oebb

enrollment guide

2022-23 Plan Year

Enrollment Required Starting August 15th

action required
Do you need to login? YES!

who

Everyone eligible for OEBB benefits must log in, even if you decline coverage.

what/where

1. Log in to **OEBBenroll.com** to make your plan selections or to decline coverage for 2022-23.

2. Look for specific plan cost information from your employer.

when

During YOUR Open Enrollment Period – Start Date August 15

OEBB's Open Enrollment is August 15 to September 15, 2022. Some employers use different end dates. **Confirm YOUR deadline with your employer.**

why

1. **If you don't, you probably won't have coverage for 2022-23.** Your current medical, dental, and vision elections will NOT roll over into 2022-23. So unless your employer defaults you into a plan, you won't have coverage.

2. **Open Enrollment is the one time per year you can make changes without a major life event.** Mid-year changes are only allowed if you experience a Qualified Status Change (QSC) event (e.g., marriage, birth or adoption of a child, divorce). Let your employer know anytime you experience a QSC, even during Open Enrollment.

   More information about QSC events can be found on the OEBB website at: **oregon.gov/OHA/OEBB/Pages/QSC-Matrix.aspx**

3. **It's your health and your paycheck! You should control what coverage you have.** If your employer does enroll you in a default plan, you may not like what you get! Don't leave your choices to someone else.

how/ need help?

Many people just log in and follow the onscreen instructions, but if you need more help, you can find detailed instructions at **oregon.gov/oha/OEBB/Pages/Eligibility.aspx**

what's inside

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getting started

avoid these common mistakes

1. **Know YOUR monthly cost for coverage.** The MyOEBB system shows the full premium cost, but most employers contribute toward that, so the amount you pay may be different. Get your specific plan option costs from your employer.

2. **Make sure your doctors/providers are in-network for the plans you select.** Some plans have limited networks and no out-of-network coverage. Be sure your plan will cover services where you want to receive them.

3. **Double-check your dependents have the right coverage.** Each dependent needs to be added to each plan (medical, dental, vision, etc.) if you want them to be covered.

4. **Make sure everyone you cover meets one of the definitions of an eligible dependent.** Grandchildren are only eligible for OEBB coverage when the eligible employee is the court-ordered legal guardian or adoptive parent of the grandchild. Definitions of eligible dependents, including child, spouse and eligible domestic partner, can be found on the OEBB website at: **www.oregon.gov/oha/OEBB/Pages/Eligibility.aspx**

5. **Before you decline dental for yourself or a dependent, recognize a 12-month wait will apply** if you choose to add dental coverage at a future Open Enrollment.

6. **Don't wait until the last minute!** OEBB and insurance carrier offices are closed on weekends and holidays and may not be available to help you during these times. Decide early, enroll early.

Double-Coverage Surcharge

The Oregon state legislature requires a surcharge on OEBB/PEBB double-coverage.

- Only pertains to OEBB/OEBB, PEBB/PEBB and OEBB/PEBB subscriber double medical coverage
- Only charged to ACTIVE employees (no Early Retirees or COBRA)
- Only charged to full-time employees (not part-time)
- One $5 surcharge per month (even if double-covering more than one dependent)
- Mainly affects spouse/partners double covered
- Children are not included unless they are also an OEBB or PEBB subscriber (if their job makes them eligible for OEBB/PEBB benefits)

what's new for the 2022-23 plan year

All the OEBB medical, dental, and vision plans available in 2021-22 will continue to be available for 2022-23. We're also pleased to share the following benefit enhancements.

Moda Health Medical Plans

- **Meeting the annual out-of-pocket maximum will be easier.** For Plans 1–5, medical and prescription drug expenses will count toward the plan's out-of-pocket maximum. Once you reach the out-of-pocket maximum, the plan pays 100% of most eligible medical and prescription drug costs for the rest of the plan year.

- **Expanded coverage for certain cancer medications.** Moda Health is enhancing their special program for cancer medications. More medications will be covered. Infusions can be done in more locations – including provider offices, infusion clinics, or sometimes even at home.

- **Diabetic monitors and testing supplies covered through the prescription benefit.** Glucose monitors and testing supplies will now be covered under the prescription drug benefit. This means you will no longer need to go through a durable medical equipment (DME) provider. You can purchase these supplies directly from a retail pharmacy with a small copay. These diabetic supplies will apply to your prescription drug plan deductible. (Note: If you received prior authorization through the medical plan, you won't need to get another authorization. Your previous authorization will transfer to your prescription drug benefit automatically.)

- **New diabetes prevention program.** To help identify pre-diabetes, members age 18 or older will be able to complete an online screening. Moda will then invite members who qualify to join the pre-diabetes program. When you join, you receive individual coaching sessions, visits with a nutritional counselor, and a free fitness tracker to use while you participate in the program. (Members who don't qualify for the program will receive a free 90-day subscription to a fitness tracker for completing the screening.)

- **Behavioral health champions available.** Members will have access to behavioral health champions. These champions will have education or experience in social work, behavioral health, or health care. What can one of these champions do for you? They can help identify treatment options, support tools, and suitable providers. They'll even schedule appointments for you and follow up afterwards to make sure the treatment you receive meets your needs. If the first provider wasn't a good fit, they will help you find another. With a behavioral health champion, you always have someone in your corner to help you get the care you need.

Kaiser Permanente Medical Plans

- **Changes to chiropractic and acupuncture services.** Starting Oct. 1, Kaiser Permanente medical plans will cover 20 chiropractic visits and 12 acupuncture visits each plan year. There will be no dollar maximum for these services. There is a $2,000 limit per plan year for these services through this plan year.

- **Changes to naturopathic services.** Naturopathic services will be covered just like any other medical benefit. There will be no limits on the number of visits and no dollar maximum.

- **New diabetes prevention program.** Kaiser Permanente will invite OEBB members with diabetes risk factors to join Omada. Omada is an interactive weekly lifestyle training program to help prevent diabetes. When you join the program, you will receive a wireless smart scale to monitor your progress. You can partner with a trained health coach to increase physical activity, reduce stress, and lose weight. You can also join a group of peers to share tips and get motivated.

Delta Dental Plans

- **Benefit maximums will stretch further.** Most charges for restorative services (such as fillings, inlays, oral surgery, extractions, endodontics, and periodontics) will not apply toward the plan year benefit maximum. This leaves more benefit available for other covered dental services.

What's NOT changing?

All the benefits on the following plans remain the same for the 2022-23 Plan Year:

- Kaiser Permanente Dental Plan
- Willamette Dental Group Dental Plan
- Kaiser Permanente Vision Plan
- VSP Vision Plans

OEBB Virtual Benefits Fair

We're excited to offer an online Virtual Benefits Fair this year!

This virtual setting is available 24/7, so you can:

- Watch videos and download PDFs to learn about your benefit options.
- Explore resources available to OEBB members at no additional cost, like gym membership discounts, mental health apps, financial planning services, and more!
- Live chat with vendor partners during scheduled times.
- Enter a raffle to win a prize!

Visit OEBBondemand.com and click the Virtual Benefits Fair link to get started!

out-of-area dependents

Information on covering dependents who do not live with you:

Kaiser Permanente

Kaiser Permanente Medical Plans

Kaiser Permanente provides access to urgent and emergency care outside of the Kaiser Permanente network. Your Dependent Out-of-Area benefit also covers routine, continuing, and follow-up care for dependent children residing outside of the Kaiser Permanente NW service area. With this benefit, you pay 20 percent co-insurance of the actual fee charged for the service the provider, facility, or vendor provided (cost share subject to deductible on Medical Plan 3). Limited to ten office visits, ten lab and X-ray (excluding specialty scans), and ten prescription drug fills per year. You can find more information about this benefit by calling Membership Services at **800-813-2000**.

Kaiser Permanente Dental Plan

Dependents residing outside the service area can access emergency dental care from non-participating providers. Coverage for this benefit is limited to $100 per incident. Non-emergency dental services will only be covered when they are provided by a Kaiser Permanente provider.

Kaiser Permanente Vision Plan

Non-emergency vision services will only be covered when they are provided by a Kaiser Permanente provider. Emergency vision services are covered under your Kaiser Permanente medical plan as described above.

Moda Health/Delta Dental

Moda Medical Plans

New this year! Out-of-area dependents living outside of the Connexus service area will use Moda's new national network partner, Aetna Signature Administrators®.

If a dependent lives outside the Connexus network area, the OEBB employee must update the dependent's address in the myOEBB system prior to the dependent seeking services. The dependent will be assigned Moda's new national network, Aetna PPO through Aetna Signature Administrators,® except for dependents who live in Idaho or Alaska. Members who live in Idaho will continue to use both the Connexus and PHCS networks. Members who live in Alaska will continue to use the PHCS network.

See Page 33 for out-of-area coordinated care and PCP 360 options.

To locate an in-network provider, call the Moda 360 Health Navigator team at **866-923-0409** or use FindCare and search by the applicable network (Aetna PPO though Aetna Signature Administrators,® Connexus, or PHCS network).

Moda Vision Plans
Vision members can see any licensed provider but benefit dollars will go further if you use an in-network Moda provider, as Moda has discounted rates with in-network providers.

You can locate a Moda Vision provider by calling the Moda 360 Health Navigator Team at **866-923-0409** or use Find Care.

Delta Dental Premier Plans
Moda's Delta Dental Premier Network is the largest dental network in Oregon and is also available nationwide. Members enrolled in Delta Dental Plan 1, 5 or 6 should seek care from a Premier Network dentist to avoid balance billing for amounts above the maximum plan allowance.

Delta Dental Exclusive PPO Plans
Members enrolled in the Delta Dental Exclusive PPO Plan or Delta Dental Exclusive PPO Incentive Plan must use a Delta Dental PPO provider (providers available nationwide) or they will receive no benefit.

To locate a Delta Dental provider, use Find Care to search for an in-network Premier or PPO provider by network or call Moda 360 Health Navigator Team at **866-923-0410**.

VSP Vision Care

VSP
VSP Vision Plans
Members can find VSP Choice providers nationwide. Search for a provider at **vsp.com**.

Willamette Dental Group

Willamette Dental Group
Willamette Dental Plan
Members can access care at any Willamette Dental Group office, nearly 50 office locations throughout Oregon, Washington, and Idaho. Dependents residing outside of the Willamette Dental Group service area will not have coverage for any dental care with a non-Willamette Dental Group provider, unless they have a dental emergency. Non-emergent services will only be covered when performed by a Willamette Dental Group provider.

early retiree information

An "Early Retiree" is an individual who retires before the age of 65. In order to be eligible for OEBB benefits, an early retiree must not be eligible for Medicare and must be eligible to receive a service retirement allowance under PERS or a retirement benefit plan or system offered by an OEBB-participating employer.

Enrollment Changes Allowable During Open Enrollment

As an Early Retiree During Open Enrollment You Can:

- Continue or change (as allowed per the QSC Matrix) your medical, dental, and/or vision enrollment
- Continue or decrease any optional coverages enrolled in, such as life or AD&D
- Drop eligible dependents from any or all coverages
- Waive, decline, or cancel any coverages

As a Reminder:

- Any coverage waived, declined or canceled cannot be added back unless you are doing so because of gaining other OEBB coverage
- Any eligible dependent removed from coverage cannot be added back unless the dependent experiences a Qualified Status Change (QSC) event that would allow the enrollment in coverage. Contact your benefits administrator within 31 days of the qualifying event.

Becoming Eligible for Medicare during the Plan Year

If you or an eligible enrolled dependent becomes eligible for Medicare, OEBB coverage will end the last day of the month prior to the Medicare eligibility effective date.

- If the Early Retiree gains Medicare eligibility, any eligible dependents currently enrolled may continue OEBB coverage until they no longer meet eligibility or become eligible for Medicare.
- The only exception to this rule is: if the Early Retiree or eligible dependent gains Medicare eligibility due to End Stage Renal Disease (ESRD), OEBB coverage can be continued for up to 30 months beyond Medicare eligibility.

The OEBB system will end coverage for Medicare eligibility gained due to turning age 65. **It is your responsibility to notify your employer if you become eligible for Medicare prior to age 65 due to a disability.** Failure to report this information could cause denial of your medical claims.

