OEBB
Plan Design Comparison - Medical

Plan Option	Med Plan 1		Med Plan 2		Med Plan 3	Med Plan 4	Med Plan 5	Med Plan 6	Med Plan 7	Med Plan 8	Med Plan 9	Trust Subtotal
	Kaiser HMO	Providence POS	Kaiser HMO	Providence POS	PPO	PPO	PPO	PPO	PPO	PPO	HSA	
Trust	OEBB		OEBB		OEBB	OEBB	OEBB	OEBB	OEBB	OEBB	OEBB	OEBB
Enrollment	14,448				16,063	16,714	2,603	2,987	5,659	1,424	109	60,007
Actuarial Value	0.98		0.99		0.90	0.85	0.81	0.77	0.72	0.64	0.58	
Preventive Services [1]												
In Network (no deductible)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	
Out of Network	-	50%	-	50%	70%	60%	60%	60%	60%	60%	60%	
Deductible (Individual/Family)												
In Network	None	None	None	None	$100/$300	$100/$300	$200/$600	$300/$900	$500/$1,500	$1,000/$3,000	$1,500/$3,000	
Out of Network	None	$300/$900	None	$300/$900	$100/$300	$100/$300	$200/$600	$300/$900	$500/$1,500	$1,000/$3,000	$1,500/$3,000	
Annual Coinsurance Maximum (Individual/Family)												
In Network	$1,000	$1,000/$2,000	$600	$600/$1,200	$500	$1,000	$1,000	$1,500	$2,000	$2,000	$5,000/$10,000 [3]	
Out of Network	-	$2,000/$4,000	-	$2,000/$4,000	$1,500	$2,000	$2,000	$3,000	$4,000	$4,000	$5,000/$10,000 [3]	
Benefit Maximum												
In Network	unlimited	$2,000,000	unlimited	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	
Out of Network	-	$2,000,000	-	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	
Coinsurance												
In Network	100%	100%	100%	100%	90%	80%	80%	80%	80%	80%	80%	
Out of Network	-	50%	-	50%	70%	60%	60%	60%	60%	60%	60%	
Office Visit Copay [2]												
In Network	$10	$10	$5	$5	$10	$15	$20	$20	20%	20%	20%	
Out of Network	-	50%	-	50%	30%	40%	40%	40%	40%	40%	40%	
Hospital Copay												
In Network	$100 per day	$100 per day	No charge	No charge	10%	20%	20%	20%	20%	20%	20%	
Out of Network	-	50%	-	50%	30%	40%	40%	40%	40%	40%	40%	
Emergency Room Copay (waived if admitted)												
In Network	$100 per visit	$100 per visit	$100 per visit	$100 per visit	$100 per visit then 10%	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%	20%	
Out of Network	-	$100 per visit then 50%	-	$100 per visit then 50%	$100 per visit then 30%	$100 per visit then 40%	$100 per visit then 40%	$100 per visit then 40%	$100 per visit then 40%	$100 per visit then 40%	40%	

[1] Preventive services covered based on USPSTF guidelines.

[2] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

[3] As a qualified High Deductible Health Plan (HDHP), the family coinsurance maximum is cumulative without regard to each individual meeting the coinsurance maximum.

OEBB
Plan Design Comparison - Medical

Plan Option	KAISER $5	KAISER $10	KAISER $15	(1099) $10/$100	(1599) $15/$100	MCP 5	Med Plan 1 HMO	Med Plan 1 POS	Med Plan 2 HMO	Med Plan 2 POS
Trust		**Several**		**OSEA**	**OSEA**	**OEA Choice**	**OEBB**	**OEBB**	**OEBB**	**OEBB**
Enrollment	2,579	8,434	2,921	472	6	36		14,448		
Actuarial Value		1.00-.98		0.98	0.97	0.97	0.98	0.98	0.99	0.99
Deductible (Individual/Family)										
In Network	None	None	None	None	None	None	None	None	None	None
Out of Network	-	-	-	-	-	$200/$600	None	$300/$900	None	$300/$900
Annual Coinsurance Maximum (Individual/Family)										
In Network	$600/$1,200	$600/$1,200	$600/$1,200	$1,500/$3,000	$1,500/$3,000	$1,000	$1,000	$1,000/$2,000	$600	$600/$1,200
Out of Network	-	-	-	-	-	$2,500	-	$2,000/$4,000	-	$2,000/$4,000
Benefit Maximum										
In Network	None	None	None	None	None	$2,000,000	unlimited	$2,000,000	unlimited	$2,000,000
Out of Network	-	-	-	-	-	$2,000,000	-	$2,000,000	-	$2,000,000
Coinsurance										
In Network	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Out of Network	-	-	-	-	-	50%	-	50%	-	50%
Office Visit Copay[1]										
In Network	$5	$10	$15	$10	$15	$5	$10	$10	$5	$5
Out of Network	-	-	-	-	-	50%	-	50%	-	50%
Hospital Copay										
In Network	No charge	No charge	No charge	$100 per day	$100 per day	$100 per stay	$100 per day	$100 per day	No charge	No charge
Out of Network	-	-	-	-	-	50%	-	50%	-	50%
Emergency Room Copay										
In Network / Out of Network	$25-$75	$25-$100	$25-$100	$100 per visit	$100 per visit	$50	$100 per visit	$100 per visit / $100 per visit then 50%	$100 per visit	$100 per visit / $100 per visit then 50%

