OEBB Plan Descriptions 2020-2021

Benefits	Plan 2			Plan 3			Plan 4		
	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network
Plan-year costs									
Deductible per person/family	$800/$2,700	$900/$2,700	$1,600/$4,800	$1,200/$3,900	$1,300/$3,900	$2,400	$1,600	$1,700/$5,100	$3,200/$9,600
Out-of-pocket max per person	$3,850	$4,250	$8,000	$4,850	$5,250	$5,250	$6,700	$7,100	$13,700
Out-of-pocket max per family	$12,750	$12,750	$24,000	$15,750	$15,750	$15,750	$15,800	$15,800	$27,400
Max cost share per person (include OOP & ACT)	$7,900	$7,900	N/A	$7,900	$7,900	$7,900	$7,900	$7,900	N/A
Max cost share per family (includes OOP & ACT)	$15,800	$15,800	N/A	$15,800	$15,800	$15,800	$15,800	$15,800	N/A
Preventive Care									
PCP 360 wellenss visit (ages 21 & over)	$0 1	$0 1	Not covered	$0 1	$0 1	Not covered	$0 1	$0 1	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations 3	$0 1	$0 1	50%	$0 1	$0 1	50%	$0 1	$0 1	50%
Professional Services									
Primary care office visits	$20 copay 1,3	20%	50%	$25 copay 1,3	25%	50%	$25 copay 1,3	25%	50%
Primary care office vists with a provider other than your PCP360	$40 copay 1	N/A	50%	$50 copay 1	N/A	50%	$50 copay 1	N/A	50%
Specialist office visits	$40 copay 1	20%	50%	$50 copay 1	25%	50%	$50 copay 1	25%	50%
Mental health office visits	$20 copay 1	$20 copay 1	50%	$25 copay 1	$25 copay 1	50%	$25 copay 1	$25 copay 1	50%
Chemical dependency services	$20 copay 1	$20 copay 1	50%	$25 copay 1	$25 copay 1	50%	$25 copay 1	$25 copay 1	50%
Virtual visits	$10 copay 1	$10 copay 1	N/A	$10 copay 1	$10 copay 1	N/A	$10 copay 1	$10 copay 1	N/A
Alternative Care Services ($2,000 plan year max)									
Acupuncture/chiropractic/manipulation/ naturopathic remedies 6	$20 copay 1	20%	50%	$25 copay 1	25%	50%	$25 copay 1	25%	50%
Maternity Care									
Physician or midwife services & hospital stay	20%	20%	50%	25%	25%	50%	25%	25%	50%
Outpatient & Hospital Services									
Inpatient care & outpatient hospital/facility care	20%	20%	50%	25%	25%	50%	25%	25%	50%
Skilled nursing facility care (60 days per plan year)	20%	20%	50%	25%	25%	50%	25%	25%	50%
Surgery	20%	20%	50%	25%	25%	50%	25%	25%	50%
ACT 100: Sleep studies, specificed imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupplementation, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea	$100 copay + 20%	$100 copay + 20%	$100 copay + 50%	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%
ACT 500: Spine surgery, knee & hip replacement knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%	$500 copay + 20%	$500 copay + 50%	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%
Gastric Bypass (Roux-en-Y) 4	$500 copay + 20%	$500 copay + 20%	Not covered	$500 copay + 25%	$500 copay + 25%	Not covered	$500 copay + 25%	$500 copay + 25%	Not covered
Emergency Services									
Urgent care visit	$40 copay 1	20%	20%	$50 copay 1	25%	25%	$50 copay 1	25%	25%
Emergency room (copay waived if admitted)	$100 copay + 20%	$100 copay + 20%	$100 copay + 20%	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%
Ambulance	20%	20%	20%	25%	25%	25%	25%	25%	25%
Other Covered Services									
Hearing aids and bone anchored hearing aids - $4,000 max/48 months for members 26 and older	10%	10%	50%	10%	10%	50%	10%	10%	50%
Physical, occupational and speech therapy (including physical therapy performed in conjection with alternative care) - Inpatient limitations: 30 days per plan year/60 days for spinal or head injury. Outpatient limitations: 30 sessions per plan year/ up to 60 sessions for spinal or head injury	20%	20%	50%	25%	25%	50%	25%	25%	50%
Outpatient diagnostic lab & X-ray	20%	20%	50%	25%	25%	50%	25%	25%	50%
Durable medical equipment	20%	20%	50%	25%	25%	50%	25%	25%	50%