Medicare Enrollment Resources

You can enroll in Medicare up to three months in advance. The Senior Health Insurance Benefits Assistance (SHIBA) Program was created to assist with Medicare and Medicare plan selection questions. The SHIBA website **(shiba.oregon.gov)** is full of helpful Medicare information and certified counselors are available by phone at **1.800.722.4134.**

Additional Resources for Early Retirees can be found online at:
oregon.gov/oha/OEBB/Pages/Retiree-Guide.aspx

definitions for benefit terms

Additional Cost Tier (ACT) Services in this tier require an additional copayment of $100 or $500. These copayments do not apply toward the deductible or the annual medical out-of-pocket maximum and are in addition to any other applicable copayment or coinsurance you must pay under your specific medical plan benefits.

Balance Billing When out-of-network providers bill you for the difference between your maximum plan allowance and their billed charges. In-network providers don't do this.

COBRA This acronym stands for the Consolidated Omnibus Budget Reconciliation Act, which is the federal law requiring employers to allow for continued coverage through a group health plan after losing eligibility in the group, on a self-pay basis.

Coinsurance The percentage of eligible health care expenses you pay after you meet any required annual deductible.

Constant Dental Plan In contrast to Incentive Dental Plans, benefits remain constant regardless of how often an individual visits the dentist.

Coordinated Care Moda medical plans allow each covered individual the option to participate in coordinated care by choosing and using a PCP 360. Participating individuals receive a lower individual deductible, a lower individual out-of-pocket maximum, and lower costs for office visits, specialist visits, and alternative care visits (compared to those enrolled in a Moda medical plan who do not choose and use a PCP 360, and therefore receive the non-coordinated care benefit).

Copayment or Copay The fixed dollar amount you pay for certain services.

Deductible The amount you must pay each plan year before your insurance begins to pay for covered health care services you receive.

Dependent An individual who qualifies for OEBB benefits based on their relationship to someone else (e.g., a spouse, domestic partner, child, or step child) as opposed to their own employment status.

Early Retiree An individual who retires before the age of 65. In order to be eligible for OEBB benefits, an Early Retiree must not be eligible for Medicare and must be eligible to receive a service retirement allowance under PERS or a retirement benefit plan or system offered by an OEBB-participating employer.

Employer Contribution The amount your employer pays toward your benefits package or health insurance premium. This is sometimes referred to as your "cap."

Exclusive PPO Dental Plans These plans have no out-of-network benefit. Under these plans, services performed outside the Delta Dental PPO network are not covered except for a dental emergency.

definitions for benefit terms

Formulary A list showing which prescription drugs are covered by a health insurance plan and which coverage tier they fall under (e.g., generic, preferred, non-preferred).

Incentive Dental Plans (Delta Dental Premier Plans 1 & 5 and Exclusive PPO Incentive Plan) Benefits start at 70 percent for your first plan year of coverage. Thereafter, benefit payments increase by 10 percent each plan year (up to a maximum of 100 percent), provided the individual has visited the dentist at least once during the previous plan year. Failure to do so will cause a 10 percent reduction in benefit the following plan year, although the benefit will never fall below 70 percent.

In-Network Provider A provider or facility contracted with a health plan to provide services at a negotiated discount.

Maximum Benefit The total amount payable by a plan per plan year.

Maximum Plan Allowance (MPA) The maximum amount a plan will pay toward the cost of a service.

Medicare Eligible A person who currently meets the requirements to receive Medicare benefits, either due to disability or age (65 or older).

Non-Coordinated Care Moda medical plans allow each covered individual the option to participate in coordinated care by choosing and using a PCP 360. If an individual enrolled in a Moda medical plan does not choose and use a PCP 360, they receive the "non-coordinated care" benefit which includes a higher individual deductible, a higher individual out-of-pocket maximum, and higher costs for office visits, specialist visits, and alternative care visits (compared to those who choose coordinated care).

If you need help understanding these terms, call OEBB Member Services at 888.469.6322

definitions for benefit terms

Out-of-Network Provider A provider who does not have a contract with the health plan. Note: Some plans will not cover services performed by out-of-network providers. Choose plans and providers carefully.

Out-of-Pocket Maximum The most you will pay for services in a year before your plan begins paying 100% of eligible expenses. Note: Monthly insurance premiums are not included in this and must continue to be paid even after the Out-of-Pocket Maximum has been met.

PCP 360 (applies only to Moda medical plans) A PCP 360 is a high-quality provider who has contracted with Moda Health to deliver full-circle care, coordinating with other providers as needed. Each individual covered on a Moda medical plan has the option to participate in coordinated care and receive enhanced benefits by choosing and using a PCP 360. Use Moda Health's online "FindCare" tool to learn which providers are "PCP 360" providers.

Pre-authorization (or Prior Authorization) An insurance plan requirement that covered services be approved by the plan prior to the date of service.

Preventive Care Measures taken for disease prevention, as compared to disease treatment.

Primary Care Provider Also referred to as General Practitioner, provides both the first contact for a person with an undiagnosed health concern as well as continuing care of varied medical conditions not limited by cause, organ system, or diagnosis.

Qualified Status Change (QSC) A life event that allows a member to change their plan elections outside the annual Open Enrollment period. For a full listing of all the Qualified Status Changes, please visit our website for our full matrix: **oregon.gov/OHA/OEBB/pages/QSC-matrix.aspx**

Self-Pay Early Retiree (SPER) An Early Retiree who does not receive any contribution from their previous employer and pays their full premium directly to OEBB.

who you gonna call?

A quick guide to "Who Does What" with your benefits

oebb

888.469.6322
OEBBinfo.com

moda HEALTH

866.923.0409
modahealth.com/oebb

KAISER PERMANENTE®

866.223.2375
my.kp.org/oebb

Willamette Dental Group

855.433.6825
willamettedental.com/oebb

vsp Vision Care

800.877.7195
vsp.com

TheStandard

866.756.8115
standard.com/mybenefits/oebb

uprisehealth

800.395.1616
members.uprisehealth.com

unum

800.227.4165
unuminfo.com/oebb

OEBB stands for the Oregon Educators Benefit Board, but we also serve cities, counties, and local governments, along with educators, so we just go by "OEBB" (pronounced OH-ebb). The OEBB Board decides which insurance plans and benefits are offered to participating employers. OEBB holds the legal contracts with the carriers, collects premiums from employers, and passes them along to the carriers.

Contact OEBB if you need help: logging into or navigating the MyOEBB enrollment system (OEBBenroll.com), clarifying rules, verifying enrollments, understanding your benefits or wellness program options.

The Carriers are the insurance companies that pay your providers for some or all of your healthcare services, as agreed to in their OEBB contract.

Contact the carrier if you need help: estimating your portion of the cost for a procedure, understanding how a claim was paid, finding an in-network provider, completing their online health assessment, or getting a new ID card.

Your Employer knows the most about your specific plan options and your monthly cost for coverage. Each employer decides which OEBB plans to offer their employees and they negotiate different financial contributions to their employee benefit packages. They also may set their own enrollment deadlines or have their own policies apart from OEBB.

Contact your employer if you need to: make a change to your benefits due to a life event (like getting married or having a baby), determine your monthly cost for coverage, plan for retirement, understand or correct your payroll deductions.

Your Providers are the professionals (doctors, dentists, specialists, etc.) who provide your healthcare, examine and diagnose illnesses, and prescribe treatments.

Contact your provider if you need to: make an appointment, estimate the total cost of a procedure, pay your portion (copay or coinsurance) for a service, get advice regarding symptoms or results of lab tests.

Focus on You

Download the New Wellness Brochure!

Need some help fitting the pieces of your overall wellness together? OEBB offers support in all areas of your wellbeing.

Visit OEBBWellness.com to learn more.

oebb

medical benefits

KAISER PERMANENTE®

Care centered around you

Care at Kaiser Permanente isn't one-size-fits-all. Our physician-led teams work together to help make sure the care you get is tailored to your needs. Your care team is all part of the same network, making it easier to share information, see your health history, and deliver high-quality, personalized care – when and where you need it.

Your healthy place should reflect who you are

We believe your story, background, and values are as important as your health history. To help deliver care that's sensitive to your culture, ethnicity, and lifestyle, we:

- Hire doctors and staff who speak more than one language
- Offer phone interpretation services in more than 150 languages
- Improved health outcomes among diverse populations for conditions like high blood pressure, diabetes, and colon cancer*

Get coordinated care with the help of your electronic health record

Share your health history and any concerns with your personal doctor.

Your doctor coordinates your care, so you don't have to worry about where to go or who to call next.

Future care teams have a full picture of your health history – without you having to repeat your story.

With your health records in hand, your care team knows your needs in the moment and reminds you to schedule checkups and tests. Plus, you can view your records 24/7.

*Kaiser Permanente improved blood pressure control in our Black/African-American members with hypertension, raised colorectal cancer screening rates in our Hispanic/Latino members, and improved blood sugar control in our members with diabetes. Self-reported race and ethnicity data are captured in Kaiser Permanente HealthConnect®, and HEDIS® measures are updated quarterly in the interregional CORE Datamart.

KAISER PERMANENTE®

Empowered by a connected system

The ways people work, play, and stay in touch with others are always changing, but one thing is constant – their need for quality care. That's why we're always adapting to help make sure you can get care in a way that's convenient for you.

Where you are

When you're at home or on the go, talk to your team of caregivers by email, video, and phone.[1,2]

When you want

Get trusted care advice 24/7 from a Kaiser Permanente medical professional.

At your fingertips

Use the Kaiser Permanente app to fill prescriptions for delivery or same-day pickup.[2,3,4]

In one location

Get it all done in one stop – doctors, labs, and pharmacy are all conveniently located under one roof at most facilities.

Telehealth is covered at no additional cost on most OEBB plans[5]

Telehealth isn't an add-on at Kaiser Permanente – it's been part of how we deliver care for years. That's why it was easier for our members to connect virtually with their doctors and care teams from the start of the pandemic. While patients nationwide saw their doctors less often in 2020, our members had 15 million more care encounters.[6]

[1] When appropriate and available. If you travel out of state, phone appointments and video visits may not be available due to state laws that may prevent doctors from providing care across state lines. Laws differ by state.

[2] These features are available when you get care from Kaiser Permanente facilities.

[3] To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.

[4] Available on most prescription orders; additional fees may apply.

[5] Members on Plan 3 are responsible for coinsurance for phone appointments and video visits until they meet their annual deductible.

[6] Kaiser Permanente Telehealth Insights Dashboard.

KAISER PERMANENTE®

Convenient ways to get what you need

You've got more ways to get quality care than ever before, so it can be easier to stay on top of your health. Visit **kp.org/getcare** to learn more about your care options.

Get care now

Kaiser Permanente clinicians are available day or night, 24/7, for urgent care needs via on-demand video and phone, no appointment necessary.[1,2,3]

Scheduled video or phone appointment

Schedule a face-to-face video visit or phone appointment with a Kaiser Permanente clinician or any specialists you've been referred to.[1,2,3]

In-person care

We offer same-day, next-day, after-hours, and weekend services at many of our locations, including our Care Essentials by Kaiser Permanente retail clinics.[3,4]

Email

Message your Kaiser Permanente doctor's office with nonurgent questions and get a reply usually within 2 business days.

Prescription delivery

Use the Kaiser Permanente app to fill most prescriptions for delivery or same-day pickup. Most members get a 3-month supply of medication for the price of 2, and shipping is free.[5]

24/7 advice

Get support with 24/7 care advice by phone.

E-visit

Complete an online questionnaire and receive a treatment plan, including prescriptions, if needed, within a few hours.[6]

[1] When appropriate and available.

[2] To have a video visit, members must be registered on kp.org and have a camera-equipped computer or mobile device. If you travel out of state, phone appointments and video visits may not be available due to state laws that may prevent doctors from providing care across state lines. Laws differ by state.

[3] These features available when you get care at Kaiser Permanente facilities.

[4] In the case of a pandemic, some facilities may be closed or offer limited hours and services.