[1] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

OEBB
Plan Design Comparison - Medical

Plan Option	(100985) $100 Deductible	Bethel Choice 200 (with referral/ without referral/ out-of-network)	PPO-COPAY-1	(P101097) 90/70 No Ded In Network	Preferred Provider Plan	PPO 100	(200985) $200 Deductible	Med Plan 3
Trust	**OSEA**	**Bethel**	**OEA Choice**	**OSEA**	**OSBA**	**OEA Choice**	**OSEA**	**OEBB**
Enrollment	311		31	78	15,045	580	18	16,063
Actuarial Value	0.92	0.91	0.91	0.90	0.90	0.90	0.89	0.90
Deductible (Individual/Family)								
In Network	$100/$300	None/$200	None	None	$100/$300	$100/$300	$200/$600	$100/$300
Out of Network	$100/$300	$400	$200/$600	$250/$750	$200/$600	$200/$600	$200/$600	$100/$300
Annual Coinsurance Maximum (Individual/Family)								
In Network	$500/$1,500	$1,000/$3,000 $1,500/$4,500	$1,000	$2,000/$6,000	$500	$500	$500/$1,500	$500
Out of Network	$500/$1,500	$2,000/$6,000	$3,000	$3,000/$9,000	$1,500	$1,500	$500/$1,500	$1,500
Benefit Maximum								
In Network	$2,000,000	$2,000,000	$2,000,000	None	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Out of Network	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Coinsurance								
In Network	90%	100%/80%	90%	90%	90%	90%	90%	90%
Out of Network	80%	60%	70%	70%	70%	70%	80%	70%
Office Visit Copay[(1)]								
In Network	10%	$20/20%	$10	$10	10%	10%	10%	$10
Out of Network	20%	40%	30%	30%	30%	30%	20%	30%
Hospital Copay								
In Network	10%	$100/$100	10%	10%	10%	10%	10%	10%
Out of Network	20%	$200	30%	30%	30%	30%	20%	30%
Emergency Room Copay								
In Network / Out of Network	10%	$50/ $25 per visit then 20%	$100 per visit then 10%	$100 per visit, then 20%	$100 per visit then 10%	$100 per visit then 10%	10%	$100 per visit then 10%

