Dental Plan Premium Detail

Moda Health/Delta Dental 2018-19 Plan Year
Plans and Rates
(Effective October 1, 2018)

DELTA DENTAL

Dental and Orthodontia					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
Provider network noted in plan name below	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Premier Plan 1 - Delta Dental Premier Network	$66.09	$130.91	$145.58	$215.59	$160.73
Premier Plan 5 - Delta Dental Premier Network	$58.32	$115.53	$128.48	$190.26	$141.85
Premier Plan 6 - Delta Dental Premier Network *(this plan has no orthodontia coverage)*	$43.63	$86.38	$87.68	$133.94	$100.31
Exclusive PPO Plan* - Delta Dental PPO Network	$38.99	$77.23	$85.88	$127.20	$94.83

* This plan has no out-of-network benefit. Services performed by providers 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.

Dental and Orthodontia					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
Must use Willamette Dental Group facilities and providers for all non-emergency services	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Willamette Dental Plan	$45.53	$90.21	$95.98	$144.20	$115.89

Dental Plan Benefits Summary

oebb

OEBB Summary of Dental Benefits 2018-19 Plan Year

LIMITED NETWORK PLANS! MUST USE IN-NETWORK PROVIDERS!
See footnotes Ω, †, and ‡ for details.

Dental	Premier Plan 1 ♦ Delta Dental Premier Network	Premier Plan 5♦ Delta Dental Premier Network	Premier Plan 6 Delta Dental Premier Network	Exclusive PPO Plan[Ω] Delta Dental PPO Network	Kaiser Dental Plan[†] Kaiser Permanente Facilities	Willamette Dental Plan[‡] Willamette Dental Group Facilities
Dental Office Visit Copayment	NA	NA	NA	NA	$20 *	$20 [3,*]
Benefit Maximum	$2,200	$1,700	$1,200	$1,500	$4,000 ***	NA
Deductible	$50	$50	$50	$50	NA	NA
Preventive & Diagnostic Services * - Deductible Waived for Preventive & Diagnostic Services on Delta Dental Plans						
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	70% + 10% each Plan Year	100%	100%	100% *	100% *
Restorative Services *						
Routine fillings, inlays and stainless steel crowns	70% + 10% [1] each Plan Year	70% + 10% [1] each Plan Year	80% [1]	90% [1]	100% [2,*]	100% *
Simple Extraction *						
Simple tooth extractions	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%	100% *	100% *
Oral Surgery *						
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%	$50 Copay *	$50 Copay *
Periodontics *						
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%	100% *	100% *
Endodontics *						
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	70% + 10% each Plan Year	80%	90%	$50 Copay*	$50 Copay*
Major Restorative Services *						
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	70%	50%	80%	$250 Copay *	$250 Copay *
Implants	70% + 10% each Plan Year	50%	50%	80%	50% * (limit of 4 per lifetime)	See Certificate of Coverage for copays
Other covered services*						
Occlusal guards (night guards)	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years	50% up to $250 maximum, once every 5 years	90%	100% [4]
Athletic mouth guards	50%	50%	50%	50%	90%	$100 Copay *
Nitrous Oxide	50%	50%	50%	50%	$25.00 (Ages 13 & Up)	$15 Copay *
Fixed and Removable Prosthetic Services *						
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	50%	80%	$100 Copay *	$100 Copay *
Bridge retainers and pontics	70% + 10% each Plan Year	50%	50%	80%	$250 Copay *	$250 Copay *
Orthodontics * (All plans except Delta Dental Plan 6)						
Orthodontic Treatment	80% to $1,800 lifetime max	80% to $1,800 lifetime max	NA	80% to $1,800 lifetime max	$2,500 Copay + $20 per visit **	$2,500 Copay + $20 per visit **

♦ Under Delta Dental Plans 1 and 5, benefits start at 70% the first plan year then increase by 10% each plan year (up to a maximum of 100%) provided the individual has visited the dentist at least once during the previous plan year. Switching between incentive plans (1 or 5) and other non-incentive plans will have an effect on benefit level.
Ω The Delta Dental Exclusive PPO plan has no out-of-network benefit. Services performed by providers 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.
† The Kaiser Dental Plan does NOT require enrollment in a Kaiser medical plan. Services must be provided by a contracted Kaiser provider in order for benefits to be payable. See handbook for details.
‡ Under the Willamette Dental Plan, services must be provided by a Willamette Dental Group provider in order for benefits to be payable. See handbook for details.
* For Kaiser Permanente and Willamette Dental Group plans: Office visit copayment applies at each visit, in addition to any plan copayments for services.
** Pre-Orthodontic Service fee of $150 is credited toward the orthodontic benefit if patient accepts treatment plan.
*** Preventive care and orthodontia do not accrue to this maximum.
[1] Posterior fillings paid to composite fee.
[2] Fillings are covered at 100% for all amalgam tooth surfaces, composite anteriors and one-surface composite posteriors. Patients can request composite fillings, which are considered a buy-up and additional fees apply. Please contact Kaiser
[3] The office visit copayment is waived for participants in the Chronic Condition Dental Management program for specific preventive services.
[4] Replacement of lost or stolen appliance once every 2 years; replacement or repair of broken appliance as needed.