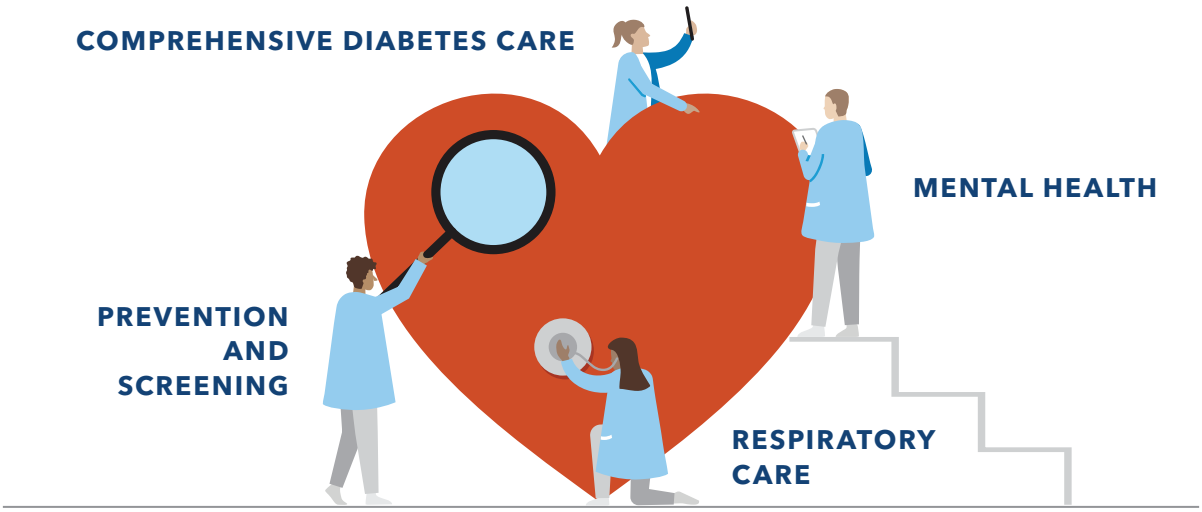
[5] Available on most prescription orders; additional fees may apply. For more information, contact the pharmacy. To use the Kaiser Permanente app, you must be a Kaiser Permanente member registered on kp.org.

[6] Applicable cost shares will apply for services or items ordered during an e-visit.

KAISER PERMANENTE®

High-quality clinical care

When your health needs serious attention, our team of specialty care doctors has you covered.



A comprehensive approach to care

With one of the largest multispecialty medical groups in the country,* we help connect you with a specialist who will create a personalized plan for your care. To learn how our specialists work together in a connected system, visit **kp.org/specialtycare**.

Support for ongoing conditions

If you have a condition like diabetes or heart disease, you're automatically enrolled in a disease management program for personal coaching and support. With a well-rounded approach backed by proven best practices and advanced technology, we'll help you get the care you need to continue living life to the fullest.

*"50 Largest US Medical Group Parents," *Becker's Hospital Review*, March 13, 2018, beckershospitalreview.com/rankings-and-ratings/50-largest-u-s-medical-group-parents.html.

KAISER PERMANENTE®

Making the most of your membership

Good health goes beyond the doctor's office. Find your healthy place by exploring some of the convenient options available to members.[1] Many of these resources are available at no additional cost.

Omada diabetes prevention program[2] NEW!

Omada combines the science of behavior change with personal support so your employees can make changes that stick. Get access to a number of online resources and support from a health coach and online peer groups.

Alternative care

Your benefit provides coverage for chiropractic, acupuncture, and naturopathic services through The CHP Group network. Visit **chpgroup.com** to find a provider.

Reduced rates on gym memberships

Stay active by joining a local fitness center, plus enjoy thousands of digital workout videos. Learn more at **kp.org/choosehealthy**.

Healthy lifestyle programs

Connect to your health with online programs to help you lose weight, quit smoking, reduce stress, and more. Learn more at **kp.org/healthylifestyles**.

Wellness coaching

Get help reaching your health goals by working one-on-one with a wellness coach by phone. Learn more at **kp.org/wellnesscoach**.

More ways to help improve your total health[3]

Calm

Use meditation and mindfulness to help build mental resilience, reduce stress, and improve your sleep.

myStrength

Set mental health goals, track progress, and get support managing depression, anxiety, and more.

ginger NEW!

This preventive, on-demand approach to mental health provides support anywhere, anytime.

[1] These services aren't covered under your health plan benefits and aren't subject to the terms set forth in your *Evidence of Coverage* or other plan documents. These services may be discontinued at any time without notice.

[2] Members must meet clinical inclusion criteria to participate in this program.

[3] Only available to Kaiser Permanente members with medical coverage; myStrength® is a trademark of Livongo Health, Inc., a wholly owned subsidiary of Teladoc Health, Inc..

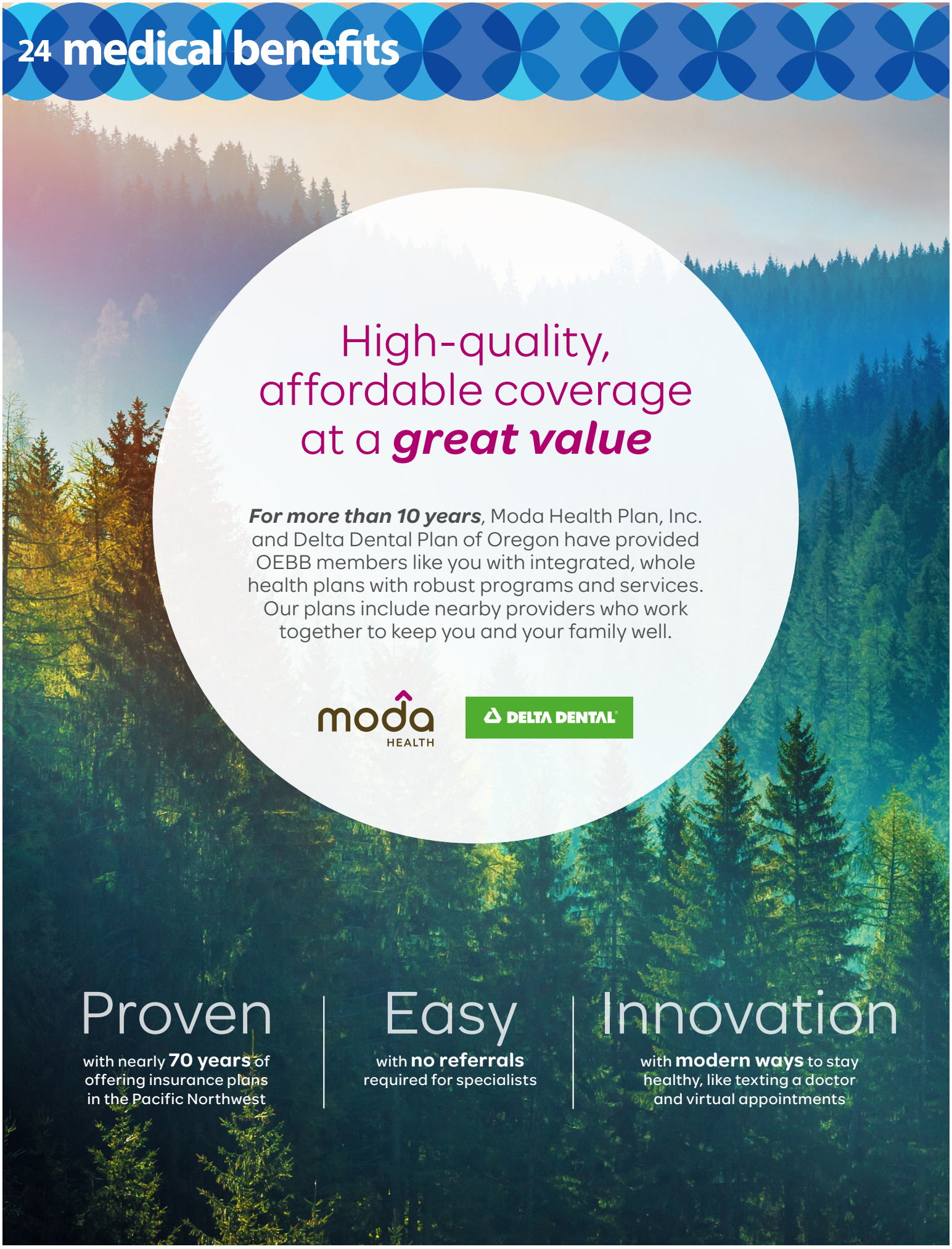
KAISER PERMANENTE®

2022–2023 medical plan benefits	Plan 1	Plan 2A	Plan 2B	Plan 3
Plan year deductible	None	$800/individual[1] $2,400/family[2]	$1,200/individual[1] $3,600/family[2]	$1,600/individual[1] $3,200/family[2]
Out-of-pocket maximum per plan year	$1,500/individual[1] $3,000/family[2]	$4,000/individual[1] $12,000/family[2]	$4,500/individual[1] $13,500/family[2]	$6,550/individual[1] $13,100/family[2]
Preventive care services	$0	$0	$0	$0
Prenatal care	$0	$0	$0	$0
Well-baby routine visits	$0	$0	$0	$0
Preventive tests	$0	$0	$0	$0
Primary care	$20	$25	$30	20% after deductible
Specialty care	$30	$35	$40	20% after deductible
Virtual care	$0	$0	$0	0% after deductible
Outpatient surgery	$75	20% after deductible	20% after deductible	20% after deductible
Emergency room	$100	20% after deductible	20% after deductible	20% after deductible
Hospital inpatient care	$100 per day, up to $500 per admission max	20% after deductible	20% after deductible	20% after deductible
Lab/X-ray/diagnostics	$20	$25	$30	20% after deductible
Prescription: Mail-order pharmacy is available at 2 copays for a 90-day supply	$5 generic $25 formulary brand $45 nonformulary brand 25% up to $100 specialty	$5 generic $25 formulary brand $45 nonformulary brand 25% up to $100 specialty	$5 generic $25 formulary brand $45 nonformulary brand 25% up to $100 specialty	20% after deductible
Self-referred alternative care: chiropractic and acupuncture	$20 20-visit limit for chiropractic 12-visit limit for acupuncture	$25 20-visit limit for chiropractic 12-visit limit for acupuncture	$30 20-visit limit for chiropractic 12-visit limit for acupuncture	20% after deductible 20-visit limit for chiropractic 12-visit limit for acupuncture

[1] For subscriber only coverage per year.

[2] For a family of 2 or more members per year.

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, exclusions and limitations, claims review, and adjudication procedures, please see your *Member Handbook,* also known as the *Evidence of Coverage (EOC),* or call Member Services. In the case of a conflict between this summary and the *EOC,* the *EOC* will prevail.



High-quality, affordable coverage at a ***great value***

For more than 10 years, Moda Health Plan, Inc. and Delta Dental Plan of Oregon have provided OEBB members like you with integrated, whole health plans with robust programs and services. Our plans include nearby providers who work together to keep you and your family well.

moda HEALTH

DELTA DENTAL

Proven

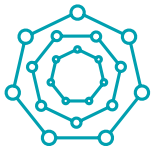
with nearly **70 years** of offering insurance plans in the Pacific Northwest

Easy

with **no referrals** required for specialists

Innovation

with **modern ways** to stay healthy, like texting a doctor and virtual appointments



Robust network

A wide choice of quality providers in Oregon, SW Washington, Idaho, and Northern California utilizing the Connexus Network

No referrals!

Referrals for specialists are not required for any of the Moda Health plans

All in one

Medical, pharmacy, vision, and dental benefits by one health partner

Working together

Team-based, coordinated care that's centered on you

As your health partner, we offer all of this and more — and we're excited to help you start on a journey to be better.

Better benefit choices and ***better care***

With Moda Health, you only need to make two choices:

1. Which plan design works best for your family
2. Whether you and your family members want to participate in ***Coordinated Care*** to receive the better benefits of:

A lower individual deductible

A lower individual out-of-pocket maximum

Lower cost for office visits, specialist visits, and alternative care visits

Coordinated care

Each plan comes with a coordinated-care option for you and each of your family members.

If you and/or your family members choose coordinated care, you must choose and use a "PCP 360" for your primary care services to receive the better benefits.

What is a PCP 360?

A PCP 360 is a primary care provider who is part of a facility that has been certified by the Oregon Patient Centered Primary Care Program or other similar programs. This means that a PCP 360 has to meet certain quality standards and agree to be accountable for your health.

Each covered family member can choose if they want to participate in coordinated care, and if so, choose their own PCP 360. Whether or not you choose coordinated care, you will pay the same premium and share the same Connexus Network of providers and ***referrals are not required***.