[(1)] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

OEBB
Plan Design Comparison - Medical

Plan Option	Plan B - 100 w / IMD	Plan A - 100	(P151587A) 80/70 No Ded In Network	$250 DED PPO Blue	Plan B - 200 w / IMD	(300971) $300 Deductible; $10,000 Stop Loss	PPO-DED-1	PPO-COPAY-2	Plan A - 200	Med Plan 4
Trust	**OSBA**	**OSBA**	**OSEA**	**Beaverton**	**OSBA**	**OSEA**	**OEA Choice**	**OEA Choice**	**OSBA**	**OEBB**
Enrollment	5,677	5,632	36	1,233	961		10	430	2,735	16,714
Actuarial Value	0.87	0.87	0.86	0.85	0.85	0.84	0.84	0.84	0.84	0.85
Deductible (Individual/Family)										
In Network	$100/$300	$100/$300	None	$250/$750	$200/$600	$300/$900	$100/$300	None	$200/$600	$100/$300
Out of Network	$100/$300	$100/$300	$250/$750	$250/$750	$200/$600	$300/$900	$200/$600	$300/$900	$200/$600	$100/$300
Annual Coinsurance Maximum (Individual/Family)										
In Network	$1,000/$2,000	$1,000/$2,000	$2,000/$6,000	$1,000	$1,000/$2,000	$1,000/$3,000	$1,000	$2,000	$1,000/$2,000	$1,000
Out of Network	$1,000/$2,000	$1,000/$2,000	$3,000/$9,000	$3,000	$1,000/$2,000	$1,000/$3,000	$3,000	$3,000	$1,000/$2,000	$2,000
Benefit Maximum										
In Network	$2,000,000	$2,000,000	None	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Out of Network	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Coinsurance										
In Network	80%	80%	80%	90%	80%	90%	80%	80%	80%	80%
Out of Network	80%	80%	70%	70%	80%	70%	60%	60%	80%	60%
Office Visit Copay[(1)]										
In Network	20%	20%	$15	10%	20%	10%	$15	$15	20%	$15
Out of Network	20%	20%	30%	30%	20%	30%	40%	40%	20%	40%
Hospital Copay										
In Network	20%	20%	$200 per day	10%	20%	10%	20%	20%	20%	20%
Out of Network	20%	20%	30%	30%	20%	30%	40%	40%	20%	40%
Emergency Room Copay										
In Network / Out of Network	$100 per visit then 20%	$100 per visit then 20%	$100 per visit, then 20%	$50	$100 per visit then 20%	10%	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%

[(1)] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

OEBB
Plan Design Comparison - Medical

Plan Option	SEA MCP 15	Plan B - 300 w / IMD	(P202087) 80/70 No Ded In Network	PPP Copay Plan 100	(500975) $500 Deductible; $5,000 Stop loss	Plan A - 300	Plan B - 500 w / IMD	Med Plan 5
Trust	**OEA Choice**	**OSBA**	**OSEA**	**OSBA**	**OSEA**	**OSBA**	**OSBA**	**OEBB**
Enrollment	1,304	213	22	676	136	70	182	2,603
Actuarial Value	0.83	0.83	0.83	0.82	0.81	0.81	0.80	0.81
Deductible (Individual/Family)								
In Network	None	$300/$900	None	$100/$300	$500/$1,500	$300/$900	$500/$1,500	$200/$600
Out of Network	$300/$600	$300/$900	$250/$750	$100/$300	$500/$1,500	$300/$900	$500/$1,500	$200/$600
Annual Coinsurance Maximum (Individual/Family)								
In Network	$2,000	$1,000/$2,000	$2,000/$6,000	$2,000	$500/$1,500	$1,000/$2,000	$1,000/$2,000	$1,000
Out of Network	$6,000	$1,000/$2,000	$3,000/$9,000	$4,000	$500/$1,500	$1,000/$2,000	$1,000/$2,000	$2,000
Benefit Maximum								
In Network	$2,000,000	$2,000,000	None	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Out of Network	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Coinsurance								
In Network	80%	80%	80%	80%	90%	80%	80%	80%
Out of Network	60%	80%	70%	60%	70%	80%	80%	60%
Office Visit Copay[(1)]								
In Network	$15	20%	$20	$15	10%	20%	20%	$20
Out of Network	40%	20%	30%	40%	30%	20%	20%	40%
Hospital Copay								
In Network	20%	20%	$300 per day	20%	10%	20%	20%	20%
Out of Network	40%	20%	30%	40%	30%	20%	40%	40%
Emergency Room Copay								
In Network / Out of Network	$100 per visit then 20%	$100 per visit then 20%	$100 per visit, then 20%	$100 per visit then 20%	10%	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%

