1-888-469-6322 for assistance.

After you log into MyOEBB, you first must click on the TRUVEN Plan Comparison Page link.

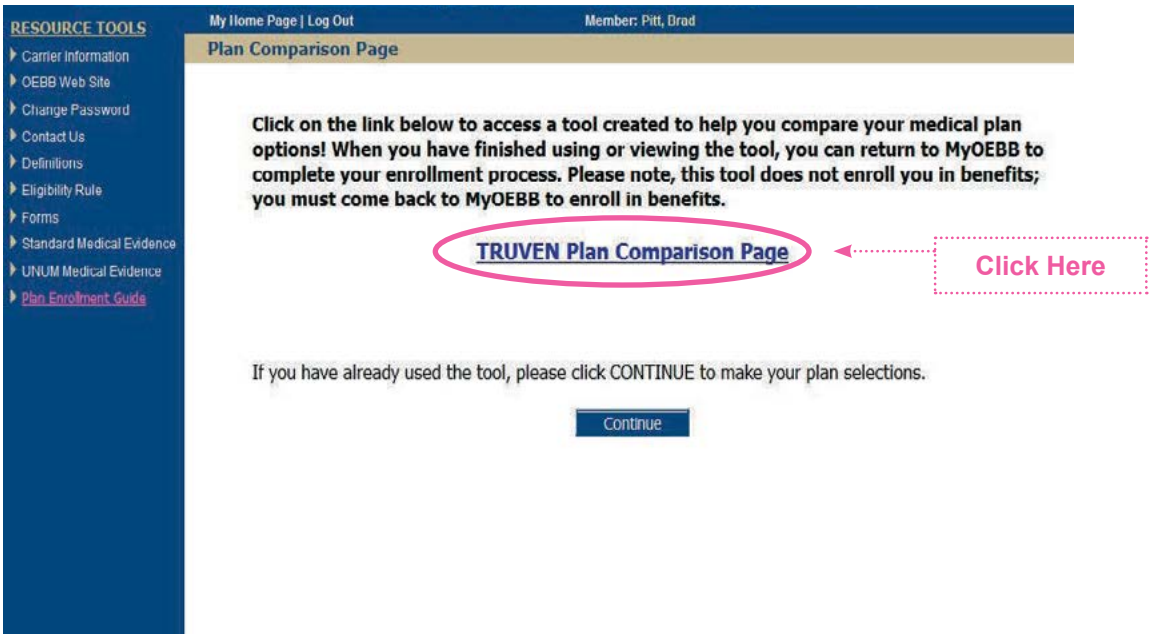
Appendix A – Guide to the MyOEBB Enrollment System (CONTINUED)

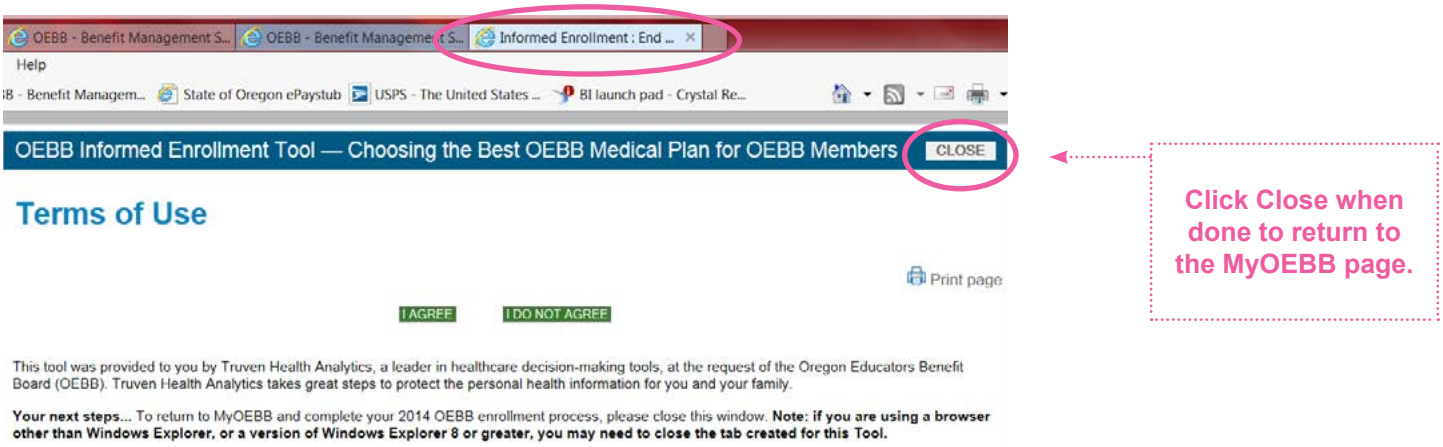
Plan Comparison Tool

Below is an example of a link that will take you to a plan comparison tool which will help you estimate the costs of each medical plan available to you and help you select the plan that best meets the needs for you and your family.

Please click this link and use this tool to explore the medical plan choices available to you through your entity. The tool will open up in a pop-up window and the MyOEBB Member Module will still be open in the background.

Note: The TRUVEN tool does not enroll you in your benefits.



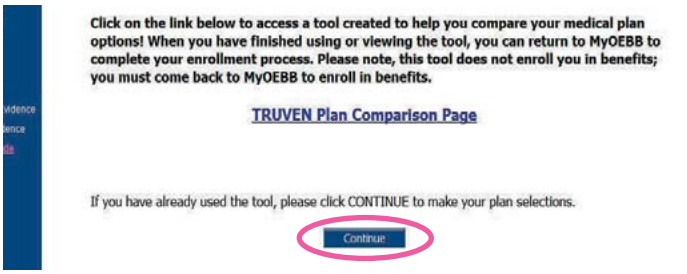


Once you have completed the TRUVEN Plan Comparison Tool, close the page and you will come back to the MyOEBB page where you can continue on with your enrollment selections.