How to choose a PCP 360

Members can choose their PCP 360 in one of two ways: They can log into their Member Dashboard or call the Moda 360 Health Navigator team.

Call your Moda 360 Health Navigators at **866-923-0409** or email them at **OEBBquestions@modahealth.com**.

Log into your Member Dashbooard at **modahealth.com/oebb** to select your PCP 360 or instantly chat with a Moda 360 Health Navigator.

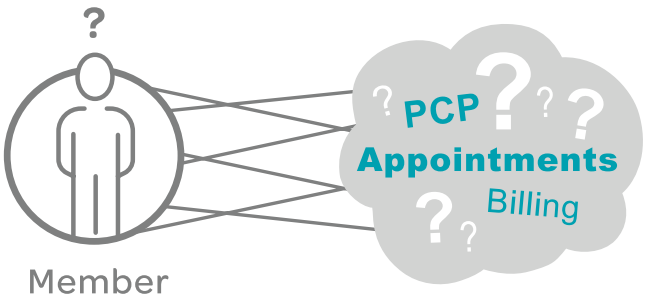
Healthcare can be complicated.

That's why we created ***Moda 360*** – your own enhanced member support team.

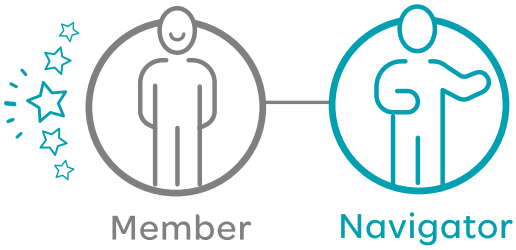
Here's how it works

Every time you call Moda Health, you will be connected to the Moda 360 Health Navigator Team. The Health Navigator will not only answer any questions you may have, but will also serve as your guide to connect you with the care, resources, and programs that will work best for you.

Healthcare can be complicated



Let Moda 360 ***help make it easier***



- Assistance with appointment scheduling
- Selecting a PCP 360
- Provider billing support
- Claims and appeals
- Care programs
- Assistance with prior authorizations

You can contact a Health Navigator if you need help with:

Scheduling support

A Health Navigator can help you find in-network providers and specialists. They can also help you with setting up appointments.

Care programs

We have many resources that help members with certain conditions or concerns. A Health Navigator can help connect you to programs that are just right for you.

Prior authorization

Some medical services require prior approval. A Health Navigator can assist you and your provider during this process and help with any questions you may have.

Selecting a PCP 360

A PCP 360 is a primary care provider who has agreed to partner with you and be accountable for your health. They deliver full-circle care and coordinate with other providers as needed.

A Health Navigator can help you find and select a PCP 360 to receive the following enhanced benefits:

- Lower individual deductible
- Lower individual out-of-pocket maximum
- Lower cost for office visits, specialist visits and alternative care visits

Claims and provider billing support

Questions about a claim or a bill you received from your provider? A Health Navigator will answer your questions and can even work with your provider to resolve issues.

NEW! Moda 360 programs

moda 360

Behavioral Health Champions

We can help you identify the best treatments that meet your health needs and determine the support tools that are best for you. We can also help find available providers, help you schedule appointments, and follow up to make sure you are able to access treatment and confirm that the treatment is meeting your needs.

moda 360 | Additional programs

Through Moda 360, you can access the following programs created to help you be your healthy best.

Meru Health

Now you can get therapy on your smartphone through our partner, Meru Health. Completely confidential, this online program provides 12 weeks of treatment to help with depression, anxiety, and burnout.

The program offers:

- Confidential access to a personal, licensed therapist and psychiatrist
- 12 weeks of empowering content
- Anonymous peer support
- A biofeedback device to increase focus and manage stress
- Mindfulness practices for balancing mood and energy
- Habit-changing activities for sleep, nutrition, and more that you can access any time and anywhere

Meru Health's program is available to qualified Moda Health members 18 or older located in Oregon, Washington, or Idaho. The initial evaluation call is the standard mental health cost sharing (which may be subject to the deductible). After that, the program is available at zero cost.

Note: They also accept FSA/HSA accounts to cover the cost of the initial copay/coinsurance.

Visit **meruhealth.com/modahealth** for more information or to enroll in the program.

Meru Health

CirrusMD – text a doctor

Enjoy fast and private access to a dedicated doctor in under a minute! Use the CirrusMD app for any health question or advice. Doctors are available 24/7 to help with **no member cost-share** (members on the High Deductible Health Plan will need to meet their deductible first)*

With the CirrusMD app, all you need is internet access to:

- Ask an urgent or general health question
- Message, share photos or video chat
- Get peace of mind, even at 2 a.m.
- Come back to conversations or follow up as often as you'd like

To start using CirrusMD, download the app and register with your date of birth and ZIP code. Open the app and start chatting with a doctor, just like you'd text with a friend.

Visit **cirrusmd.com/modahealth** for more information or to register.

*Effective 10/1/22, members on the High Deductible Health Plan will be subject to the deductible with no member cost sharing after their deductible has been met.

CIRRUS MD

Better together — Moda 360 integrates medical and dental care

Let a Moda 360 Health Navigator be your guide for both medical and dental care.

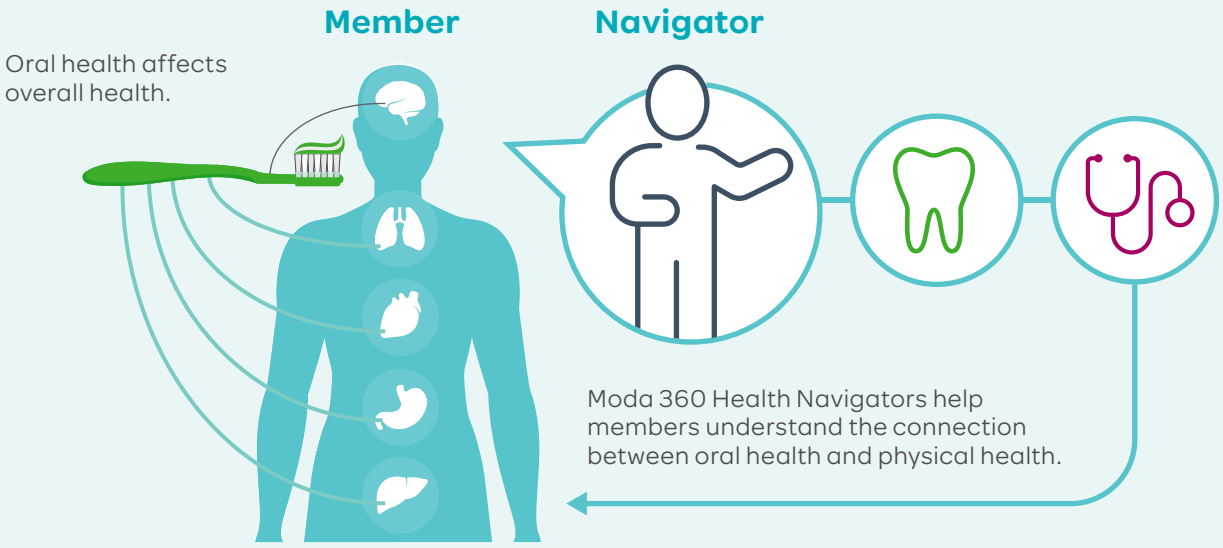
Why are medical and dental better together?

Our oral health affects our overall health. In fact, gum disease has been connected to:

- Diabetes
- Coronary heart disease (plaque buildup on the walls of the arteries that supply blood to the heart)
- Cerebrovascular disease (conditions that affect the flow of blood to the brain)

With Moda 360 integrated medical and dental care, you get integrated disease management, education, and everything you need to take good care of your whole body.

Members with a Moda Health medical plan and a Delta Dental plan will now have medical and dental integration. This means a Health Navigator will help you with any questions you may have and connect you to the medical and dental programs, services, and tools that will work best for you.



Oral health = ***Total health***

A network that ***protects*** you

Health happens, whether at home or on the road. We want to make sure you stay covered, no matter where you go. So we've made it easy for you to find in-network coverage.

All plans use the Connexus Network

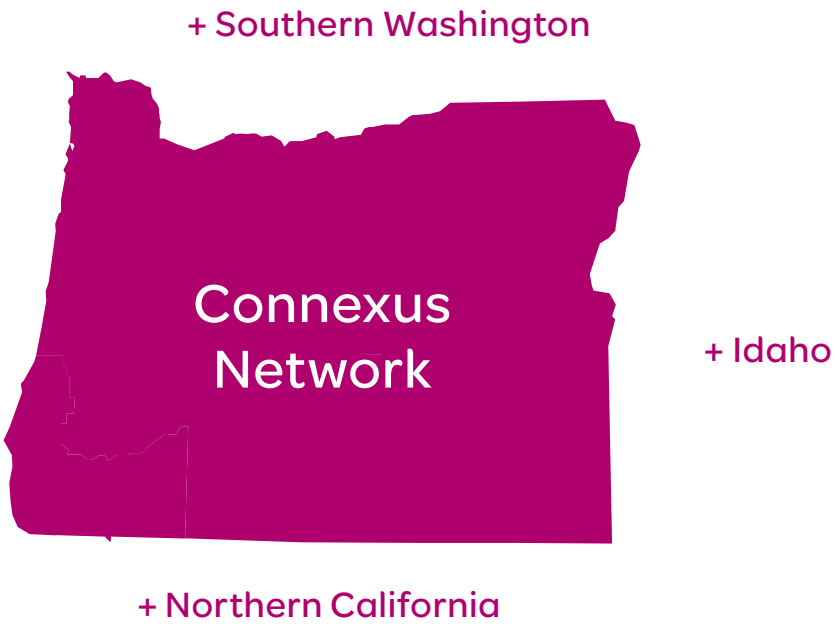
Each medical plan comes with our Connexus provider network. Within the Connexus Network, members have access to more than 36,000 providers, 75 hospitals and 65,000 pharmacies across Oregon, Idaho, Southern Washington, and Northern California. These providers offer quality care and services to Moda Health members at an agreed-upon cost.

Connect with care across the state

When you want a broad selection of providers across Oregon, SW Washington, Idaho, and Northern California, the Connexus Network has you covered. You'll find in-network doctors and specialists just about everywhere.

Is your provider in-network?

Find out by visiting modahealth.com and choosing Find Care, Moda's online provider directory. Simply select the applicable network option and look for providers near you.



How coordinated care works for out-of-area members

Dependents who live part-time out of the Connexus Network service (e.g., college students) must use their chosen PCP 360 when home to continue receiving the better benefits. Please update the out-of-area address in the myOEBB system. That way, they can access Moda's new national network to get in-network benefits for services they receive away from home. They will receive benefits at the "not my chosen PCP 360" level when they get care from a primary care provider that is not their chosen PCP 360.

Members who live full-time outside of the Connexus Network service area are not eligible for coordinated care and enhanced benefits.

Travel with peace of mind

When you hit the road, care is never far. While traveling outside the network service area, you can use **Moda's new national network, Aetna Signature Administrators® PPO**, for urgent and emergency care to receive in-network benefit level. Traveling for the purpose of seeking care will not be covered at the in-network benefit level and may be subject to balance billing.

NEW! this year!

Members who live outside of the Connexus service area (Oregon, SW Washington, and Idaho) will use **Moda's new National Network, Aetna Signature Administrators® PPO** (members who live in Alaska and Idaho will continue to have access to the PHCS network).

To find in-network providers, you can use Moda's online provider directory, Find Care and choose the network option and look for providers near you.