[(1)] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

OEBB
Plan Design Comparison - Medical

Plan Option	PPP Copay Plan 200	$15 COPAY PLAN	PPP Copay Plan 300	(P203V2LX) $300 Deductible	Plan A - 500	PPO-DED-2	$500 DED PPO Orange	Med Plan 6
Trust	**OSBA**	**OEA Choice**	**OSBA**	**OSEA**	**OSBA**	**OEA Choice**	**Beaverton**	**OEBB**
Enrollment	291	829	150	5	68	424	1,220	2,987
Actuarial Value	0.79	0.78	0.77	0.77	0.77	0.77	0.76	0.77
Deductible (Individual/Family)								
In Network	$200/$600	$300/$600	$300/$900	$300/$900	$500/$1,500	$300/$900	$500/$1,500	$300/$900
Out of Network	$200/$600	$300/$600	$300/$900	$300/$900	$500/$1,500	$600/$1,800	$500/$1,500	$300/$900
Annual Coinsurance Maximum (Individual/Family)								
In Network	$2,000	$2,000	$2,000	$2,000/$6,000	$1,000/$2,000	$2,000	$2,000	$1,500
Out of Network	$4,000	$6,000	$4,000	$4,000/$12,000	$1,000/$2,000	$5,000	$4,000	$3,000
Benefit Maximum								
In Network	$2,000,000	$2,000,000	$2,000,000	None	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Out of Network	$2,000,000	$2,000,000	$2,000,000	$1,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Coinsurance								
In Network	80%	80%	80%	80%	80%	80%	80%	80%
Out of Network	60%	40%	60%	60%	80%	60%	60%	60%
Office Visit Copay[1]								
In Network	$15	$15	$15	$20	20%	$15	$10	$20
Out of Network	40%	40%	40%	40%	20%	40%	40%	40%
Hospital Copay								
In Network	20%	20%	20%	20%	20%	20%	20%	20%
Out of Network	40%	40%	40%	40%	40%	40%	40%	40%
Emergency Room Copay								
In Network / Out of Network	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%	20%	$100 per visit then 20%	$100 per visit then 20%	$100	$100 per visit then 20%

[1] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

OEBB
Plan Design Comparison - Medical

Plan Option	Plan C-500	PPP Copay Plan 500	PPO 500	Basic Health Plan VAR Package 3	PPO-DED-2A	SEA PPO-2	500 DED PLAN	FA50010008060	(PPO 40-50/50-2500)	Med Plan 7
Trust	**OSBA**	**OSBA**	**OEA Choice**	**Bend LaPine**	**OEA Choice**	**OEA Choice**	**OEA Choice**	**Clakamas ESD**	**OSEA**	**OEBB**
Enrollment	3,951	592	22	163	383	320	209	19		5,659
Actuarial Value	0.74	0.74	0.73	0.72	0.72	0.72	0.72	0.71	0.69	0.72
Deductible (Individual/Family)										
In Network	$500/$1,500	$500/$1,500	$500	None	$500/$1,500	$500/$1,000	$500/$1,000	$1,000/$3,000	None	$500/$1,500
Out of Network	$500/$1,500	$500/$1,500	$500	None	$1,000/$3,000	$500/$1,000	$500/$1,000	$2,000/$6,000	None	$500/$1,500
Annual Coinsurance Maximum (Individual/Family)										
In Network	$2,000	$2,000	$2,000	$2,500/$5,000	$3,000	$3,500	$3,500	$4,000/$8,000	$2,500/$7,500	$2,000
Out of Network	$2,000	$4,000	$2,000	$2,500/$5,000	$6,000	$7,000	$7,000	$8,000/$24,000	$5,000/$15,000	$4,000
Benefit Maximum										
In Network	$2,000,000	$2,000,000	$2,000,000	$1,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	None	$2,000,000
Out of Network	$2,000,000	$2,000,000	$2,000,000	$1,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000	$1,000,000	$2,000,000
Coinsurance										
In Network	80%	80%	80%	50%	80%	80%	80%	80%	50%	80%
Out of Network	80%	60%	80%	50%	60%	60%	60%	60%	50%	60%
Office Visit Copay[1]										
In Network	20%	$15	20%	50%	$15	20%	20%	20%	$40	20%
Out of Network	20%	40%	20%	50%	40%	40%	40%	40%	50%	40%
Hospital Copay										
In Network	20%	20%	20%	50%	20%	20%	20%	20%	50%	20%
Out of Network	20%	40%	20%	50%	40%	40%	40%	40%	50%	40%
Emergency Room Copay										
In Network / Out of Network	20%	$100 per visit then 20%	$100 per visit then 20%	50%	$100 per visit then 20%	$100 per visit then 20%	$100 per visit then 20%	20%	50%	$100 per visit then 20%