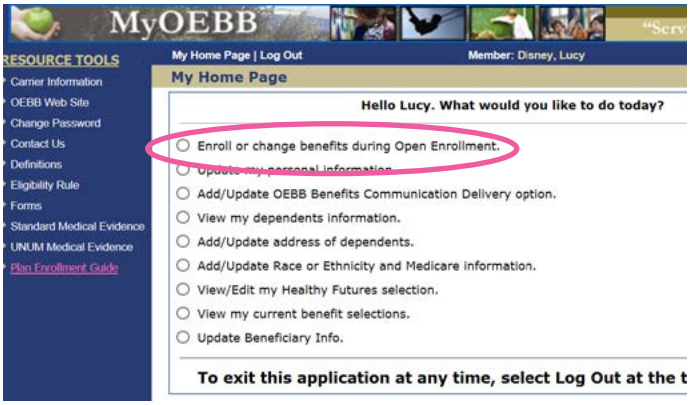
Appendix A – Guide to the MyOEBB Enrollment System (CONTINUED)

Returning to MyOEBB Page

Once you have closed the Truven Plan Comparison Tool window, or clicked on the tab where you already logged in to your MyOEBB account, you are now ready to click on the Continue button and make your benefit enrollments.



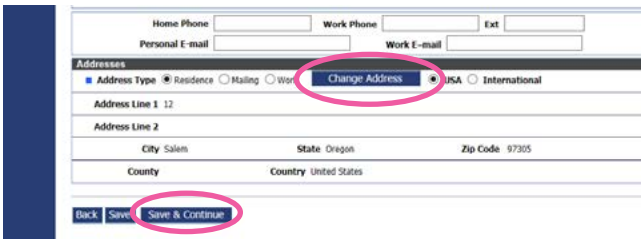
When you are ready to start enrolling in your open enrollment benefits select **Enroll or change benefits during Open Enrollment.** The screen will refresh and take you to "My Personal Information".



Verifying Personal Information

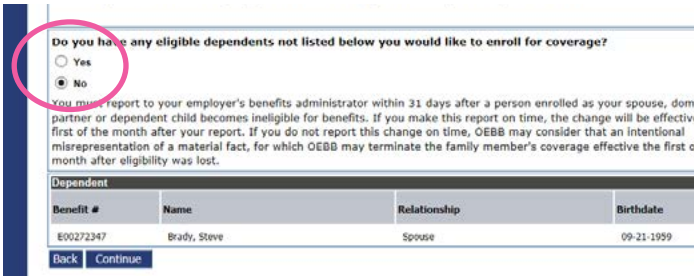
You are now ready to verify and/or update your personal information. This includes your home phone, work phone, personal e-mail, work e-mail and residence address. Under "Address Type" your mailing and work address are optional. To update your address, click on **Change Address** and enter your correct address or simply update your phone numbers or e-mail. You must click on each address type that you wish to update. Click **Save & Continue**.

Note: If you find your name, gender or birth date is incorrect, contact your Entity Benefits Office to get it corrected.



Adding Dependents

If you have eligible dependents not already listed in MyOEBB, you can add their information during Open Enrollment. Eligible dependents include spouse, domestic partner, and children. Remember, adding their information here does not automatically enroll them in benefits. You will need to also select the correct tier and select them for coverage during plan enrollment.



The dependent information page appears as shown below. Fill in any required fields (those with the blue square next to the field description), using one row for each dependent. When the form is complete, click **Save & Continue**.

Medicare Eligible Dependent Healthcare Coverage Information

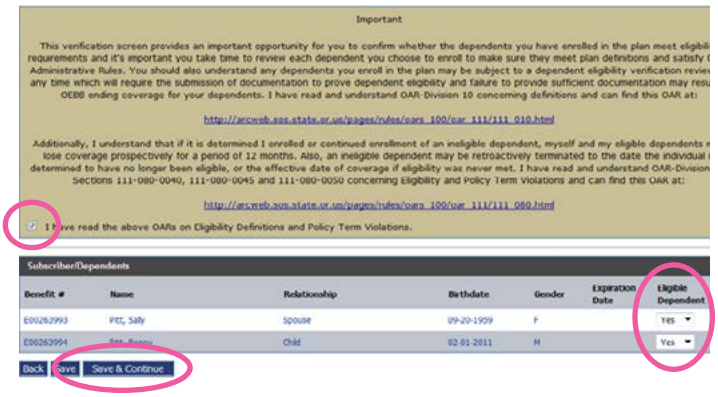
This screen will only appear if you list a dependent over age 45. Ensure the Medicare eligiblity question is answered correctly for this dependent. Enter the dependent's Social Security Number (SSN) or Medicare Health Insurance Claim Number (HICN), or if you prefer not to provide either of these numbers, click in the small square next to **No Response**.

Appendix A – Guide to the MyOEBB Enrollment System (CONTINUED)

Dependent Eligibility Verification

Please review the dependents you have listed in the system and make sure only eligible dependents are enrolled in benefit plans. Answer "**YES**" or "**NO**" to indicate which of your dependents meet OEBB's eligibility requirements in the "Eligible Dependent" column.

Mark the statement at the bottom of the brown text box acknowledging that you have read OEBB's eligibility rules and policies, and confirm that any dependents marked "**YES**" in the section below are eligible to enroll for the 2015-16 plan year. Click the **Save & Continue** button.



Dependent Addresses

To ensure your dependents are in the appropriate network, please update their addresses to reflect where they currently live.

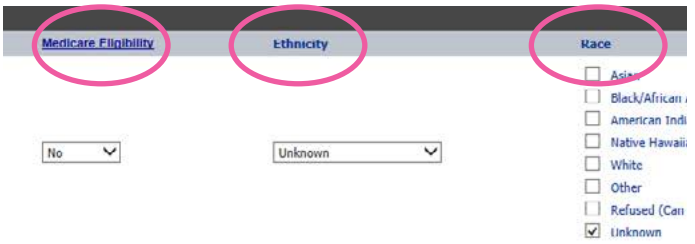
To change the address of a dependent, click the **Update** button in the far right column.

When all dependent addresses are current, click the **Continue** button at the bottom of the screen.

Required Questions

Complete Medicare Eligibility, Ethnicity, Race, and Tobacco Usage questions for yourself and your eligible dependents.

Click the **Save & Continue** button at the bottom of the screen.

