

Klamath Falls City Schools - OEBC 2018 - 2019 Plan Summary

	Birch		Cedar		Douglas		Evergreen	
	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
Plan Year Costs - Deductibles and Copayments apply to the annual out-of-pocket maximum.								
Deductible per person	\$800	\$1,600	\$1,200	\$2,400	\$1,600	\$3,200	1600	\$3,200
Maximum deductible per family	\$2,400	\$4,800	\$3,600	\$7,200	\$4,800	\$9,600	\$3,200	\$6,400
Out-of-pocket (OOP) maximum per person	\$4,000	\$8,000	\$5,000	\$10,000	\$6,850	\$13,700	\$6,550	\$13,100
Out-of-pocket (OOP) maximum per family	\$12,000	\$24,000	\$13,700	\$27,400	\$13,700	\$27,400	\$13,100	\$26,200
Maximum cost share per person	\$7,350	N/A	\$7,350	N/A	\$7,350	N/A	N/A	N/A
Maximum cost share per family	\$14,700	N/A	\$14,700	N/A	\$14,700	N/A	N/A	N/A
Preventive Care Services								
Wee flex visit	\$0	Not Covered	\$0	Not Covered	\$0	Not Covered	\$0	Not Covered
Routine adult, well-child and women's exams; annual obesity screen & immunizations	\$0	50%	\$0	50%	\$0	50%	\$0	50%
Office Services								
Moda Medical Home - primary care services	\$30	50%	\$30	50%	\$30	50%	20%	50%
Primary care office visits - Connexus (w/non medical home doctor)	20%	50%	20%	50%	20%	50%	20%	50%
Primary care office visits - Synergy	\$30 copay	50%	\$30 copay	50%	\$30 copay	50%	20%	50%
Specialist office visits	20%	50%	20%	50%	20%	50%	20%	50%
Urgent care	\$50	50%	\$50	50%	\$50	50%	20%	50%
Incentive Care Services (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)								
Moda Medical Home incentive care	\$15 copay	50%	\$15 copay	50%	\$15 Copay	50%	20%	50%
Incentive office visits and home visits - Connexus (w/non medical home doctor)	20%	50%	20%	50%	20%	50%	20%	50%
Incentive office visits and home visits - Synergy	\$15 copay	50%	\$15 copay	50%	\$15 copay	50%	20%	50%
Mental Health Services								
Mental health office visit	\$30 copay	50%	\$30 copay	50%	\$30 copay	50%	20%	50%
Mental health inpatient and residential services	20%	50%	20%	50%	20%	50%	20%	50%
Chemical dependency services (inpatient, outpatient or residential)	\$0	50%	\$0	50%	\$0	50%	20%	50%
Outpatient Services								
Outpatient surgery/facility care	20%	50%	20%	50%	20%	50%	20%	50%
Outpatient rehabilitation (physical, occupational & speech therapy)	20%	50%	20%	50%	20%	50%	20%	50%
Moda plans: 30 sessions per year/ 60 for spinal or head injury								
Tests (outpatient)								
Preventive tests	\$0	50%	\$0	50%	\$0	50%	\$0	50%
Laboratory	20%	50%	20%	50%	20%	50%	20%	50%
X-ray, imaging and special diagnostic procedures	20%	50%	20%	50%	20%	50%	20%	50%
CT, MRI, PET scans	\$100 + 20%	\$100 + 50%	\$100 + 20%	\$100 + 50%	\$100 + 20%	\$100 + 50%	20%	50%
Alternative Care Services (\$2,000 combined maximum)								
Acupuncture, chiropractic & naturopathic services, lab, diagnostics, etc.	20%	50%	20%	50%	20%	50%	20%	50%
Cost of supplies & procedures performed in Alternative Care provider's office applies to Alternative care benefit maximum								
Maternity Care								
Outpatient maternity care	20%	50%	20%	50%	20%	50%	20%	50%
Physician or midwife services & hospital stay, delivery & routine newborn nursery care	20%	50%	20%	50%	20%	50%	20%	50%
Hospital Services								
Inpatient care/surgery	20%	50%	20%	50%	20%	50%	20%	50%
Skilled nursing facility care (Moda plans: 60 days per plan year)	20%	50%	20%	50%	20%	50%	20%	50%
Additional Cost Tier								
\$100 Additional Cost Tier (ACT): specified imaging (MRI, CT, PET) spinal injections, tonilllectomies for members under age 18 with chronic tonsillitis or sleep apnea, viscosupplementation, upper endoscopies, sleep studies, lumbar discographies	\$100 + 20%	\$100 + 50%	\$100 + 20%	\$100 + 50%	\$100 + 20%	\$100 + 50%	20%	50%
\$500 Additional Cost Tier (ACT): spine surgery, knee & hip replacement, knee & shoulder arthroscopy, uncomplicated hernia repair	\$500 + 20%	\$500 + 50%	\$500 + 20%	\$500 + 50%	\$500 + 20%	\$500 + 50%	20%	50%
Emergency Services								
Emergency room (copay waived if admitted)	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 20%	\$100 copay + 20%	20%	20%
Ambulance	20%	50%	20%	50%	20%	50%	20%	50%
Other Covered Services								
Hearing aids: \$4,000 maximum benefits every 48 months for adults, see handbook for State mandated benefits for children	10%	50%	10%	50%	10%	50%	20%	50%
Durable Medical Equipment (DME)	20%	50%	20%	50%	20%	50%	20%	50%
Bariatric Surgery (Roux-en-Y and gastric sleeve)	\$500 + 20%	Not Covered	\$500 + 20%	Not Covered	\$500 + 20%	Not Covered	\$500 + 20%	Not Covered