[1] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

OEBB
Plan Design Comparison - Medical

Plan Option	(P201V2LX) $1,000 Deductible	Clear Choice Select POS Basic	Plan C-1000	(PPO A25-1000-2-2500) $1,000 Deductible 20%/40%	PPO-DED-3	SEA PPO-3	$1000 DED POS	Med Plan 8
Trust	**OSEA**	**Bend LaPine**	**OSBA**	**OSEA**	**OEA Choice**	**OEA Choice**	**High Desert ESD**	**OEBB**
Enrollment		83	489		246	578	28	1,424
Actuarial Value	0.67	0.66	0.66	0.65	0.64	0.61	0.64	0.64
Deductible (Individual/Family)								
In Network	$1,000/$3,000	None	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000	$1,000/$3,000
Out of Network	$1,000/$3,000	None	$1,000/$3,000	$1,000/$3,000	$2,000/$6,000	$1,000/$3,000	$2,000/$6,000	$1,000/$3,000
Annual Coinsurance Maximum (Individual/Family)								
In Network	$2,000/$6,000	$3,750/person	$2,000	$2,500/$7,500	$5,000	$5,000	$2,000/person	$2,000
Out of Network	$4,000/$12,000	$7,500/person	$2,000	$5,000/$15,000	$10,000	$10,000	$4,000/person	$4,000
Benefit Maximum								
In Network	None	$1,000,000	$2,000,000	None	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Out of Network	$1,000,000	$1,000,000	$2,000,000	$1,000,000	$2,000,000	$2,000,000	$2,000,000	$2,000,000
Coinsurance								
In Network	80%	50%	80%	80%	80%	80%	80%	80%
Out of Network	60%	50%	80%	60%	60%	60%	60%	60%
Office Visit Copay[1]								
In Network	$20	50%	20%	$25	$15	20%	$25	20%
Out of Network	40%	50%	20%	40%	40%	40%	40%	40%
Hospital Copay								
In Network	20%	50%	20%	20%	20%	20%	20%	20%
Out of Network	40%	50%	20%	40%	40%	40%	40%	40%
Emergency Room Copay								
In Network / Out of Network	20%	50%	20%	$100 per visit, then 20%	$100 per visit then 20%	$100 per visit then 20%	$100	$100 per visit then 20%

[1] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

OEBB
Plan Design Comparison - Medical

Plan Option	HSA Plan	MAJOR MED	Med Plan 9	Trust Subtotal
Trust	**OSBA**	**OEA Choice**	**OEBB**	**OEBB**
Enrollment	15	94	109	60,007
Actuarial Value	0.58	0.47	0.58	
Deductible (Individual/Family)				
In Network	$1,500/$3,000	$2,000/$6,000	$1,500/$3,000	
Out of Network	$1,500/$3,000	$2,000/$6,000	$1,500/$3,000	
Annual Coinsurance Maximum (Individual/Family)				
In Network	$5,000/$10,000	$5,000	$5,000/$10,000	
Out of Network	$5,000/$10,000	$10,000	$5,000/$10,000	
Benefit Maximum				
In Network	$2,000,000	$2,000,000	$2,000,000	
Out of Network	$2,000,000	$2,000,000	$2,000,000	
Coinsurance				
In Network	80%	70%	80%	
Out of Network	60%	50%	60%	
Office Visit Copay[(1)]				
In Network	20%	30%	20%	
Out of Network	40%	50%	40%	
Hospital Copay				
In Network	20%	30%	20%	
Out of Network	40%	50%	40%	
Emergency Room Copay				
In Network / Out of Network	20%	$100 per visit then 30%	20%	

[(1)] Plans 3 - 6, only the copay applies to in-network visits, no deductible.

Final Recommendation

OEBB

Plan Design Comparison - Pharmacy

Recommended OEBB Plan Options

	Rx Plan 1 HMO	Option A PPO	Option B PPO	Option C PPO	
Trust	**OEBB**	**OEBB**	**OEBB**	**OEBB**	**Total**
Enrollment	13,000	48,511		729	62,240
Actuarial Value	0.93	0.90	0.89	0.76	
Deductible	None	None	None	None	
Annual Copay/ Coinsurance Maximum	$1,000	$1,000	$1,000	$1,000	
Retail					
Generic	$5	$5	$5	50%	
Preferred	$15	20%	$25	50%	
Non Preferred	N/A	50%	50%, $50 max	50%	
Mail					
Generic	$10	$10	$10	50%	
Preferred	$30	20%	$50	50%	
Non Preferred	N/A	50%	50%, $100 max	50%	