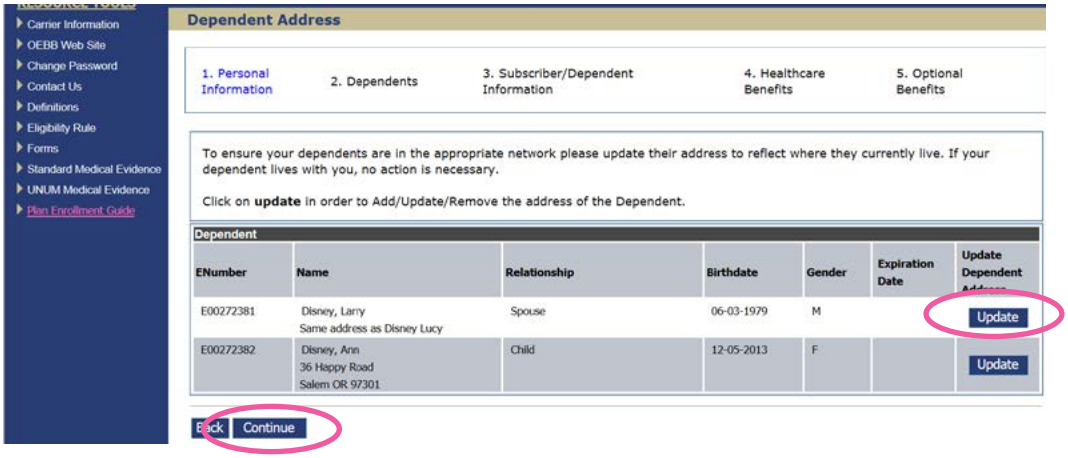


Enrolling in Healthy Futures

Before you enroll in medical coverage, you will be given an opportunity to lower your deductible/copays for the upcoming 2015-16 plan year by participating in Healthy Futures.

Note: If you cover a spouse or domestic partner on your medical plan, your agreement to participate indicates that your spouse or domestic partner also agrees to participate. You both will need to complete the Healthy Futures requirements in order for either of you to receive the lower deductible/copays.

Learn more about the Healthy Futures program online at: www.oregon.gov/oha/oebb/pages/Healthy-Futures.aspx.

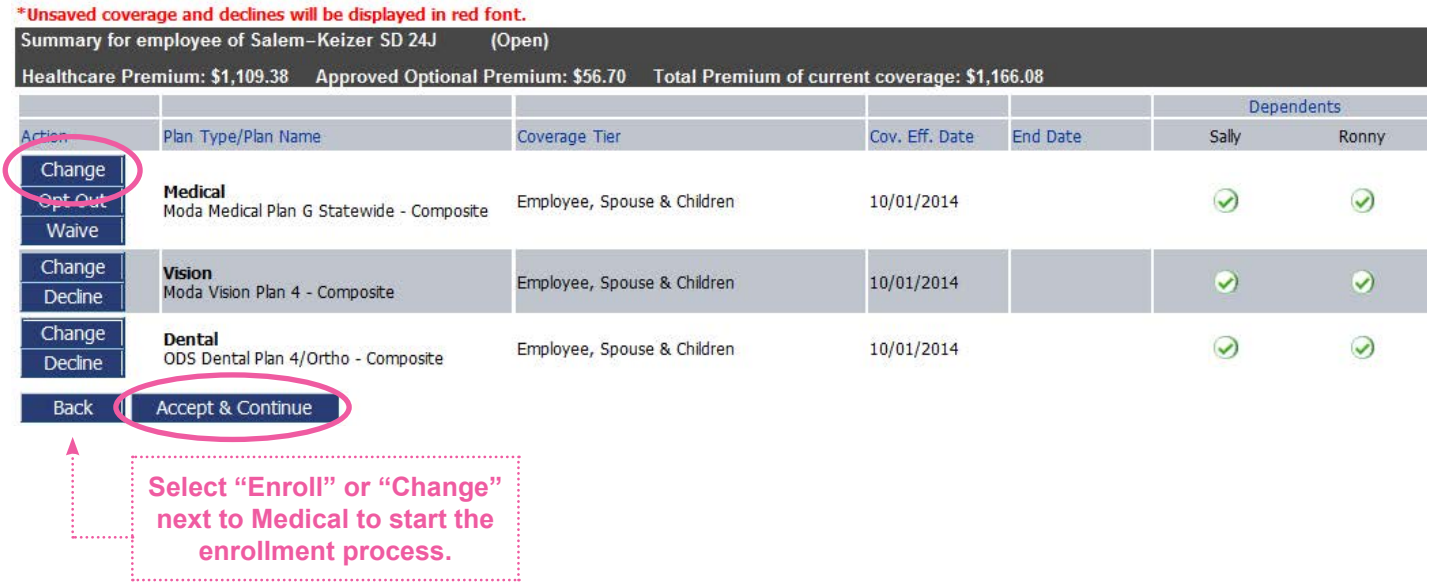


Appendix A – Guide to the MyOEBB Enrollment System (CONTINUED)

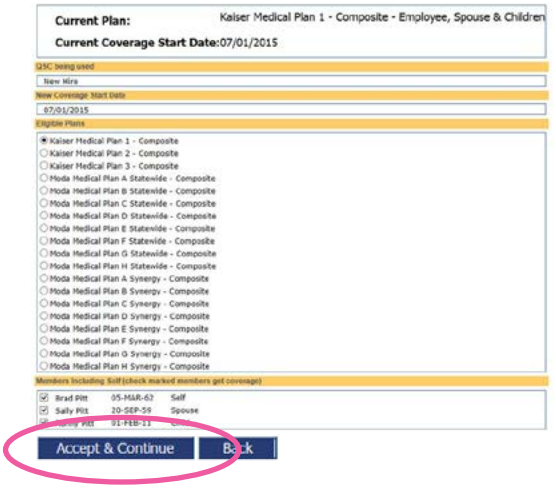
Enrolling in Medical, Vision, and Dental Benefits

It is now time to enroll in Medical, Vision, and Dental benefits. Depending on your group's rules and options, you may choose to **Opt Out** of Medical coverage (you may need to provide proof of other group insurance), or you may **Waive** your medical coverage. Contact your Benefits Office for your opt out or waive options and rules. Click on **Change** if you wish to change your plan or add dependents. If you have not enrolled in a plan, click **Enroll** to enroll in the plan.

Click **Accept & Continue**.



At the bottom of the screen you will see the plans you are currently enrolled in through September 30, 2015. Click the radio button to select the plan you wish to enroll in for 2015-16, and check the box next to each dependent you want to cover on that plan.



Once that's done, the screen refreshes to show your current selection. Make sure each dependent you want to cover has a check mark next to their name, and any dependents you don't want to cover do not have a check mark next to their name. When all looks correct, click **Accept & Continue**.