* If enrolled in Moda CCM plan using synergy network, you must select a medical home (primary care clinic) for each individual on the plan. Primary care must be performed at the designated Medical Home in order to receive the "In-Network" benefit; if these services are performed outside the individual's selected Medical Home, they will be paid at the "out-of-network" benefit level.

• Deductible waived

• 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 plan also includes an embedded per member out-of-pocket max, which is \$6,550. Under this plan, deductible must be met before benefits will be paid.

• For PPO plans, OOP max includes medical copayments and coinsurance.

• Benefit is subject to a reference price limitation. This is not applicable to CCM plans.

Dental Plans	Delta Dental Plan 5	Delta Dental Plan 6	Delta Dental PPO	Willamette Dental
Dental Office Visit Copayment	NA	NA	NA	\$20
Benefit Maximum	\$1,700	\$1,200	\$1,500	NA
Deductible	\$50	\$50	\$50	NA
Preventive & Diagnostic Services - Deductible waived for Preventive & Diagnostic Services on Delta Dental Plans				
Oral exams, x-rays, cleaning (prophylaxis), fluoride treatment, and space maintainers	70% - 100%	100%	100%	100%
Restorative Services				
Routine fillings, inlays and stainless steel crowns	70% - 100%	80%	90%	100%
Simple Extraction				
Simple tooth extractions	70% - 100%	80%	90%	100%
Oral Surgery				
Surgical tooth extractions, including diagnosis and evaluation	70% - 100%	80%	90%	\$50 copay
Periodontics				
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% - 100%	80%	90%	100%
Endodontics				
Root canal and related therapy including diagnosis and evaluation	70% - 100%	80%	90%	\$50 Copay
Major Restorative Services				
Gold or porcelain crowns and onlays	70%	50%	80%	\$250 Copay
Implants	50%	50%	80%	See Certificate of Coverage for copays
Other Covered Services				
Occlusal guards (night guards)	50% up to \$350 max. once every 5 years	50% up to \$350 max. once every 5 years	50% up to \$250 max. once every 5 years	100%
Athletic mouth guards	50%	50%	50%	\$100 copay
Nitrous Oxide	50%	50%	50%	\$15 Copay
Fixed and Removable Prosthetic Services				
Full and partial dentures, relines, rebases	50%	50%	80%	\$100 Copay
Bridge restorers and pontics	50%	50%	80%	\$250 Copay
Orthodontics				
Orthodontic Treatment	80% to \$1,800 lifetime max	N/A	80% to \$1,800 lifetime max	\$2,500 Copay + \$20 per visit