2022-23 Medical plan benefit table	Medical Plan 1 Connexus Network		Medical Plan 2 Connexus Network	
	With in-network, non-coordinated care, you pay	**Coordinate your care for better benefits**	With in-network, non-coordinated care, you pay	**Coordinate your care for better benefits**
Plan-year costs				
Deductible per person / family	**$500** / $1,500	**$400** / $1,500	**$900** / $2,700	**$800** / $2,700
Out-of-pocket max per person[7]	**$3,250**	**$2,850**	**$4,250**	**$3,850**
Out-of-pocket max per family[7]	$9,750		$12,750	
Preventive care				
Incentive care office visits (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)	**20%**	**$15 copay**[1,6]	**20%**	**$15 copay**[1,6]
Periodic health exams, routine women's exams, annual obesity screening, immunizations	$0[1]		$0[1]	
Professional services				
Primary care office visits	**20%**	**$20 copay**[1,2]	**20%**	**$20 copay**[1,2]
Primary care office visits with a provider other than your chosen PCP 360	N/A	**$40 copay**[1]	N/A	**$40 copay**[1]
Specialist office visits	**20%**	**$40 copay**[1]	**20%**	**$40 copay**[1]
Mental health office visits and Meru Health	$20 copay[1]		$20 copay[1]	
Chemical dependency services	$20 copay[1]		$20 copay[1]	
Virtual Care (CirrusMD telehealth)	$0 copay[1]		$0 copay[1]	
Alternative care services				
Acupuncture/chiropractic manipulation (subject to a combined 12 visit maximum per plan year)[5]	**20%**	**$20 copay**[1]	**20%**	**$20 copay**[1]
Maternity care				
Physician or midwife services and hospital stay	20%		20%	
Outpatient and hospital services				
Inpatient care and outpatient hospital/facility care	20%		20%	
Skilled nursing facility care (60 days per plan year)	20%		20%	
Surgery	20%		20%	
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%	
ACT 500: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 20%		$500 copay + 20%	
Gastric bypass (Roux-en-Y)[3]	$500 copay + 20%		$500 copay + 20%	
Emergency care				
Urgent care visit	**20%**	**$40 copay**[1]	**20%**	**$40 copay**[1]
Emergency room (copay waived if admitted)	$100 copay + 20%		$100 copay + 20%	
Ambulance	20%		20%	
Other covered services				
Hearing aids and bone-anchored hearing aids — $4,000 max/48 months for members 26 and older	10%		10%	
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%	
Outpatient diagnostic lab and X-ray	20%		20%	
Durable medical equipment	20%		20%	

Medical Plan 3 Connexus Network		Medical Plan 4 Connexus Network	
With in-network, non-coordinated care, you pay	**Coordinate your care for better benefits**	With in-network, non-coordinated care, you pay	**Coordinate your care for better benefits**
$1,300 / $3,900	**$1,200** / $3,900	**$1,700** / $5,100	**$1,600** / $5,100
$5,250	**$4,850**	**$7,100**	**$6,700**
$15,750		$15,800	
25%	**$20 copay**[1,6]	**25%**	**$20 copay**[1,6]
$0[1]		$0[1]	
25%	**$25 copay**[1,2]	**25%**	**$25 copay**[1,2]
N/A	**$50 copay**[1]	N/A	**$50 copay**[1]
25%	**$50 copay**[1]	**25%**	**$50 copay**[1]
$25 copay[1]		$25 copay[1]	
$25 copay[1]		$25 copay[1]	
$0 copay[1]		$0 copay[1]	
25%	**$25 copay**[1]	**25%**	**$25 copay**[1]
25%		25%	
25%		25%	
25%		25%	
25%		25%	
$100 copay + 25%		$100 copay + 25%	
$500 copay + 25%		$500 copay + 25%	
$500 copay + 25%		$500 copay + 25%	
25%	**$50 copay**[1]	**25%**	**$50 copay**[1]
$100 copay + 25%		$100 copay + 25%	
25%		25%	
10%		10%	
25%		25%	
25%		25%	
25%		25%	

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

1 Deductible waived. All amounts reflect member responsibility.

2 To receive the copay benefit, members must see their chosen PCP 360.

3 This benefit is available to subscriber and spouse/partners and dependents age 18 and older. Members must use an approved Moda Health Center of Excellence. Travel benefits are available for services that are subject to reference pricing. Please see your handbook for more details.

4 If enrolled in a Moda medical plan, each covered individual must choose and use a PCP 360 with Moda for that individual to receive the better benefits under the "coordinated care" benefit shown on the right column under that plan when using a provider in the Connexus network. If an individual has not selected a PCP 360 with Moda, they will receive the "non coordinated" benefit shown on the left if using an in-network provider.

5 For all other services (eg. Labs, diagnostics, specified imaging (MRI, CT,PET), office visits, etc) will be subject to the appropriate benefit level listed for each services provided.

6 Members must see their chosen PCP 360 or any in-network specialist to receive the copay benefit.

7 Medical copays, coinsurance, deductibles, ACT copays, and pharmacy expenses all apply to the medical out of pocket maximum.

2022-23 Medical plan benefit table	Medical Plan 5 Connexus Network[5]	
	With in-network, non-coordinated care, you pay	**Coordinate your care for better benefits**
Plan-year costs		
Deductible per person / family	**$2,100** / $6,300	**$2,000** / $6,300
Out-of-pocket max per person[7]	**$7,200**	**$6,800**
Out-of-pocket max per family[7]	$15,800	
Preventive care		
Incentive care office visits (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)	**25%**	**$25 copay**[1,6]
Periodic health exams, routine women's exams, annual obesity screening, immunizations	$0[1]	
Professional services		
Primary care office visits	**25%**	**$30 copay**[1,2]
Primary care office visits with a provider other than your chosen PCP 360	N/A	**$50 copay**[1]
Specialist office visits	**25%**	**$50 copay**[1]
Mental health office visits	$30 copay[1]	
Chemical dependency services	$30 copay[1]	
Virtual Care (CirrusMD telehealth)	$0 copay[1]	
Alternative care services		
Acupuncture/chiropractic manipulation(subject to a combined 12 visit maximum per plan year)[5]	**25%**	**$30 copay**[1]
Maternity care		
Physician or midwife services and hospital stay	25%	
Outpatient and hospital services		
Inpatient care and outpatient hospital/facility care	25%	
Skilled nursing facility care (60 days per plan year)	25%	
Surgery	25%	
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 + 25%	
ACT 500: Spine surgery, knee and hip replacement, knee and shoulder arthroscopy, uncomplicated hernia repair	$500 copay + 25%	
Gastric bypass (Roux-en-Y)[3]	$500 copay + 25%	
Emergency care		
Urgent care visit	**25%**	**$50 copay**[1]
Emergency room (copay waived if admitted)	$100 copay + 25%	
Ambulance	25%	
Other covered services		
Hearing aids and bone-anchored hearing aids — $4,000 max/48 months for members 26 and older	10%	
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.*	25%	
Outpatient diagnostic lab and X-ray	25%	
Durable medical equipment	25%	

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

1 Deductible waived. All amounts reflect member responsibility.

2 To receive the copay benefit, members must see their chosen PCP 360.

3 This benefit is available to subscriber and spouse/partners and dependents age 18 and older. Members must use an approved Moda Health Center of Excellence. Travel benefits are available for services that are subject to reference pricing. Please see your handbook for more details.

4 If enrolled in a Moda medical plan, each covered individual must choose and use a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the right column under that plan when using a provider in the Connexus network. If an individual has not selected a PCP 360 with Moda, they will receive the "non coordinated" benefit shown on the left if using an in-network provider.

5 For all other services (eg. Labs, diagnostics, specified imaging (MRI, CT,PET), office visits, etc) will be subject to the appropriate benefit level listed for each services provided.

6 Members must see their chosen PCP 360 or any in-network specialist to receive the copay benefit.

7 Medical copays, coinsurance, deductibles, ACT copays, and pharmacy expenses apply to the medical out of pocket maximum.

2022-23 Medical HDHP plan benefit table	Medical Plan 6 Connexus Network HDHP HSA Compliant [9]		Medical Plan 7 Connexus Network HDHP HSA Compliant [9]	
	With in-network, non-coordinated care, you pay	Coordinate your care for better benefits	With in-network, non-coordinated care, you pay	Coordinate your care for better benefits
Plan-year costs				
Subscriber-only plan deductible[2]	**$1,700**	**$1,600**	**$2,100**	**$2,000**
Family plan deductible[3]	$3,400		$4,200	
Individual out-of-pocket max	**$6,750**	**$6,400**	**$6,750**	**$6,500**
Family plan out-of-pocket max[3]	$13,500		$13,500	
Preventive care				
Incentive care office visits (for asthma, heart conditions, cholesterol, high blood pressure, diabetes)	**20%**	**15%[11]**	**25%**	**20%[11]**
Periodic health exams, routine women's exams, annual obesity screening, immunizations	$0[1]		$0[1]	
Professional services				
Primary care office visits	**20%**	**15%**	**25%**	**20%**
Primary care office visits with a provider other than your chosen PCP 360	N/A	**15%**	N/A	**20%**
Specialist office visits	**20%**	**15%**	**25%**	**20%**
Mental health office visits	**20%**	**15%**	**25%**	**20%**
Chemical dependency services	**20%**	**15%**	**25%**	**20%**
Virtual Care (CirrusMD telehealth)	$0 copay		$0 copay	
Alternative care services				
Acupuncture/chiropractic manipulation(subject to a combined 12 visit maximum per plan year)[8]	**25%**	**20%**	**25%**	**20%**
Maternity care				
Physician or midwife services and hospital stay	**25%**	**20%**	**25%**	**20%**
Outpatient and hospital services				
Inpatient care and outpatient hospital/facility care	**25%**	**20%**	**25%**	**20%**
Skilled nursing facility care (60 days per plan year)	**25%**	**20%**	**25%**	**20%**
Surgery	**25%**	**20%**	**25%**	**20%**
Sleep studies, specified imaging (MRI, CT, PET), upper endoscopy, spinal injections, viscosupplementation, tonsillectomies for members under age 18 with chronic tonsillitis or sleep apnea	**25%**	**20%**	**25%**	**20%**
Spine surgery, knee and hip replacement,[5] knee and shoulder arthroscopy, uncomplicated hernia repair	**25%**	**20%**	**25%**	**20%**
Gastric bypass (Roux-en-Y)[4]	**$500 copay + 25%**	**$500 copay + 20%**	**$500 copay + 25%**	**$500 copay + 20%**
Emergency care				
Urgent care visit	**20%**	**15%**	**25%**	
Emergency room	**25%**	**20%**	**25%**	**20%**
Ambulance	**25%**	**20%**	**25%**	**20%**
Other covered services				
Hearing aids and bone-anchored hearing aids — $4,000 max/48 months for members 26 and older	**25%**	**20%**	**25%**	**20%**
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.*	**25%**	**20%**	**25%**	**20%**
Outpatient diagnostic lab and X-ray	**25%**	**20%**	**25%**	**20%**
Durable medical equipment	**25%**	**20%**	**25%**	**20%**
Major medical prescription coverage[6]	**25%**	**20%**	**25%**	**20%**
Value tier	$4 per 31 day supply[1]		$4 per 31 day supply[1]	

Be a better saver with an ***HSA***

Our health savings account (HSA)-compliant, high-deductible health plans (HDHP) give you flexibility and choice. You have the freedom to choose any financial institution for your HSA.

Plans 6 and 7 with the HSA option

You can use HSA tax-free dollars to pay for deductibles, coinsurance, and other qualified expenses not covered by your health plan. HSA members enjoy a number of tax advantages, including:

- Contributions made on a tax-advantaged basis
- Unused funds carried over from year to year, growing tax-deferred
- Tax-free withdrawal of funds to pay for qualified medical expenses

Eligibility

To be eligible to participate in an HSA plan, you must:

- Be covered by a qualified high-deductible health plan
- Not be covered under another non-HSA-compliant medical plan (including your spouse's plan)
- Not be enrolled in Medicare
- Not be claimed as a dependent on someone else's tax return

Prescriptions

Your pharmacy benefit is covered under the medical portion of Plans 6 and 7. The plans include value-tier medications that waive your annual deductible. Just present your ID card at a participating pharmacy to use this benefit.