PLEASE VERIFY YOU HAVE SELECTED THE CORRECT TIER AND THE APPROPRIATE DEPENDENTS HAVE COVERAGE FOR THE 2015-16 PLAN YEAR.

You will be returned to the **Benefits** window. Now, you can enroll in Vision and Dental by following the same process as above.

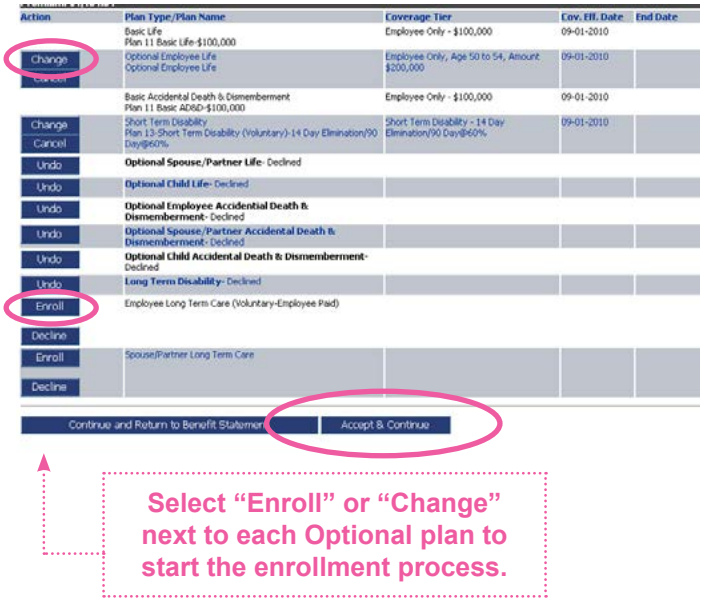
12-month Waiting Period/Late Enrollee

If you do not enroll yourself or any eligible dependent in dental or vision when initially eligible, and then later choose to enroll during an Open Enrollment period, whoever is being added to the coverage will be considered a "late enrollee". Late enrollees are subject to a 12-month waiting period on all dental and vision plans, meaning only diagnostic and preventive care on the dental plans and routine eye exams on the vision plans will be covered for the first full 12 months of coverage.

Appendix A – Guide to the MyOEBB Enrollment System (CONTINUED)

Enrolling in Optional Benefits

It is now time to enroll in optional plans (if offered by your entity). This screen will show any current coverage you have with a past "Coverage Effective Date" and no "End Date", indicating it is still in effect. If you would like to adjust the coverage amount or terminate coverage for existing plans, click Change. If you would like to enroll in new coverage, select Enroll next to the optional benefit you want, and select the coverage amount you desire. For any plan you do not want, you will need to click on the Decline button. Continue through each optional benefit. Contact your Benefits Office if you have questions regarding the plan selections.

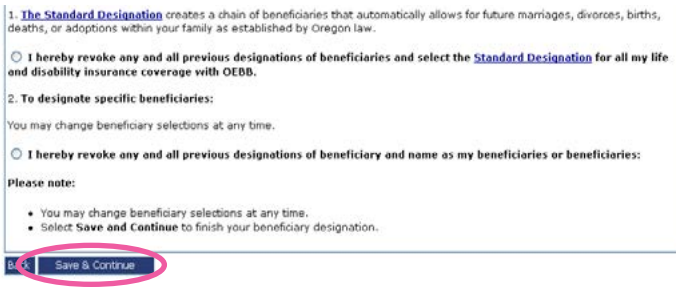


Select "Enroll" or "Change" next to each Optional plan to start the enrollment process.

Once that's done, the screen refreshes to show your current selections. If you previously declined coverage, but wish to enroll, click Undo to change your benefit selections. If all of your selections appear as you want them, click **Accept & Continue**.

Designate or Confirm Beneficiaries

The beneficiaries designated on this page will receive the benefits of your life insurance coverage in case of a claim. You may select the "standard designation" or name specific beneficiaries. Click **Save & Continue**.



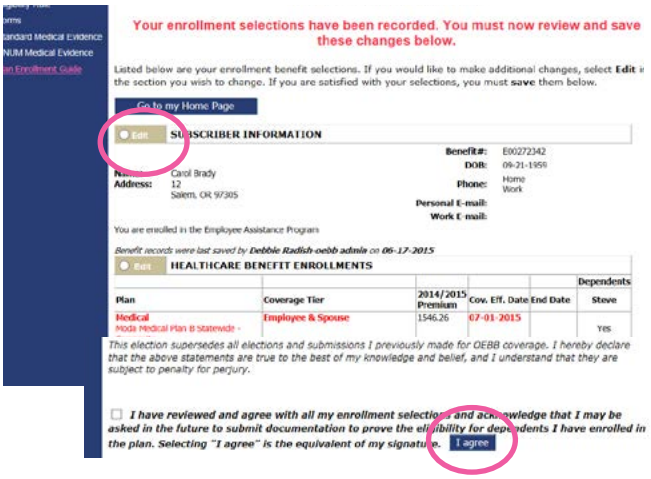
OEBB Benefits Communications Delivery Option

Indicate how you prefer to receive communications from OEBB. This will be applied to your Post-Open Enrollment benefits confirmation statement in October, as well as your Open Enrollment materials next year, and potentially other benefits communications throughout the year. Click **Save & Continue**.

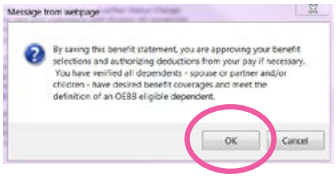
Benefits Statement

The Benefits Statement appears showing all your plan selections for 2015-16. Remember, the choices have been recorded, but not yet saved. (You can tell this is the case by the red warning message at the top of the screen.

If you wish to change anything, you can click the **Edit** button next to each of the enrollment categories to go back to that section. Once you have confirmed all your coverages are correct, click the checkbox at the bottom to acknowledge the statement and then click "**I agree**".