Pharmacy Services

Synergy			
RX applies towards plan Out of Pocket Maximum			
	Retail	Mail	Specialty
Value	\$0	\$0	N/A
Select Generic	\$ 8 per 31-day supply	\$16 per 90-day supply	N/A
Preferred	25% up to \$50 per 31-day supply	25% up to \$100 per 90-day supply	25% up to \$100 per 31-day supply
Non-Preferred	50% up to \$150 per 31-day supply	50% up to \$300 per 31-day supply	50% up to \$500 per 31-day supply
Evergreen			20%

Connatus			
RX applies towards Maximum Cost Share			
	Retail	Mail	Specialty
Value	\$4	\$8 per 90-day supply	N/A
Select Generic	\$12 per 31-day supply	\$24 per 90-day supply	N/A
Preferred	25% up to \$75 per 31-day supply	25% up to \$150 per 90-day supply	25% up to \$200 per 31-day supply
Non-Preferred	50% up to \$175 per 31-day supply	50% up to \$450 per 90-day supply	50% up to \$500 per 31-day supply
Evergreen			20%

Vision Plans	Meda Opal	VSP - Choice Plus
Plan Year 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
		\$0 Copay - Standard Progressive Lenses \$15 Copay - Anti-Reflective coating \$15 Copay - Progressive Lenses
Lens Enhancements	Plan Pays 100% (Up to plan max)	Every 12 months
Frequency	Once per plan year	
Frames/contacts		
Benefit	Plan Pays 100% (Up to plan max)	Covered in full up to retail allowance of \$300, 20% off amount above
Frequency	Age 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.

2018 - 2019 DISTRICT CAPS

Tier	6 - 8 Hours	4 - 5.99 Hours
Employee Only	\$505.60	\$347.60
Employee + Spouse	\$1,102.40	\$757.90
Employee + Child(ren)	\$965.60	\$663.85
Family	\$1,512.00	\$1,039.50

Tier	12 Month
Employee Only	\$600.00
Employee + Spouse	\$1,309.00
Employee + Child(ren)	\$1,145.00
Family	\$1,858.00

2018 - 2019 Monthly Premiums

Moda Connexus

Tier	Birch	Cedar	Dogwood	Evergreen
Employee Only	\$640.46	\$593.50	\$550.77	\$494.02
Employee + Spouse	\$1,408.99	\$1,305.68	\$1,211.70	\$1,086.84
Employee + Child(ren)	\$1,216.88	\$1,127.65	\$1,046.50	\$938.65
Family	\$1,985.44	\$1,839.87	\$1,707.45	\$1,531.46

Moda Synergy

Tier	Birch	Cedar	Dogwood	Evergreen
Employee Only	\$576.41	\$534.14	\$495.69	\$444.62
Employee + Spouse	\$1,268.09	\$1,175.13	\$1,090.51	\$978.14
Employee + Child(ren)	\$1,095.16	\$1,014.90	\$941.83	\$844.77
Family	\$1,786.88	\$1,655.92	\$1,536.66	\$1,378.31

Dental & Vision

Tier	Dental Plan 5	Dental Plan 6	Delta Dental PPO	Willamette Dental	Moda Opal	VSP - Choice Plus
Employee Only	\$58.32	\$43.63	\$38.99	\$45.53	\$23.07	\$18.80
Employee + Spouse	\$115.53	\$86.38	\$77.23	\$90.21	\$50.71	\$41.37
Employee + Child(ren)	\$128.48	\$87.68	\$85.88	\$95.98	\$43.77	\$35.73
Family	\$190.26	\$133.94	\$127.20	\$144.20	\$71.45	\$58.29