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

1 *Deductible waived. All amounts reflect member responsibility.*
2 *Individual deductible applies only if employee is enrolling in the plan with no other family members.*
3 *Family deductible and out-of-pocket maximum can be met by one or more family members. This deductible must be met before benefits will be paid. Deductible and copayments apply toward the plan-year out-of-pocket maximum.*
4 *Travel benefits are available for services that are subject to reference pricing. Please see your handbook for more details.*
5 *This benefit is available to subscriber and spouse/partners and dependents age 18 and older. Members must use an approved Moda Health Center of Excellence.*
6 *A formulary exception must be approved for high-cost generics and non-preferred brand prescription medication.*
7 *For all other services (eg. Labs, diagnostics, specified imaging (MRI, CT,PET), office visits, etc) will be subject to the appropriate benefit level listed for each services provided.*
8 *If enrolled in a Moda medical plan, each covered individual must choose and use a PCP 360 with Moda for that individual to receive the enhanced "coordinated" benefit shown in the left column under that plan when using a provider in the Connexus network. If an individual has not selected a PCP 360 with Moda, they will receive the "non coordinated" benefit shown in the right column if using a provider in the Connexus network. Any services by a provider outside the Connexus network will be paid at the "out-of-network" level regardless of whether the individual has selected a PCP 360 with Moda or not.*
9 *To receive the lower coinsurance benefit, members must see their chosen PCP 360.*
10 *Members must see their chosen PCP 360 or any in-network specialist to receive the lower coinsurance benefit.*

Expect ***quality*** pharmacy benefits

Quality prescription coverage is right at the heart of a great plan. We're here to support your pharmacy needs, every step of the way.

Access medications your way

As the administrator of the Oregon Prescription Drug Program (OPDP), we take pride in actively managing your pharmacy benefits. We provide quality, comprehensive coverage that reflects the most current industry standards.

Through the prescription program, you can access a high-performance formulary (a list of prescription drugs) with options under the value, select generic, and preferred tiers. Each tier has a copay or coinsurance amount set by the plan.

Pharmacy plan savings

There are a few ways to save on prescription drug costs. Use your 90-day mail-order benefit through Postal Prescription Services (PPS) or Costco. You can receive significant savings by using the mail-order benefit.

You can fill a 90-day prescription for value, select generic, and preferred medications at many participating pharmacies.

To find an in-network pharmacy and check drug prices, log in to your Member Dashboard, and choose Find Care.

Value-tier medications

Value medications include commonly prescribed products used to treat chronic medical conditions and preserve health. They are identified — based on the latest clinical information and medical literature — as being safe, effective, cost-preferred treatment options.

The Moda Health OEBB value tier includes products for the following health issues:

- Asthma
- Heart, cholesterol, high blood pressure
- Diabetes
- Osteoporosis
- Depression

A list of medications included under the value tier can be found on the pharmacy tab at: **modahealth.com/oebb**

Ardon Health specialty pharmacy services

Ardon Health is the specialty pharmacy for OEBB members. Ardon, based in Portland, Oregon, provides free delivery of specialty medications to a patient's home or physician's office. Ardon Health provides specialty medications for conditions including Crohn's disease, hepatitis C, multiple sclerosis, rheumatoid arthritis, and more. You can learn about Ardon Health at ardonhealth.com. You can also call Ardon Customer Service toll-free at **855-425-4085**. TTY users, please call 711.

Pharmacy benefits

	Medical Plans 1-5[4]	Medical Plans 6-7[5, 6]	
	Coordinated and non-coordinated care	Coordinated care	Non-Coordinated care
Value	$4 per 31-day supply[1]	$4 per 31-day supply*	$4 per 31-day supply*
Select generic	$12 per 31-day supply[1]	20%	25%
Preferred[2,3]	25% up to $75 per 31-day supply[1]	20%	25%
Non-preferred brand[3]	50% up to $175 per 31-day supply[1]	20%	25%
Mail			
Value	$8 per 90-day supply		
Select generic	$24 per 90-day supply	20%	25%
Preferred[2,3]	25% up to $150 per 90-day supply	20%	25%
Non-preferred brand[3]	50% up to $450 per 90-day supply	20%	25%
Specialty			
Generic	$12 per 31 day supply or $36 for 90-day supply when allowed.	20%	25%
Preferred[2,3]	25% up to $200 per 31 day supply or $400 for 90-day supply when allowed.	20%	25%
Non-preferred brand[3]	50% up to $500 per 31 day supply or $1,000 for 90-day supply when allowed.	20%	25%

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

**Deductible waived. All amounts reflect member responsibility.*

1 A 90-day supply for value, select generic, preferred, and non-preferred medications is available at retail pharmacies for three times the 31-day copay.

2 This benefit level includes select generic medications that have been identified as having no more favorable outcomes from a clinical perspective than other cost-effective generics.

3 Copay maximum is per prescription. A formulary exception must be approved for high-cost generics and non-preferred brand prescription medication.

4 Pharmacy expenses accrue towards the maximum cost share.

5 Pharmacy expenses accrue towards the out-of-pocket maximum.

6 You must meet your individual or family deductible first before any pharmacy expenses are paid.

oebb

dental benefits

If you or a dependent don't enroll in dental coverage when initially eligible, then choose to enroll during an Open Enrollment period, you or your dependent will be considered a "late enrollee."

You or your dependent will be subject to a **12-month waiting period** on all dental plans. This means **only diagnostic and preventive care will be covered** for the first 12 months of coverage.

KAISER PERMANENTE®

We believe in total health, beginning with high-quality dental and oral care. That's why every member gets a personalized prevention and treatment plan. And that's why dental preventive care is at the core of our philosophy.

Our philosophy of care

Integrated approach

Our dentists collaborate with your doctors, providing integrated care, which helps you rest easy, knowing we are looking out for your total health.

Your dental team has access to your health history, so the team can alert you to important health screenings or tests you may need.

Quality

We have been independently recognized for more than 30 years by the Accreditation Association for Ambulatory Health Care (AAAHC) as a leader in providing high-quality, patient-centered, comprehensive care.[1] This means our Dental Program has met rigorous national standards. Currently we are the only dental practice in the Pacific Northwest with AAAHC accreditation.

Urgent and emergency care

Emergency dental conditions include severe swelling or infection, severe traumatic injury to teeth, bleeding that doesn't stop, and extreme pain. If you need emergency care, please call the Appointment Center any time, any day.

[1] Continuously accredited by the Accreditation Association for Ambulatory Health Care (AAAHC) since 1990. Kaiser Permanente Dental is the only AAAHC-accredited dental home in the Northwest, and the third in the nation to achieve dental home accreditation. aaahc.org

[2] When members receive care from a Kaiser Permanente Dental provider; as appropriate and available.

[3] Email capability is available for members with both Kaiser Permanente medical and dental coverage who are registered on kp.org. Video capability is currently available for orthodontic services.

KAISER PERMANENTE®

2022–2023 dental plan benefits	Dental Plan[1]
Dental office visit copay[2]	$20
Preventive care office visit copay	$0
Deductible	None
Plan year maximum	$4,000
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	$0
Routine fillings, inlays, and stainless steel crowns[3,4,5]	$0
Simple tooth extractions[5]	$0
Surgical tooth extractions, including diagnosis and evaluation[5]	$50
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing[5]	$0
Root canal and related therapy including diagnosis and evaluation[3]	$50
Gold or porcelain crowns and onlays[5]	$250
Full and partial dentures, relines, and rebases[5]	$100
Bridge retainers and pontics[5]	$250
Orthodontic treatment[5]	$2,500 copay + $20 per visit
Implants	50% (limit of 4 per lifetime)

[1] Services must be provided by a contracted Kaiser Permanente provider in order for benefits to be payable. See your *Member Handbook,* also known as the *Evidence of Coverage (EOC),* for details.
[2] Office visit copay applies at each visit, in addition to any plan copays for services, except for preventive services, for which you will pay a $0 office copay.
[3] Posterior fillings paid to amalgam fee.
[4] Fillings are covered at 100% for amalgam fillings on back teeth and composite tooth color fillings on front (smile line) teeth. Patients can request composite fillings for back teeth and pay additional fees. Contact Kaiser Permanente directly for fee information.
[5] Benefit is subject to a 12-month benefit waiting period for late enrollees.

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, exclusions and limitations, claims review, and adjudication procedures, please see your *Member Handbook,* also known as the *Evidence of Coverage (EOC),* or call Member Services. In the case of a conflict between this summary and the *EOC,* the *EOC* will prevail.

To learn more about Kaiser Permanente, visit **kp.org.**

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WILLAMETTE DENTAL ENROLLMENT BENEFITS

Willamette Dental Group

For more than 50 years, Willamette Dental has proudly partnered with public employers throughout the Pacific Northwest, offering high quality dental care and outstanding insurance coverage to more than 450,000 patients. Our evidence-based, proactive treatment approach to dental care focuses on what matters most: providing quality, individualized care to each patient that educates for the future rather than only solving the immediate issues at hand.

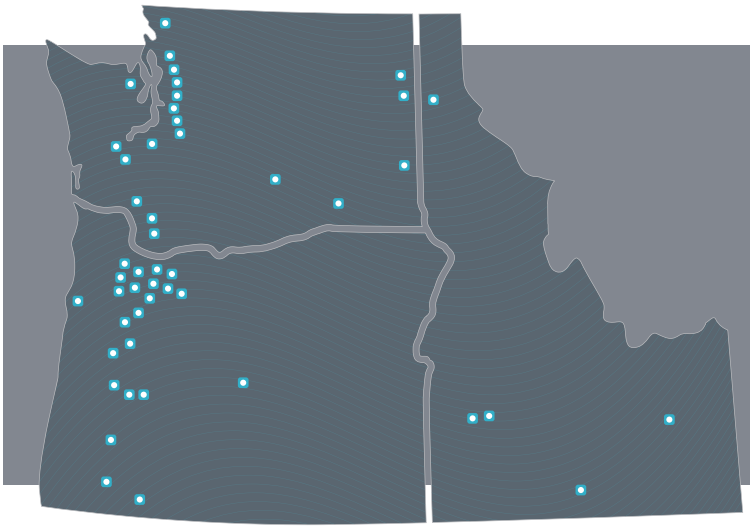
QUICK FACTS

- No annual maximum[1], no deductibles
- Services covered at predictable, low copays
- Affordable orthodontic coverage for adults and children
- 9 out of 10 OEBB members highly recommend Willamette Dental
- Most offices open 7 a.m. to 5:30 p.m. Mon - Fri with Saturday appointments available
- No copay changes for 2022 / 2023 plan year

START YOUR PARTNERSHIP WITH US TODAY!

Practicing daily oral hygiene at home, and partnering with your dentist keeps your body healthier. Our dentists are here for you. For current and new Willamette Dental plan members, we're eager to start our partnership with you. **So much so that we're waiving the office visit copay for your new patient appointment if you haven't come in to see us yet.**

CONVENIENT DENTAL OFFICE LOCATIONS



Locations Include:

Albany, OR
Bend, OR
Boise, ID
Corvallis, OR
Eugene, OR
Grants Pass, OR
Lincoln City, OR
Medford, OR
Meridian, ID
Portland Metro (11 locations)
Richland, WA
Roseburg, OR
Salem, OR (2 locations)
Springfield, OR (2 locations)
Vancouver, WA (2 locations)

Learn more about providers and locations at willamettedental.com/oebb

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019-OR91(5/22) Underwritten by Willamette Dental Insurance, Inc.

WILLAMETTE DENTAL PLAN BENEFIT SUMMARY

To receive the excellent benefits of the Willamette Dental plan, members must use a Willamette Dental provider at one of our conveniently located Willamette Dental offices.

This is a summary. Refer to the Certificate of Coverage for a complete description of benefits, exclusions, and limitations.