OEBB Plan Descriptions 2020-2021

Benefits	Plan 5			Plan 6 (HSA Option)			Plan 7 (HSA Option)		
	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network	Coordinated Care In-Network	Non-Coordinated Care In-Network	Out-of-Network
Plan-year costs									
Deductible per person/family	$2,000	$2,100/$6,300	$4,000/$12,600	$1,600/$3,400	$1,700/$3,400	$3,200/$6,400	$2,000/$4,200	$2,100/$4,200	$4,000/$8,000
Out-of-pocket max per person	$6,800	$7,200	$13,700	$6,400	$6,750	$13,100	$6,500	$6,750	$13,300
Out-of-pocket max per family	$15,800	$15,800	$27,400	$13,500	$13,500	$26,200	$13,500	$13,500	$26,600
Max cost share per person (include OOP & ACT)	$7,900	$7,900	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Max cost share per family (includes OOP & ACT)	$15,800	$15,800	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Preventive Care									
PCP 360 wellenss visit (ages 21 & over)	$0 1	$0 1	Not covered	$0 1	$0 1	Not covered	$0 1	$0 1	Not covered
Periodic health exams, routine women's exams, annual obesity screening, immunizations 3	$0 1	$0 1	50%	$0 1	$0 1	50%	$0 1	$0 1	50%
Professional Services									
Primary care office visits	$30 copay 1,3	25%	50%	15%	20%	50%	20%	25%	50%
Primary care office vists with a provider other than your PCP360	$50 copay 1	.	50%	15%	N/A	50%	20%	N/A	50%
Specialist office visits	$50 copay 1	25%	50%	15%	20%	50%	20%	25%	50%
Mental health office visits	$30 copay 1	$30 copay 1	50%	15%	20%	50%	20%	25%	50%
Chemical dependency services	$30 copay 1	$30 copay 1	50%	15%	20%	50%	20%	25%	50%
Virtual visits	$10 copay 1	$10 copay 1	N/A	$10 copay	$10 copay	N/A	$10 copay	$10 copay	N/A
Alternative Care Services ($2,000 plan year max)									
Acupuncture/chiropractic/manipulation/ naturopathic remedies 6	$30 copay 1	25%	50%	20%	25%	50%	20%	25%	50%
Maternity Care									
Physician or midwife services & hospital stay	25%	25%	50%	20%	25%	50%	20%	25%	50%
Outpatient & Hospital Services									
Inpatient care & outpatient hospital/facility care	25%	25%	50%	20%	25%	50%	20%	25%	50%
Skilled nursing facility care (60 days per plan year)	25%	25%	50%	20%	25%	50%	20%	25%	50%
Surgery	25%	25%	50%	20%	25%	50%	20%	25%	50%
ACT 100: Sleep studies, specificed imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupplementation, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea	$100 copay + 25%	$100 copay + 25%	$100 copay + 50%	20%	25%	50%	20%	25%	50%
ACT 500: Spine surgery, knee & hip replacement knee & shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25%	$500 copay + 25%	$500 copay + 50%	20%	25%	50%	20%	25%	50%
Gastric Bypass (Roux-en-Y) 4	$500 copay + 25%	$500 copay + 25%	Not covered	$500 copay + 20%	$500 copay + 25%	Not covered	$500 copay + 20%	$500 copay + 25%	Not covered
Emergency Services									
Urgent care visit	$50 copay 1	25%	25%	15%	20%	20%	20%	25%	25%
Emergency room (copay waived if admitted)	$100 copay + 25%	$100 copay + 25%	$100 copay + 25%	20%	25%	25%	20%	25%	25%
Ambulance	25%	25%	25%	20%	25%	25%	20%	25%	25%
Other Covered Services									
Hearing aids and bone anchored hearing aids - $4,000 max/48 months for members 26 and older	10%	10%	50%	20%	25%	50%	20%	25%	50%
Physical, occupational and speech therapy (including physical therapy performed in conjection with alternative care) - Inpatient limitations: 30 days per plan year/60 days for spinal or head injury. Outpatient limitations: 30 sessions per plan year/ up to 60 sessions for spinal or head injury	25%	25%	50%	20%	25%	50%	20%	25%	50%
Outpatient diagnostic lab & X-ray	25%	25%	50%	20%	25%	50%	20%	25%	50%
Durable medical equipment	25%	25%	50%	20%	25%	50%	20%	25%	50%