Note: a group/district may *not* offer both options A and B

OEBB
Plan Design Comparison - Pharmacy

	$5 Copay*	KAISER $5	$10 Copay*	KAISER $10	PDL/06	$15 Copay*	Rx Plan 1 HMO
Trust	**Several**	**OEA Choice**	**Several**	**Several**	**OSEA**	**Several**	**OEBB**
Enrollment	1,837	778	5,163	2,224	TBD	2,998	13,000
Actuarial Value	1.00	0.99	0.96	0.93	0.93	0.92	0.93
Deductible	None	None	None	None	None	None	None
Annual Copay/ Coinsurance Maximum	None	None	None	None	None	None	$1,000
Retail							
Generic	$5	$5	$10	$10	$5	$15	$5
Preferred	$5	$5	$10	$10	$10	$15	$15
Non Preferred	$5	N/A	$10	N/A	$25	$15	N/A
Mail							
Generic	$5	$10	$10	$20	$10	$15	$10
Preferred	$5	$10	$10	$20	$20	$15	$30
Non Preferred	$5	N/A	$10	N/A	$50	$15	N/A

* Actuarial value does not fully reflect additional member cost-sharing penalty incurred for filling a brand name drug that has a generic equivalent

OEBB

Plan Design Comparison - Pharmacy

	PPL/06	KAISER $15	OSBA	PML/06	$10/$20/50% Plan* 500 DED PLAN $15 COPAY PLAN SEA MCP15 SEA PPO-2	PNL/06
Trust	**OSEA**	**Several**	**OSBA**	**OSEA**	**OEA Choice**	**OSEA**
Enrollment	TBD	848	37,994	TBD	6,961	TBD
Actuarial Value	0.89	0.89	0.89	0.88	0.88	0.88
Deductible	None	None	None	None	None	None
Annual Copay/ Coinsurance Maximum	$1,000	None	$1,000	None	None	None
Retail						
Generic	$10	$15	$10	$10	$10	$10
Preferred	$20	$15	20%	$15	$20	$15
Non Preferred	$40	N/A	50%	$25	50%, $50 max	$30
Mail						
Generic	$20	$30	$30	$20	$10	$20
Preferred	$40	$30	20%	$30	$20	$30
Non Preferred	$80	N/A	50%	$50	50%, $50 max	$60

* Actuarial value does not fully reflect additional member cost-sharing penalty incurred for filling a brand name drug that has a generic equivalent

OEBB

Plan Design Comparison - Pharmacy

	$250 DED PPO Blue	PPO 100	MAJOR MED SEA PPO-3	PPO 500	High Option	Option A PPO	Option B PPO
Trust	**Beaverton**	**OEA Choice**	**Several**	**OEA Choice**	**High Desert ESD (Crook County)**	**OEBB**	**OEBB**
Enrollment	1,233	580	766	22	107	48,511	48,511
Actuarial Value	0.87	0.87	0.85	0.84	0.83	0.90	0.89
Deductible	$50	$50	None	$100	None	None	None
Annual Copay/ Coinsurance Maximum	$1,050	$1,000	None	$1,000	$1,500	$1,000	$1,000
Retail							
Generic	20%	20%	50%, $50 max	20%	$10	$5	$5
Preferred	20%	20%	50%, $50 max	20%	$35	20%	$25
Non Preferred	20%	50%	50%, $50 max	50%	$45	50%	50%, $50 max
Mail							
Generic	20%	20%	50%, $50 max	20%	$20	$10	$10
Preferred	20%	20%	50%, $50 max	20%	$70	20%	$50
Non Preferred	20%	50%	50%, $50 max	50%	$90	50%	50%, $100 max

OEBB
Plan Design Comparison - Pharmacy

	50%*	FA50010008060	P4L/06	Option C PPO
Trust	**OEA Choice**	**Clakamas ESD**	**OSEA**	**OEBB**
Enrollment	710	19	TBD	729
Actuarial Value	0.80	0.77	0.77	0.76
Deductible	None	None	None	None
Annual Copay/ Coinsurance Maximum	None	None	None	$1,000
Retail				
Generic	50%, max $100	$15	$15	50%
Preferred	50%, max $100	$30	$30	50%
Non Preferred	50%, max $100	$50	$60	50%
Mail				
Generic	50%, max $100	$30	$30	50%
Preferred	50%, max $100	$60	$60	50%
Non Preferred	50%, max $100	$100	$100	50%

* Actuarial value does not fully reflect additional member cost-sharing penalty incurred for filling a brand name drug that has a generic equivalent