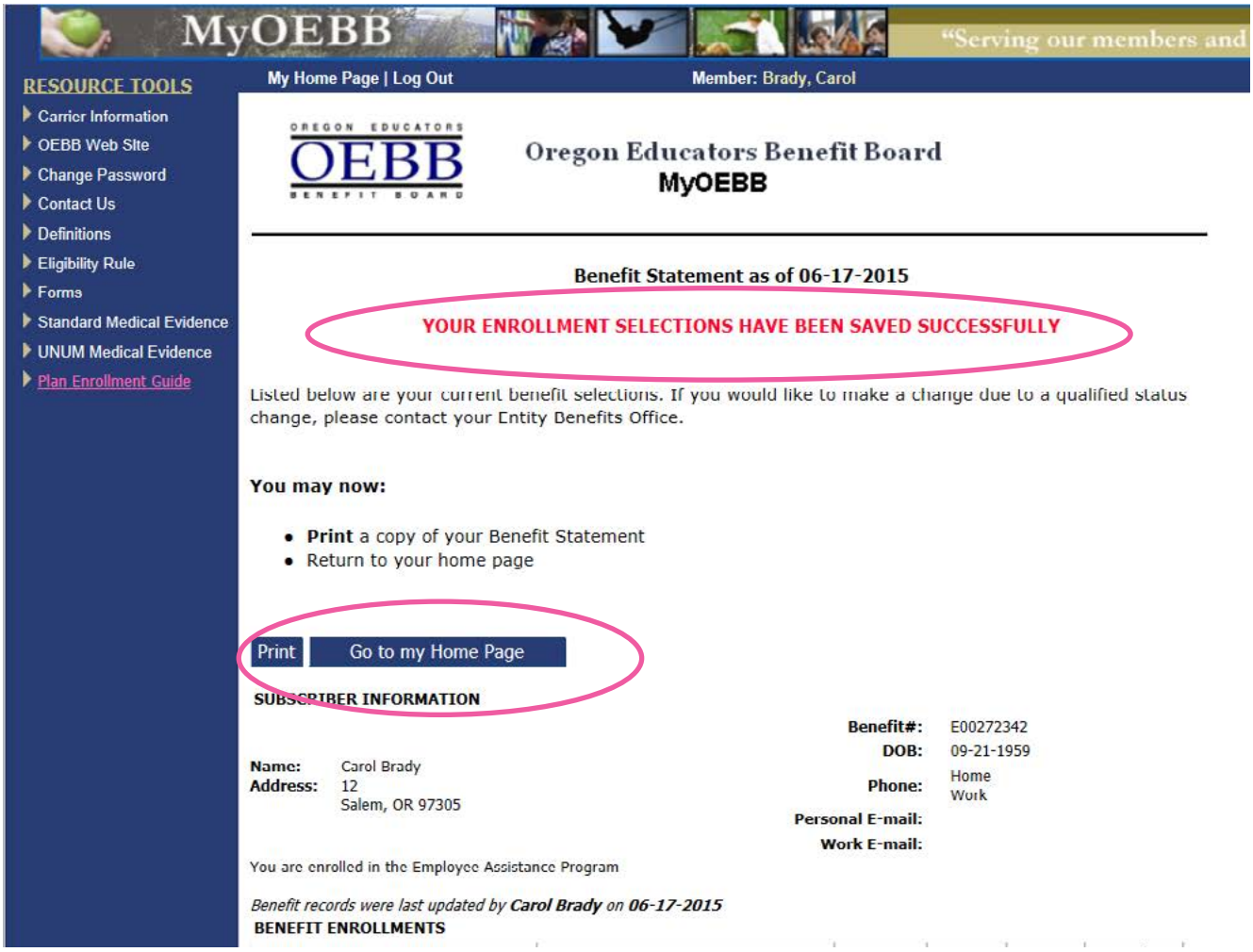


You will see a prompt that states you are about to approve your benefit selections and authorizations for payroll deductions (if applicable, based on entity contributions).



Click **OK** to approve and save your selections.

Appendix A – Guide to the MyOEBB Enrollment System (CONTINUED)



Your Benefit Summary will appear, with a red statement at the top confirming you have successfully saved your selections.

Provided you do not make any further changes during this Open Enrollment period, these are the benefits that will go into effect October 1st. You are welcome to return to the MyOEBB system as many times as you like during the Open Enrollment period and review or change your elections – just remember to save any changes you make. The last elections saved when the Open Enrollment period ends will go into effect October 1st.

It's always a good idea to **print a copy of your benefit summary** for your records.

Log Out

When you're finished with your MyOEBB session, simply click Log Out in the top blue navigation bar.

Appendix B – Guide to the Truven Informed Enrollment Tool

OEBB's Informed Enrollment Tool

Gathering this information before you begin will make the plan comparison process faster and your results more accurate:

- Your employer's monthly contribution toward your benefits (either a dollar amount or a percentage)
- Birthdates for eligible dependents you want to add to your coverage
- Any major medical treatments or procedures you or your covered dependents expect to receive during the upcoming plan year
- If not previously enrolled in an OEBB plan, estimated healthcare costs from the past 12 months

Getting Started

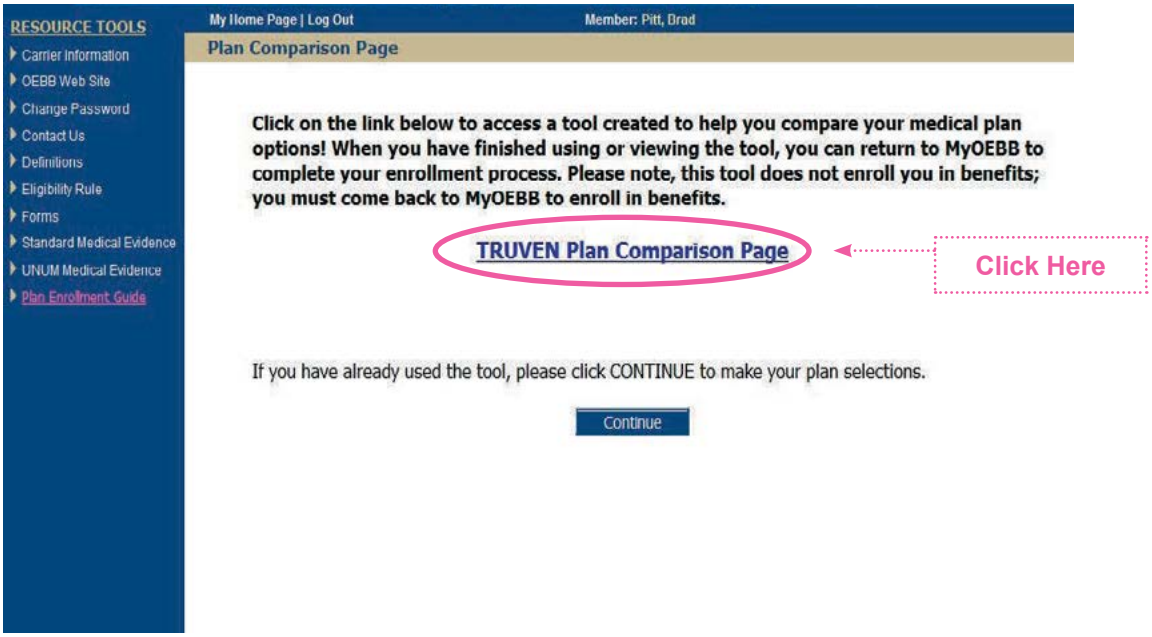
Once you have logged in to the MyOEBB member system, the next screen will be the Plan Comparison Page. Below is an example of what the page looks like with the link that will take you to the Truven Plan Comparison Tool which will help you decide which of the medical plans offered best meets the needs of you and your family. Please use this tool to explore the medical plan choices available to you through your entity. The tool will open up in a pop-up window and the MyOEBB Member Module will still be open in the background.