2020-2021 Dental Plans

Benefits	Delta Dental Plan 1	Delta Dental Plan 5	Delta Dental Plan 6	Delta Dental PPO	Willamette Dental
Dental Office Visit Copayment	NA	NA	NA	NA	$20
Benefit Maximum	$2,200	$1,700	$1,200	$1,500	NA
Deductible	$50	$50	$50	$50	NA
Preventive & Diagnostic Services - Deductible waived for Preventive & Diagnostic Services on Delta Dental Plans					
Oral exams, x-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% - 100%	70% - 100%	100%	100%	100%
Restorative Services					
Routine fillings, inlays and stainless steel crowns	70% - 100%	70% - 100%	80%	90%	100%
Simple Extraction					
Simple tooth extractions	70% - 100%	70% - 100%	80%	90%	100%
Oral Surgery					
Surgical tooth extractions, including diagnosis and evaluation	70% - 100%	70% - 100%	80%	90%	$50 copay
Periodontics					
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% - 100%	70% - 100%	80%	90%	100%
Endodontics					
Root canal and related therapy including diagnosis and evaluation	70% - 100%	70% - 100%	80%	90%	$50 Copay
Major Restorative Services					
Gold or porcelain crowns and onlays	70% - 100%	70%	50%	80%	$250 Copay
Implants	70% - 100%	50%	50%	80%	See Certificate of Coverage for copays
Other Covered Services					
Occlusal guards (night guards)	50% up to $250 max. once every 5 years	50% up to $250 max. once every 5 years	50% up to $250 max. once every 5 years	50% up to $250 max. once every 5 years	100%
Athletic mouth guards	50%	50%	50%	50%	$100 copay
Nitrous Oxide	50%	50%	50%	50%	$15 Copay
Fixed and Removable Prosthetic Services					
Full and partial dentures, relines, rebases	70% - 100%	50%	50%	80%	$100 Copay
Bridge retainers and pontics	70% - 100%	50%	50%	80%	$250 Copay
Orthodontics					
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NO ORTHO COVERAGE ON THIS PLAN	80% to $1,800 lifetime max	$2,500 Copay + $20 per visit

2020-2021 Vision Plans

Benefits	Moda Opal	VSP - Choice Plus
Benefit Maximum	$600	N/A
Routine Eye Exam		
Benefit	Plan pays 100% (up to plan max)	$10 copay
Frequency	Once per plan year	Every 12 months
Lenses		
Basic lens benefit	Plan pays 100% (up to plan max)	$20 copay
Lens enhancements	Plan pays 100% (up to plan max)	$0 copay - scratch-resistant/UV coating $15 copay - Anti -reflective coating $15 copay - progressive lenses
Frequency	Once per plan year	Every 12 months
Frames/Contacts		
Benefit	Plan pays 100% (up to plan max)	Covered in full up to retail allowance of $300
Frequency	Ages 0 - 16: Once per plan year Age 17+ : Once every two plan years Contacts: Once per plan year	Once every 12 months
Non-prescription Benefit		
Benefit	Not Covered	OEBB members can use their frame allowance to pay for non-prescription sunglasses in lieu of prescription glasses or contacts.