COVERED BENEFITS	COPAYS
Annual Maximum	No Annual Maximum[1]
Deductible	No Deductible
General or Orthodontic Office Visit	You Pay $20 per Visit[2]
DIAGNOSTIC & PREVENTIVE SERVICES	
Routine & Emergency Exams	Covered with the Office Visit Copay
X-rays	Covered with the Office Visit Copay
Teeth Cleaning	Covered with the Office Visit Copay
Fluoride Treatment	Covered with the Office Visit Copay
Sealants (per Tooth)	Covered with the Office Visit Copay
Head and Neck Cancer Screening	Covered with the Office Visit Copay
Oral Hygiene Instruction	Covered with the Office Visit Copay
Periodontal Charting	Covered with the Office Visit Copay
Periodontal Evaluation	Covered with the Office Visit Copay
RESTORATIVE DENTISTRY[3]	
Fillings	Covered with the Office Visit Copay
Porcelain-Metal Crown	You Pay a $250 Copay[4]
PROSTHODONTICS[3]	
Complete Upper or Lower Denture	You Pay a $100 Copay[4]
Bridge (per Tooth)	You Pay a $250 Copay[4]
ENDODONTICS & PERIODONTICS[3]	
Root Canal Therapy – Anterior / Bicuspid / Molar	You Pay a $50 Copay
Osseous Surgery (per Quadrant)	Covered with the Office Visit Copay
Root Planing (per Quadrant)	Covered with the Office Visit Copay
ORAL SURGERY[3]	
Routine Extraction (Single Tooth)	Covered with the Office Visit Copay
Surgical Extraction	You Pay a $50 Copay
ORTHODONTIA TREATMENT[3]	
Pre-Orthodontia Treatment	You Pay a $150 Copay[5]
Comprehensive Orthodontia Treatment	You Pay a $2,500 Copay
DENTAL IMPLANTS[3]	
Dental Implant Surgery	Implant benefit maximum of $1,500 per calendar year
MISCELLANEOUS[3]	
Occlusal Guard	Covered with the Office Visit Copay
Athletic Mouth Guard	You Pay a $100 Copay
Local Anesthesia	Covered with the Office Visit Copay
Dental Lab Fees	Covered with the Office Visit Copay
Nitrous Oxide	You Pay a $15 Copay
Specialty Office Visit	You Pay $20 per Visit[2]
Out of Area Emergency Care Reimbursement	You pay charges in excess of $100

[1]Benefits for implant surgery have a benefit maximum. [2]An office visit copayment applies at each visit, in addition to any copayments for services. [3]Benefit is subject to a 12-month waiting period for members who previously waived dental coverage. [4]Dental implant-supported prosthetics (crowns, bridges, and dentures) are not a covered benefit. [5]Copay credited towards the Comprehensive Orthodontia Treatment copay if patient accepts treatment plan.

Quality coverage for your smile

DELTA DENTAL®

With Delta Dental of Oregon plans, you'll have access to Delta Dental, the nation's largest dental networks.

Dental benefit highlights

Our Delta Dental of Oregon plans connect you with great benefits and quality in-network dentists. You can count on:

- Freedom to choose a dentist
- Contracted-fee savings from participating dentists
- Savings from in-network dentists
- Cleanings every six months
- Predetermination of benefits if requested in a pretreatment plan
- No claim forms
- Superior customer service

Our dental plans also include useful online tools, resources, and special programs for those of you who may need extra attention for your pearly whites.

Oral health can improve overall health

With the combination of a medical plan from Moda Health and a dental plan from Delta Dental, you'll get coordinated care and service that can address and combat health issues that start in your mouth, such as:

- Diabetes
- Coronary heart disease
- Cerebrovascular disease

With Moda 360 integrated medical and dental care, you get integrated disease management, education, and everything you need to take care of yourself from head to toe.

NEW! Preventive First Program

Preventive services do not accrue towards your benefit maximum. This means that services such as regular dental cleanings do not reduce your benefit maximum and can be used for other basic and major services.

Delta Dental networks go where you go

Each Delta Dental of Oregon plan comes with a Delta Dental network. It includes thousands of dentists across the state and country.

In-network dentists agree to accept our contracted fees as full payment. They also don't balance bill — the difference between what we pay and the dentist's fees. This can help you save on out-of-pocket costs. If you see providers outside the network, you may pay more for care.

Delta Dental Premier® Network

This is the largest dental network in Oregon and nationwide. It includes more than 2,200 providers in Oregon and over 154,000 Delta Dental Premier Dentists nationwide. To have access to our Premier Network, you will want to select Dental Plan 1, 5, or 6.

Delta Dental PPO℠ Network

This is one of the largest preferred provider organization (PPO) dental networks in Oregon and across the country. It includes more than 1,200 participating providers in Oregon and offers access to over 113,000 Delta Dental PPO dentists nationwide. These providers have agreed to lower contracted rates, which means more savings for you. In order to access the PPO network savings, you will want to select one of the two Exclusive PPO plans.

Exclusive PPO plan options

The Exclusive PPO plan options use the Delta Dental PPO Network. It is important to keep in mind that the Exclusive PPO plans do not cover for services provided by a Premier or non-contracted dentist.

Health through Oral Wellness

DELTA DENTAL®

When it comes to oral health, we know some people need more care than others. Delta Dental of Oregon's Health through Oral Wellness® program offers extra benefits to members who have a greater risk for oral diseases.

The program uses a clinical oral health assessment to find out your risk of tooth decay, gum disease, and oral cancer. Based on your risk score, you may qualify for additional cleanings, fluoride treatments, sealants, and periodontal maintenance.

With extra benefits and related care, you can:

- Take charge of your oral health
- Prevent oral health issues before they happen
- Access resources to manage your oral health
- Learn how to achieve and maintain better oral wellness

Ready to get started?

Follow these simple steps to see if you qualify:

1. Visit **modahealth.com/oebb** to learn more about the program and take a free oral health risk self-assessment. You can choose to share your results with your dentist to start the conversation.
2. Talk to your dentist about the program. If they're not registered, ask them to call our toll-free Health through Oral Wellness provider line at 844-663-4433. Once registered, they can perform an oral health risk exam and let you know if you qualify.

2022-23 Dental plan benefit table	Plan 1[2]	Plan 5[2]	Plan 6[3]	ExclusivePPO - Incentive Plan[3,4]	Exclusive PPO[3,4]
Network	Premier			PPO	PPO
	In-network, you pay			In-network, you pay	In-network, you pay
Plan-year costs					
Deductible	$50	$50	$50	$50	$50
Benefit maximum	$2,200	$1,700	$1,200	$2,300	$1,500
Preventive* and diagnostic services[1]					
Exam and prophylaxis/cleanings (once every six months)	30% - 0%[2]	30% - 0%[2]	0%	0%	0%
Bitewing X-rays (once every 12 months)	30% - 0%[2]	30% - 0%[2]	0%	0%	0%
Topical fluoride application (ages 18 and under)	30% - 0%[2]	30% - 0%[2]	0%	0%	0%
Sealants and space maintainers	30% - 0%[2]	30% - 0%[2]	0%	0%	0%
Restorative services					
Fillings (posterior teeth paid to composite)	30% - 0%[2]	30% - 0%[2]	20%	30 - 0%[2]	10%
Inlays (composite reimbursement fee)	30% - 0%[2]	30% - 0%[2]	20%	30 - 0%[2]	10%
Oral surgery and extractions	30% - 0%[2]	30% - 0%[2]	20%	30 - 0%[2]	10%
Endodontics and periodontics	30% - 0%[2]	30% - 0%[2]	20%	30 - 0%[2]	10%
Major restorative services					
Gold or porcelain crowns	30% - 0%[2]	30%	50%	30 - 0%[2]	20%
Implants	30% - 0%[2]	50%	50%	30 - 0%[2]	20%
Onlays	30% - 0%[2]	30%	50%	30 - 0%[2]	20%
Prosthodontics services					
Dentures and partial dentures	30% - 0%[2]	50%	50%	30 - 0%[2]	20%
Bridges	30% - 0%[2]	50%	50%	30 - 0%[2]	20%
Other services					
Nitrous Oxide	50%	50%	50%	50%	50%
Occlusal guards (night guards[5] and athletic mouthguards)	50%	50%	50%	50%	50%
Orthodontic services[1,6]					
Lifetime maximum — $1,800	20%	20%	N/A	20%	20%

***NEW!** Preventive costs will not accrue toward the benefit maximum.

1 Deductible waived.

2 Under this incentive plan, benefits start at 70 percent for your first plan year of coverage. Thereafter, benefit payments increase by 10 percent each plan year (up to a maximum benefit of 100 percent) provided the individual has visited the dentist at least once during the previous plan year. Failure to do so will cause a 10 percent reduction in benefit payment the following plan year, although payment will never fall below 70 percent.

3 Moving from a constant benefit plan (6 or Exclusive PPO) to an incentive benefit plan (1 or 5) will cause the benefit level to start at 70 percent.

4 This plan has no out-of-network benefit. Services performed outside the Delta Dental PPO network are not covered unless for a dental emergency. Covered emergencies consist of problem focused exam, palliative treatment and X-rays. All other services are considered non-covered.

5 $250 maximum, once every five years.

6 Orthodontic services do not apply toward the plan-year benefit maximum.

For limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.


oebb
vision benefits

Bringing it all into *focus*

Seeing is believing when it comes to better health. These vision plans ensure that you can focus on feeling your best.

2022-23 Vision plan benefit table	Opal	Pearl	Quartz
Benefit maximum	$600	$400	$250
	What you pay		
Eye examinations (including refraction) *Frequency: Once per plan year*	0%[1]		
Lenses[2] *Frequency: Contacts (including disposable contacts) or one pair of lenses per plan year*	0%[1]		
Frames *Frequency: One pair per plan year for members under 17 years old. One pair every two plan years for members 17 and older.*	0%[1]		

1 Subject to benefit maximum.

2 Includes single vision, bifocal, trifocal, or contacts.

Limitations and exclusions

- Vision exam and hardware benefits are all subject to the plan-year benefit maximum.
- Percentages shown reflect what members pay for covered vision exam, frames, and lenses.
- Noncovered, excluded services are the member's responsibility and do not apply toward the plan-year maximum.

For more limitations and exclusions, visit modahealth.com/oebb/members and refer to your Member Handbook.

KAISER PERMANENTE®

At Vision Essentials by Kaiser Permanente, we see eye care differently. Healthy sight is more than glasses and contact lenses. Our optometrists and ophthalmologists provide comprehensive eye care, including routine eye exams, to help keep your vision sharp and your eyes healthy.

Integrated care

Through our electronic health record system, all your care providers can see a comprehensive picture of your health and act as part of a team to help you make better health care decisions.

Providers will notify you of gaps in your health care and help you schedule preventive appointments, including vaccinations, physicals, and important eye health screenings.

Convenience

We have clinic locations from Salem to Longview, most located in medical offices. To schedule an exam, order contact lenses, or find a location near you, visit **kp2020.org** or call **1-800-813-2000** (TTY **711**).

Getting care in Lane County

Members in Lane County can get routine eye exams at Oregon Eye Associates or PeaceHealth Eye Care and Optical Shop.

To make an appointment, please contact:

Oregon Eye Associates: **541-484-3937** or **1-800-426-3937**

PeaceHealth Eye Care and Optical Shop: **458-205-6257**

KAISER PERMANENTE®

2022–2023 vision plan benefits*	Plan 1	Plan 2A	Plan 2B	Plan 3
Vision exam	$5	$5	$5	20% after deductible
Hardware allowance – once per plan year				
Frames, lenses, and contact lenses	$250	$250	$250	$250
Additional benefits				
50/50 Protection Plan	Members can return their damaged, broken, or chewed glasses purchased at Kaiser Permanente Vision Essentials, and we'll apply 50% of the original price paid to replace them.			
Second pair of complete glasses	Save 30% on a second complete set of eyeglasses. Choose from styles that are made for different purposes, like sports glasses, reading glasses, blue-blocking computer glasses, and safety glasses.			

Don't forget to make use of your hardware allowance

$100 of OEBB members' $250 hardware allowance may be used toward nonprescription sunglasses and/or digital eyestrain glasses.

Want to talk? We're here to help.

Kaiser Permanente Member Services can answer your questions – like where to get care or what options are included. Call **1-800-813-2000** (TTY **711**), Monday through Friday, 7 a.m. to 6 p.m.

To learn more about Kaiser Permanente, visit **kp.org**.

*Must be enrolled in a Kaiser Permanente medical plan to enroll in the Kaiser Permanente vision plan.
This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details of your benefit coverage, exclusions and limitations, claims review, and adjudication procedures, please see your *Member Handbook,* also known as the *Evidence of Coverage (EOC),* or call Member Services. In the case of a conflict between this summary and the *EOC,* the *EOC* will prevail.

YOUR EYES HAVE OPTIONS

Open enrollment is here! Enroll in VSP to take care of your eyes and overall health. With two VSP plans to choose from, you can show your eyes the love they deserve.

The choice is yours – stick with the VSP Choice Plan® or upgrade to the VSP® Choice Plus Plan to save more on frames or contacts.