**Note – The Truven Plan Comparison Tool will not enroll you in plans. You will need to return to this page by closing the Truven Tool pop-up window and click the* Continue *button to complete the process.*

Truven Plan Comparison Tool

You should now be viewing the Truven Health Analytics OEBB Informed Enrollment Tool webpage. This tool will help you identify which plan options are estimated to be the most cost-effective for you and your family as well as suggesting an amount you may wish to contribute to an FSA or HSA. (These accounts allow you to lower your tax liability by setting aside funds for eligible healthcare expenses with pre-tax payroll deductions.)

Click the START button to begin.

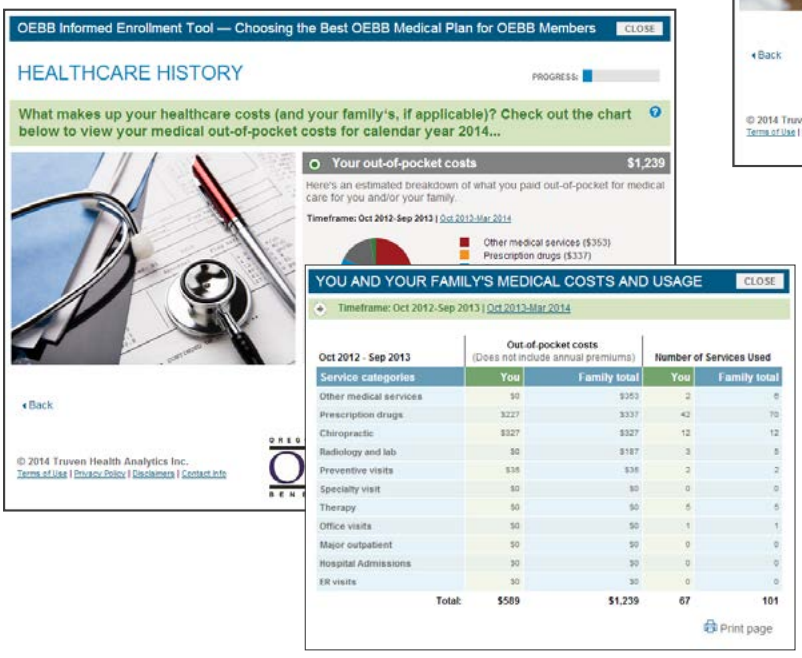


Appendix B – Guide to the Truven Informed Enrollment Tool (CONTINUED)

Healthcare History Page

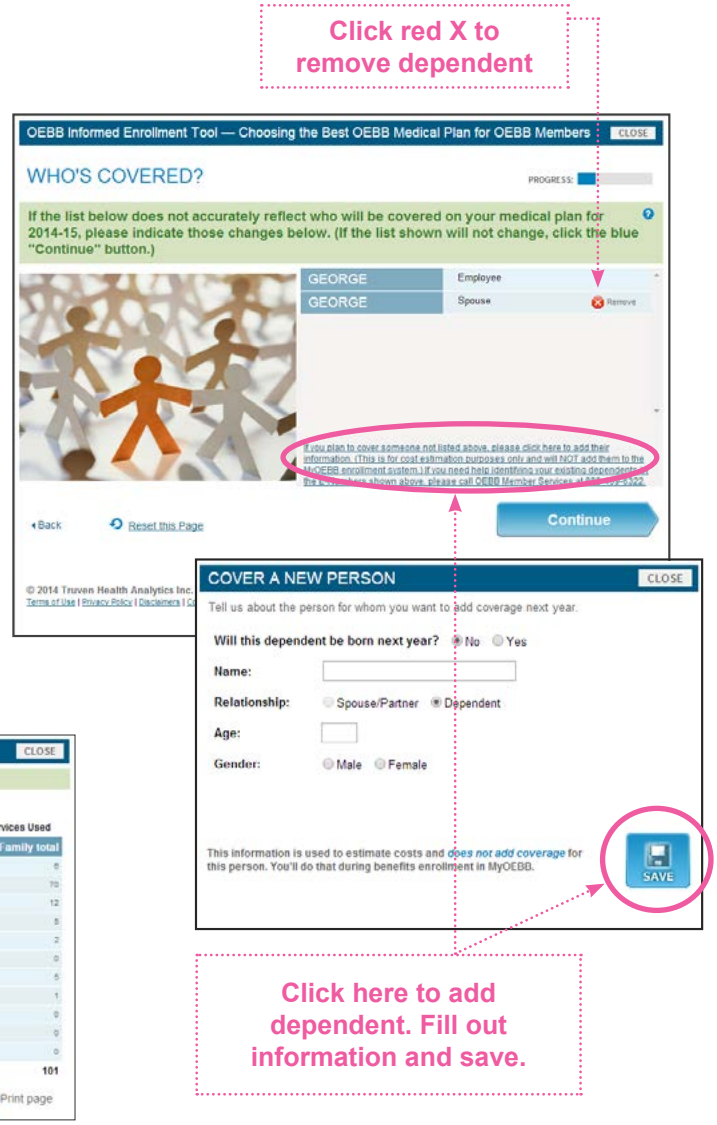
If you have been covered on an OEBB plan within the past nine months, your healthcare history page uses your actual claims history to provide a summary of healthcare costs paid during that period. If you are new to OEBB coverage, the tool will use the average healthcare costs for someone your age and gender to begin your estimate. You can refine these estimated costs based on your expected healthcare needs for the upcoming year if you wish to do so.

