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.

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

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 - Vision

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