Final Recommendation

OEBB
Plan Design Comparison - Dental and Orthodontia

Trust/District	Dental Plan 1	Dental Plan 2	Dental Plan 3	Dental Plan 4	Dental Plan 5	Dental Plan 6	Dental Plan 7	Dental Plan 8	Subtotal
Enrollment	TBD	12,527	7,980	17,665	5,989	1,052	3,271		48,484
Actuarial Value	1.00	0.90	0.88	0.81	0.74	0.64	N/A	N/A	
Deductible	None	None	None	$25	$50	$50	None	None	
Annual Maximum	$2,200	$1,500	$1,500	$1,500	$1,500	$1,000	None	None	
Preventive Care	70%+10% year	70%+10% year	70%+10% year	100%	100%	100%	100% ($5 per visit)	100% ($10 per visit)	
Restorative Services	70%+10% year	70%+10% year	70%+10% year	80%	80%	80%	100% ($5 per visit)	100% ($10 per visit)	
Major Services	70%+10% year	70%+10% year	70%+10% year	80%	50%	50%	$45	100%	
Prosthodontics	70%+10% year	70%+10% year	50%	50%	50%	50%	$95 partial denture, $65 full denture, $25 reline	100%	
Orthodontics	No Coverage OR 80% to $1,500 lifetime max						No Coverage OR Alternate 1: 50% to $2,000 lifetime max	Alternate 2: $1,500 copay + $10 per visit	

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

OEBB
Plan Design Comparison - Dental

Trust/District	OEA ER	Dental Plan 1
Enrollment	TBD	TBD
Actuarial Value	1.00	1.00
Deductible	None	None
Annual Maximum	$2,200	$2,200
Preventive Care	70%+10% year	70%+10% year
Restorative Services	70%+10% year	70%+10% year
Major Services	70%+10% year	70%+10% year
Prosthodontics	70%+10% year	70%+10% year

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

OEBB
Plan Design Comparison - Dental

Trust/District	Several	OEA	Dental Plan 2
Enrollment	12,514	13	12,527
Actuarial Value	0.90	0.90	0.90
Deductible	None	None	None
Annual Maximum	$1,500	$1,500	$1,500
Preventive Care	70%+10% year	70% PPO, 50% non-PPO (+10% a year, 3 years)	70%+10% year
Restorative Services	70%+10% year	70% PPO, 50% non-PPO (+10% a year, 3 years)	70%+10% year
Major Services	70%+10% year	70% PPO, 50% non-PPO (+10% a year, 3 years)	70%+10% year
Prosthodontics	70%+10% year	70% PPO, 50% non-PPO (+10% a year, 3 years)	70%+10% year

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

OEBB
Plan Design Comparison - Dental

Trust/District	Several	Several	McKenzie	Dental Plan 3
Enrollment	7,809	171	TBD	7,980
Actuarial Value	0.88	0.87	0.87	0.88
Deductible	None	None	None	None
Annual Maximum	$1,500	$1,500	$2,000	$1,500
Preventive Care	70%+10% year	70%+10% year	70%+10% year	70%+10% year
Restorative Services	70%+10% year	70%+10% year	70%+10% year	70%+10% year
Major Services	70%+10% year	80%	50%	70%+10% year
Prosthodontics	50%	80%	50%	50%

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

OEBB
Plan Design Comparison - Dental

Trust/District	OEA ER	Several	OSBA	OSBA	OEA	OSBA	Dental Plan 4
Enrollment	1,000	9,626	5,408	502	164	965	17,665
Actuarial Value	0.83	0.81	0.81	0.81	0.81	0.79	0.81
Deductible	$25	None	$100, $300 family	$100/$300 Preferred $200/$600 Non-Preferred	None	$200, $600 family	$25
Annual Maximum	$2,000	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500
Preventive Care	100%	70%+10% year	100%	100%	70% PPO, 50% non-PPO (+10% a year, 3 years)	100%	100%
Restorative Services	80%	70%+10% year	80%	80%	70% PPO, 50% non-PPO (+10% a year, 3 years)	80%	80%
Major Services	60%	50%	80%	80%	50% for both PPO and non-PPO	80%	80%
Prosthodontics	60%	50%	50%	50%	50% for both PPO and non-PPO	50%	50%