Click the heading **"Your out-of-pocket costs"** to change the display of categorized expenses to either a pie chart or a data table.



Who's Covered? Page

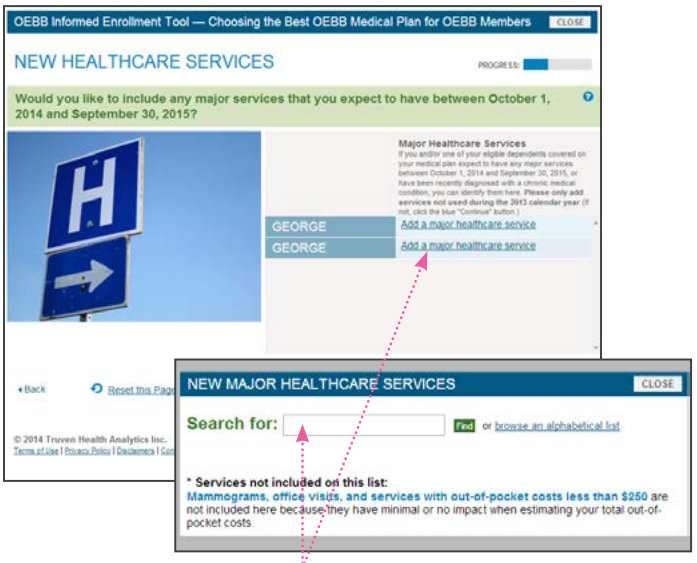
This page displays the E-Number of any dependents listed as eligible in the MyOEBB system. The dependents' E-Numbers (benefit ID number in OEBB) are used in place of names for added security. You can add or remove dependents here for plan comparison and cost evaluation. If a dependent you wish to add to your coverage is not listed, click the paragraph underlined below and enter the requested information for that dependent. If a dependent is listed whom you do not wish to cover for the upcoming plan year, click the red x to remove them from the list and the estimate. Note that adding or removing dependents on this page will not make changes in the MyOEBB enrollment system, so you can play with different hypothetical scenarios.



Appendix B – Guide to the Truven Informed Enrollment Tool (CONTINUED)

New Healthcare Services Page

On this page you can add major health services you are planning such as a pregnancy, elective surgery, or if you or a covered dependent have a new chronic condition you want to include in the cost estimate.

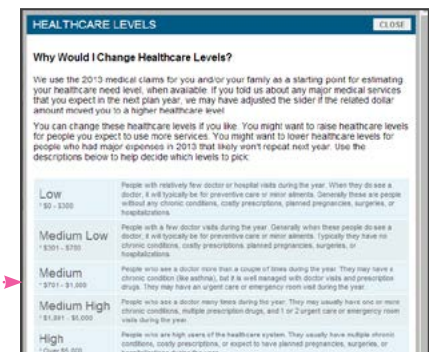


Click to add a healthcare service.

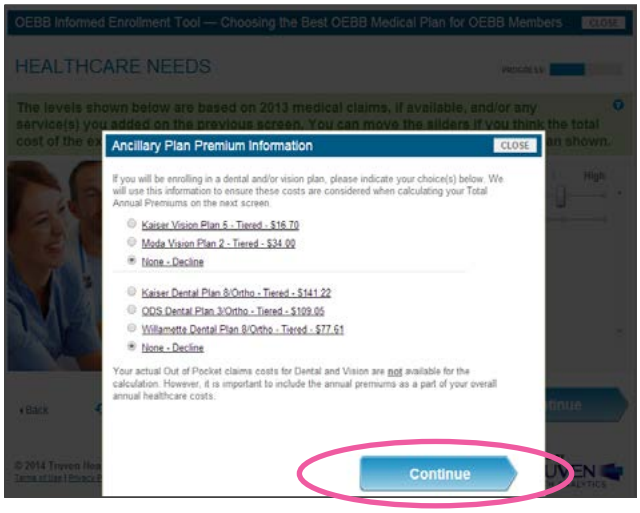
Healthcare Needs Page

On this page you will see how each covered member's usage of healthcare is based on the overall estimate of out-of-pocket costs using the previous medical claims and any new information added on the New Healthcare Services page. You can use the sliders to adjust the level of anticipated healthcare needs for each individual as you feel appropriate.

The help button will offer dollar ranges for levels of expected utilization. The help button is available on all of the pages.

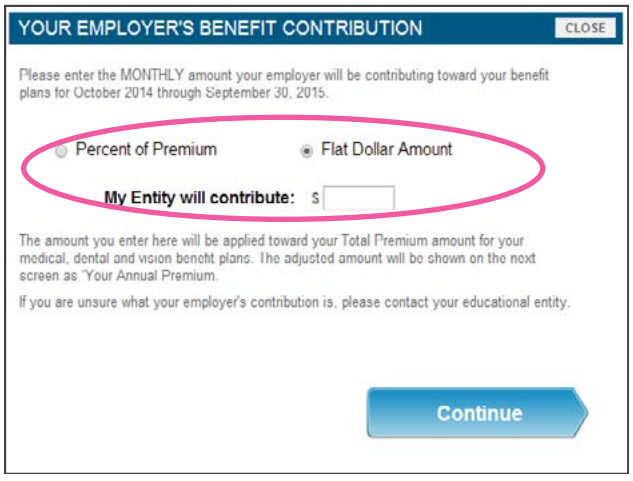


You can also include Vision and Dental premiums in your cost estimate. The monthly premiums shown are calculated to a yearly rate and then added into the overall cost of your benefits.



Employer Benefit Contribution Page

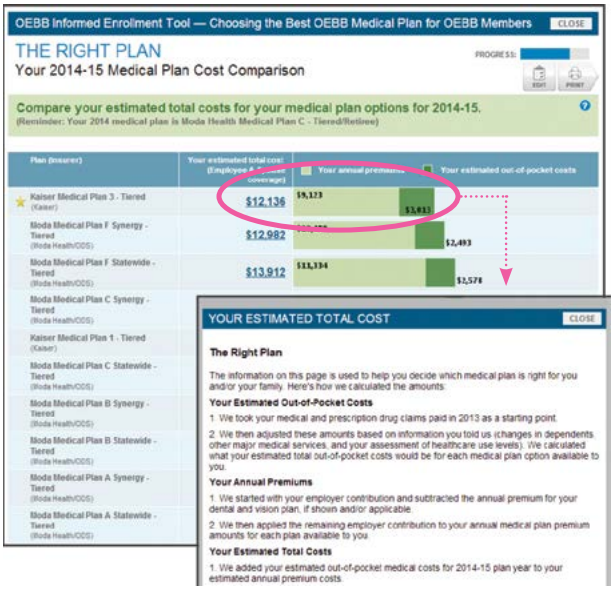
Now you are ready to add in the amount your employing entity contributes towards your medical, dental, and vision benefits. This can be entered as a Percent of Premium or as a Flat Dollar Amount to calculate the remaining cost to you.



