

OEBB Plan Descriptions 2020-2021

Benefits	Plan 2			Plan 3			Plan 4		
	Coordinated Care	Non-Coordinated Care	Out-of-Network	Coordinated Care	Non-Coordinated Care	Out-of-Network	Coordinated Care	Non-Coordinated Care	Out-of-Network
	In-Network	In-Network		In-Network	In-Network		In-Network	In-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 wellness 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 visits 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, specified 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 conjunction 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%

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 planning	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.