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

OEBB
Plan Design Comparison - Dental

Trust/District	OSBA	OSBA	OEA	OSEA	OSEA	OSBA	Beaverton	Dental Plan 5
Enrollment	4,061	194	TBD	TBD	TBD	179	1,555	5,989
Actuarial Value	0.77	0.77	0.76	0.74	0.74	0.73	0.73	0.74
Deductible	$25	$300, $900 family	$25	$50	$50 (in and out of network)	$500, $1,500 family	$25	$50
Annual Maximum	$1,500	$1,500	$1,500	$1,500	$1,500 (in and out of network)	$1,500	$1,500	$1,500
Preventive Care	70%+10% year	100%	100%	100%	100% in 80% out	100%	65%+10% year (to 95%)	100%
Restorative Services	70%+10% year	80%	80%	80%	80% in 60% out	80%	65%+10% year (to 95%)	80%
Major Services	50%	80%	50%	50%	50% (in and out of network)	80%	45%	50%
Prosthodontics	50%	50%	50%	50%	50% (in and out of network)	50%	45%	50%

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

OEBB
Plan Design Comparison - Dental

Trust/District	Crook County	Beaverton	Dental Plan 6
Enrollment	122	930	1,052
Actuarial Value	0.67	0.63	0.64
Deductible	$25	$50	$50
Annual Maximum	$1,000	$1,500	$1,000
Preventive Care	100%	80%	100%
Restorative Services	80%	80%	80%
Major Services	50%	50%	50%
Prosthodontics	50%	50%	50%

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

OEBB
Plan Design Comparison - Dental

Trust/District	OEA	OEA	Hillsboro	Clackamas ESD	OEA	OEA
Enrollment	294	TBD	190	65	1,063	59
Actuarial Value						
Deductible	None	None	None	None	None	None
Annual Maximum	None	None	None	None	None	None
Preventive Care	$10 per visit	$10 per visit	$10 per visit	$5 per visit	100% ($5 per visit)	100%
Restorative Services	$10 per visit	$10 per visit	$10 per visit	$5 per visit	100% ($5 per visit)	100%
Major Services	100%	$10 per visit	$10 per visit + 80% coinsurance	$5 per visit	$45	Perio/endodontics 80% Major restorative 50%
Prosthodontics	100%	$10 per visit	$10 per visit + 50% coinsurance	$5 per visit	$95 partial denture, $65 full denture, $25 reline	50%

Trust/District	NW Regional ESD	Portland	Beaverton	Dental Plan 7	Dental Plan 8
Enrollment	100	212	1,288	3,271	
Actuarial Value					
Deductible	$5 copay	$5 copay	None	None	None
Annual Maximum	None	None	None	None	None
Preventive Care	$5 per visit	$5 per visit	$4 per visit	100% ($5 per visit)	100% ($10 per visit)
Restorative Services	$5 per visit	$5 per visit + 80%	$4 per visit plus $20 - $80 copay	100% ($5 per visit)	100% ($10 per visit)
Major Services	$5 per visit + 50% - 80%	$5 per visit + 50%	$4 per visit plus $20 - $80 copay	$45	100%
Prosthodontics	$5 per visit + 50%	$5 per visit + 50%	$4 per visit plus $20 - $80 copay	$95 partial denture, $65	100%

1) For plans with increasing coinsurance, we assumed 2 - 3 years of completed requirements
2) For integrated medical/dental plans we assumed 25% of deductible is attributable to dental
3) On proposed OEBB plans we assumed deductible does not apply to preventive services

Plan Option	Vision Plan 1	Vision Plan 2	Vision Plan 3	Vision Plan 4	Vision Plan 5
Vision					
Plan Maximum	$250	$350	$450	$600	See allowances
Routine Eye Exam	$10 copay	100%	100%	100%	100% up to $64.50
Exam Frequency	12 months	12 months	12 months	12 months	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 / year
Bifocal	100%	100%	100%	100%	100% up to $86.00 / year
Lenticular	100%	100%	100%	100%	100% up to $86.00 / year
Trifocal	100%	100%	100%	100%	100% up to $109.00 / year
Contact Lenses	100%	100%	100%	100%	100% up to $192.50 / year
Lens Frequency	12 months	12 months	12 months	12 months	12 months
Frames	100%	100%	100%	100%	100% up to $75.00 / year
Frame Frequency	child: 12 months, adult: 24 months	child: 12 months, adult: 24 months	child: 12 months, adult: 24 months	child: 12 months, adult: 24 months	child: 12 months, adult: 24 months