Appendix B – Guide to the Truven Informed Enrollment Tool (CONTINUED)

The Right Plan Page

The Right Plan page shows the estimated total costs for the plan options available to you for the 2015-16 Plan Year and displays the plans from lowest cost to highest cost based on your estimated total out-of-pocket for the Plan Year (your portion of premiums plus your estimated out-of-pocket for expected healthcare services). Clicking on the estimated total cost amount will show the breakdown of the estimated amount.

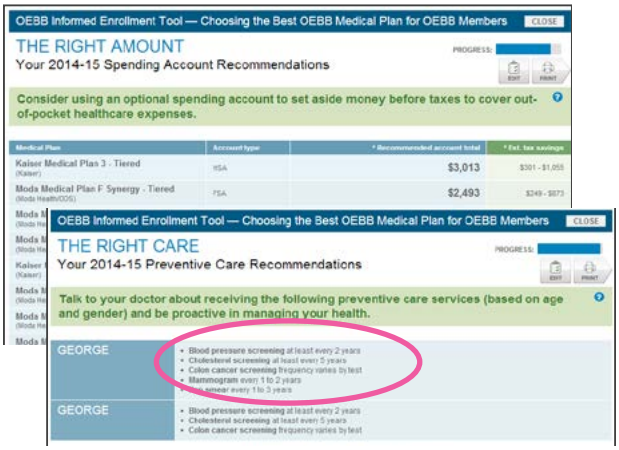


The Right Amount Page

The Right Amount page shows recommendations for Flexible Spending Account or Health Savings Account annual contributions based on the estimated out-of-pocket amounts calculated.

The Right Care Page

The Right Care page shows recommendations based on age and gender for Preventive Care screenings and actions to take over the next plan year for each member.

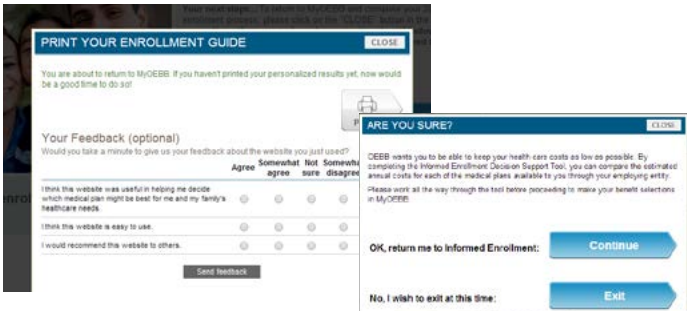


Congratulations Page

Congratulations! You have made it to the final page of the Informed Enrollment Tool. You have one last opportunity to print your results. When you are ready to exit the comparison tool, click on the button. You may also need to close the tab for the open window to return to the MyOEBB system and continue your enrollment.

Closing the Truven Tool Page

Truven would like to learn about your experience with their online tool. A short optional survey will appear as you print your results. As you exit the Truven tool a pop-up window will appear to confirm you really want to exit. Should you choose to return to the Truven Tool after closing it, your previous entries will not be saved. All information will need to be re-entered in order to see your results again.



Returning to MyOEBB Page

Once you have closed the Truven Plan Comparison Tool window, or clicked on the tab where you already logged in to your MyOEBB account, you are now ready to click on the button and make your benefit enrollments.

Contacting OEBB

OEBB Member Services

Hours: Monday – Friday, 8:00 AM – 5:00 PM

Phone: 888-4My-OEBB (888-469-6322)

Email: oebb.benefits@oregon.gov

Log in and make your plan selections:

MyOEBB Enrollment System

https://myoebb.org/oebb/!pb.main

Please note: The MyOEBB system will not be available between 8:00 p.m. Monday, August 31st, and approximately 9:00 a.m. Tuesday, September 1st in order to handle the monthly billing processes.

Please plan your enrollment activities accordingly.

Following is a schedule of when OEBB member services representatives will be available by phone to assist you this Open Enrollment period.

August 15	Saturday	8:00 a.m. – 2:00 p.m.
August 16	Sunday	OEBB offices closed
August 17 – 21	Monday – Friday	7:00 a.m. – 6:00 p.m.
August 22 & 23	Saturday & Sunday	OEBB offices closed
August 24 – 28	Monday – Friday	7:00 a.m. – 6:00 p.m.
August 29 & 30	Saturday & Sunday	10:00 a.m. – 4:00 p.m.
August 31 – September 4	Monday – Friday	7:00 a.m. – 6:00 p.m.
September 5 – 7 (Labor Day Weekend)	Saturday – Monday	OEBB offices closed
September 8 – 11	Tuesday – Friday	7:00 a.m. – 6:00 p.m.
September 12 & 13	Saturday & Sunday	10:00 a.m. – 4:00 p.m.
September 14	Monday	7:00 a.m. – 6:00 p.m.
September 15	Tuesday	7:00 a.m. – 11:59 p.m.

Contacting the Carriers

To contact the carriers about specific plan details or coverage, use the information below:

BenefitHelp Solutions (COBRA) (800) 556-2230 www.benefithelpsolutions.com/oebb	**Reliant Behavioral Health** (866) 750-1327 www.myrbh.com	**WageWorks** (866) 531-8170 www.wageworks.com/oebb
Kaiser Permanente (866) 223-2375 http://my.kp.org/nw/oebb	**The Standard Insurance Company** (866) 756-8115 www.standard.com/mybenefits/oebb	**Weight Watchers®** (866) 531-8170 www.weightwatchers.com
Moda Health (866) 923-0409 www.modahealth.com/oebb	**Unum** (800) 227-4165 https://w3.unum.com/enroll/OEBB	**Willamette Dental Group** (800) 460-7644 www.willamettedental.com/oebb

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