GET THE BASICS WITH THE VSP CHOICE PLAN

You get access to quality eye care and eyewear all at low out-of-pocket costs:

- Annual WellVision Exam®
- Glasses or contacts
- VSP LightCare™
- Special offers and savings
- Vision Therapy

UPGRADE TO THE VSP CHOICE PLUS PLAN TO PERSONALIZE YOUR VISION COVERAGE

You and your eyes are unique and your coverage should be too. When you upgrade to the VSP Choice Plus Plan, you'll get all the above basics, plus a whole lot more.

CREATE YOUR ACCOUNT ON VSP.COM*

Log in to confirm in-network locations. Contact us at **800.877.7195**.

eyeconic®

Get contacts, glasses and sunglasses using your vision benefits on **eyeconic.com®** – the VSP preferred online retailer.

HERE'S A LOOK AT THE VSP CHOICE PLUS PLAN

- **VSP LightCare**
  Increased allowance for non-prescription sunglasses
- **Increased Frame Allowance**
  Covers more of your favorite designer frames
- **Anti-glare Coating**
  Reduce glare and combat reflection
- **Progressive Lenses**
  See clearly at any distance
- **Vision Therapy**
  Fully covered evaluation and 75% off approved therapy sessions

Get the details. View your member benefit summary on the next page.

vision benefits

VSP Choice Plus Plan **VSP Provider Network:** VSP Choice

Benefit	Description	Copay
VSP CHOICE PLUS PLAN Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$20
Frame	• $350 featured frame brands allowance • $300 frame allowance • 20% savings on the amount over your allowance • $165 Walmart/Sam's Club/Costco frame allowance • Every 12 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Impact-resistant lenses • Scratch-resistant coating • UV protection • Premium progressive lenses • Custom progressive lenses • Anti-glare coating • Average savings of 30% on other lens enhancements • Every 12 months	$0 $0 $0 $0 $15 $15 $15
Contacts (instead of glasses)	• $300 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
VSP LightCare	• $300 allowance to ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • Every 12 months	$20

VSP Choice Plan **VSP Provider Network:** VSP Choice

Benefit	Description	Copay
VSP CHOICE PLAN Coverage with a VSP Provider		
WellVision Exam	• Focuses on your eyes and overall wellness • Every 12 months	$10
Prescription Glasses		$20
Frame	• $200 featured frame brands allowance • $150 frame allowance • 20% savings on the amount over your allowance • $80 Walmart/Sam's Club/Costco frame allowance • Every 12 months	Included in Prescription Glasses
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Impact-resistant lenses for dependent children • Every 12 months	Included in Prescription Glasses
Lens Enhancements	• Standard progressive lenses • Scratch-resistant coating • UV protection • Premium progressive lenses • Custom progressive lenses • Average savings of 30% on other lens enhancements • Every 12 months	$0 $0 $0 $95 – $105 $150 – $175
Contacts (instead of glasses)	• $150 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation) • Every 12 months	Up to $60
VSP LightCare	• $150 allowance to ready-made non-prescription sunglasses, or ready-made non-prescription blue light filtering glasses, instead of prescription glasses or contacts • Every 12 months	$20

Essential Medical Eye Care	• Retinal screening for members with diabetes • Additional exams and services beyond routine care to treat immediate issues from pink eye to sudden changes in vision or to monitor ongoing conditions such as dry eye, diabetic eye disease, glaucoma, and more • Coordination with your medical coverage may apply. Ask your VSP doctor for details.	$0 $20 Per Exam Available As Needed
Vision Therapy	• You get a fully covered evaluation and 75% off approved therapy sessions up to $750 annually. Sessions cover diagnosis and treatment of turned eye, eye teaming, lazy eye, eye focusing, and general eye movement ability. Check with your doctor to see if you qualify.	$20
Extra Savings	**Glasses and Sunglasses** • Additional $50 to spend on featured frame brands. Go to **vsp.com/framebrands** for details. • 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last Well Vision Exam.	
	Retinal Screening • No more than a $39 copay on routine retinal screening as an enhancement to a WellVision Exam	
	Laser Vision Correction • Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

YOUR COVERAGE WITH OUT-OF-NETWORK PROVIDERS

Get the most out of your benefits and greater savings with a VSP network doctor. Call Member Services for out-of-network plan details.

Coverage with a retail chain may be different or not apply. Log in to **vsp.com** to check your benefits for eligibility and to confirm in-network locations based on your plan type. VSP guarantees coverage from VSP providers only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail. Based on applicable laws, benefits may vary by location. In the state of Washington, VSP Vision Care, Inc., is the legal name of the corporation through which VSP does business.

Log in to **vsp.com** to find an in-network provider based on your plan type.

oebb

optional benefits

uprisehealth

Digitally Enabled Employee Assistance Program (EAP) with Coaching

If your employer offers EAP benefits to your employment group, the benefits shown on this page are available to you and your family at NO COST to you. The EAP offers confidential advice, support, and practical solutions to real-life issues. You can access these confidential services by calling the toll-free number and speaking with our care team or accessing online.

Digital Mental Health and EAP Platform

- Access is confidential. Take the Wellbeing Check and get a wellbeing score.
- Receive your own personalized recommendations.
- Take digital courses to develop your resilience, stress management, and mental fitness.
- Use up to **4 sessions** with a coach via phone or unlimited asynchronous chat.
- Visit **app.uprisehealth.com** or download the Uprise Health app on Google Play or Apple App Store.
- Create an account with your email and the access code: **OEBB**

Mental Health and Wellbeing Services for OEBB Members & Families

- **Confidential Counseling: up to 6** face-to-face, video, or telephonic counseling sessions for relationship and family issues, stress, anxiety, and other common challenges.
- **Online Group Sessions:** for addiction recovery, anxiety, depression, frontline workers, grief and loss, parenting, and more.
- **24-hour Crisis Help:** toll-free access for you or a family member experiencing a crisis.
- **Tess, AI Chat-bot:** 24/7 chatbot for emotional support and check-ins to boost wellness.

Work-Life Services for OEBB Members & Families

- **Financial Help**: 30-days of access with a personal financial expert who will work with the member toward financial wellness by identifying financial goals, assessing current financial situation, and providing a suggested detailed action plan.
- **Legal Services:** one 30-minute legal consultation per each separate legal matter at no cost, 25% reduction from the normal hourly rate if member retains attorney or mediator.
- **Legal Forms:** create, save, print, and revise online legal forms including wills, contracts, leases, and more.
- **Child & Parenting Services:** get information and support on parenting, school issues, adoption, daycare, and other important issues for parents.
- **Adult & Eldercare Services:** get assistance in finding quality information and services including transportation, meals, activities, daytime care, housing, and more.
- **Webinars & Trainings:** industry experts will present monthly work-life webinars on a variety of topics.

EAP Services & Support for Supervisors

All supervisors have access to phone consultations and trainings about the EAP and management topics:

- Critical incidents
- Drug-free workplace
- Making employee referrals
- Organizational development
- Education and training
- Conflicts in the workplace

Contact Uprise Health:
members.uprisehealth.com
Access Code: OEBB
Call: 866-750-1327

Life and AD&D Insurance

Visit The Standard's OEBB microsite at **standard.com/mybenefits/oebb/** to access product information, a needs estimator, and our Decision Support Tool, which can help you assess your specific coverage needs.

Optional Life Insurance

Eligible employees may elect Optional Life coverage in units of $10,000, to a maximum of $500,000. Dependent coverage is available for a spouse/domestic partner in units of $10,000, to a maximum of $500,000 and for eligible children in units of $2,000, to a maximum of $10,000. Optional Dependent Life coverage cannot exceed 100% of the Employee Optional Life coverage.

The guaranteed issue amount for employee coverage elected when first eligible is $200,000. Any amount requested in excess of the Guarantee Issue amount will be subject to medical underwriting approval. For members who have already elected Optional Life coverage, you may increase coverage by $20,000 during the annual enrollment period (not to exceed the Guarantee Issue amount) without providing evidence of insurability. The Guaranteed Issue amount for spouse/partner coverage when first eligible is $30,000. Any amount requested in excess of the guarantee issue amount will be subject to medical underwriting approval.

For your convenience, Life insurance from The Standard also includes helpful life planning and travel assistance tools.

- **The Life Services Toolkit*** is a resource that can help employees and their beneficiaries deal with the loss of a loved one or plan for the future. Employees can access an online portal for estate planning, funeral arrangement, identity theft prevention, financial planning, and health and wellness resources. Services for beneficiaries include grief and loss support, financial counseling, and legal services.

- **Travel Assistance*** is available to covered employees and their family members when traveling more than 100 miles from home or internationally for up to 180 days. In addition to travel planning, this service includes assistance with lost credit card replacement, passport replacement, legal and medical resources, medical evacuation, and repatriation.

Optional Life Brochure:
standard.com/eforms/10391d_646595.pdf

AD&D – Accidental Death and Dismemberment Insurance

By participating in the group Optional AD&D insurance plan through OEBB, your employer offers you an excellent opportunity to help protect your loved ones. With Optional AD&D coverage, you, your dependents, or your beneficiaries, as applicable, may receive an AD&D insurance benefit in the event of death and dismemberment as a result of a covered accident. You may elect coverage for yourself or elect coverage for yourself and your spouse/domestic partner and/or eligible children.

- **Employee** in units of $10,000, up to a maximum of $500,000

- **Spouse/domestic partner** in units of $10,000, up to a maximum of $500,000 (not to exceed the amount of the employee's coverage)

- **Children** in units of $2,000, up to a maximum of $10,000 (not to exceed the amount of the employee's coverage)

Optional AD&D Brochure:
standard.com/eforms/4241_646595.pdf

**The Life Services Toolkit is provided through an arrangement with Health Advocate,℠ which is not affiliated with The Standard. Travel Assistance is provided through an arrangement with Assist America, which is not affiliated with The Standard. These services are not insurance products and may be subject to limitations or exclusions.*

Disability Insurance

Disability Insurance
Short Term Disability (STD) and Long Term Disability (LTD) insurance are designed to pay a benefit to you in the event you cannot work because of a covered illness, injury, or pregnancy. These benefits replace a portion of your income, thus helping you meet your financial commitments in your time of need. Check with your employer for enrollment availability.

Short Term Disability
STD insurance is designed to pay a weekly benefit to you in the event you cannot work because of a covered non-occupational illness or injury. This benefit is an income replacement insurance. The weekly benefit amount, calendar day waiting period, and benefit duration will depend upon the plan selected by your employer.

Note: If you enroll after you first became eligible or with a qualifying mid-year change event, you will be subject to a late enrollment penalty. This means that if you file a claim for any condition other than an accidental injury during the first 12 months your coverage is effective, STD benefits will not become payable until after you have been continuously disabled for 60 days and remain disabled.

Short Term Disability Brochure:
standard.com/eforms/10388d_646595.pdf

Long Term Disability
LTD insurance is designed to pay a monthly benefit to you in the event you cannot work because of a covered illness or injury. This benefit is an income replacement insurance. The monthly benefit amount and calendar day waiting period will depend upon the plan selected by your employer.

Long Term Disability Brochure:
standard.com/eforms/10386d_646595.pdf

Long Term Care Insurance

Unum
OEBB offers **Long Term Care Insurance** through Unum as a valuable benefit option for participating employers to offer OEBB members. Long Term Care is the type of care you may need if you couldn't independently perform the basic activities of daily living: bathing, dressing, using the toilet, transferring from one location to another, continence and eating, or if you suffered severe cognitive impairment from a condition such as Alzheimer's disease. If this situation were to occur, this coverage could help pay for a home health aide, an assisted living facility, or a private nursing home.

Please confirm with your employer whether this benefit is available to you and, if so, how to access it. Learn more at: **unuminfo.com/OEBB**

oebb

How to contact OEBB

Call OEBB at **888.469.6322** • Monday-Friday, 8 a.m-5 p.m

During Open Enrollment **Aug. 15-Sept. 15, 2022** • Monday-Friday, 7 a.m.-6 p.m.

Email OEBB at **OEBB.benefits@state.or.us**

Easy to find OEBB web pages

OEBBinfo.com Explore the OEBB home page

OEBBenroll.com Enroll in OEBB benefits

OEBBreminders.com Sign up for text or email reminders

OEBBondemand.com Find all kinds of on-demand resources, such as educational videos, presentation slides, and additional handouts.

Attend the **Virtual Benefits Fair**

Alternate Formats
You can get this document in other languages, large print, braille, or a format you prefer. Contact OEBB at **888.469.6322**