This document is for comparison purposes only and is not intended to fully describe the benefits of each Plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.

v1 5/3/2018

Vision Plan Premiums

Moda Health 2018-19 Plan Year
Plans and Rates
(Effective October 1, 2018)

Vision					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
May use any licensed provider	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
Opal Plan	$23.07	$50.71	$43.77	$71.45	$52.64
Pearl Plan	$18.82	$41.46	$35.80	$58.41	$43.02
Quartz Plan	$13.29	$29.28	$25.26	$41.22	$30.37

VSP Vision 2018-19 Plan Year
Plans and Rates
(Effective October 1, 2018)

Vision					
OEBB Plan	**Tier-Rated Groups**				**Composite-Rated Groups**
Vision plans using the VSP Choice network	**Employee Only**	**Employee + Spouse or Domestic Partner**	**Employee + Child(ren)**	**Employee + Spouse or Domestic Partner + Child(ren)**	**Unit**
VSP Choice Plus Plan	$18.80	$41.37	$35.73	$58.29	$45.13
VSP Choice Plan	$9.15	$20.12	$17.37	$28.34	$21.94

Vision Benefits Summary

OEBB Summary of Vision Benefits 2018-19 Plan Year

Vision	Kaiser Vision Plan** Kaiser Permanente Facilities	Opal Plan May use any licensed provider	Pearl Plan May use any licensed provider	Quartz Plan May use any licensed provider	VSP Choice Plus Plan VSP Choice Network	VSP Choice Plan VSP Choice Network
Plan Year Maximum	$250	$600*	$400*	$250*	N/A	N/A
Routine Eye Exam:						
Benefit:	Covered under the Kaiser Permanente medical plan	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% after $10 copay	Plan pays 100% after $10 copay
Frequency:	As needed	Once per Plan Year	Once per Plan Year	Once per Plan Year	Every 12 months	Every 12 months
Lenses:						
Basic lens benefit:	Under age 19: No charge for one pair of standard frames and lenses or contacts Age 19+: Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. **Polycarbonate lenses, scratch resistant and UV coatings covered in full**	$20 copay (applied towards lenses & frame): Glass or plastic single vision, lined bifocal, lined trifocal, or lenticular lenses covered in full. **Scratch resistant and UV coatings covered in full**
Lens enhancements:					**$0 copay for standard progressive lenses** **$15 copay for anti-reflective coating or progressive lenses**	**$0 copay for standard progressive lenses** Discounts for polycarbonate, anti-reflective coating or progressive lenses
Frequency:	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once per Plan Year	Once every 12 months	Once every 12 months
Frames / Contacts:						
Benefit:	Under age 19: No charge for one pair of standard frames and lenses or contacts Age 19+: Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Plan pays 100% (up to plan maximum)	Covered in full up to retail allowance of **$300**; 20% off amount over retail allowance for frames Additional $50 or higher allowance for feature frame brands (i.e. Nike, Calvin Klein, Columbia Sportswear, Cole Haan, etc.) Available in-network at VSP doctor and participating retail chain locations (not applicable at Costco or Walmart) Not eligible to combine the Enhanced Featured Frame Allowance with Extra $20 or Extra $40 promotions.	Covered in full up to retail allowance of **$150**; 20% off amount over retail allowance for frames Additional $50 or higher allowance for feature frame brands (i.e. Nike, Calvin Klein, Columbia Sportswear, Cole Haan, etc.) Available in-network at VSP doctor and participating retail chain locations (not applicable at Costco or Walmart) Not eligible to combine the Enhanced Featured Frame Allowance with Extra $20 or Extra $40 promotions.
Frequency:	Once per Plan Year	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	**Frames:** *Age 0-16:* Once per Plan Year *Age 17+:* Once every two Plan Years **Contacts**: Once per Plan Year	Once every 12 months	Once every 12 months
Non-Prescription Bene						
Benefit:	$100 benefit for non-prescription sunglasses or digital eyestrain computer glasses in lieu of $50 hardware allowance	Not Covered	Not Covered	Not Covered	OEBB members can use their frame allowance to pay for non-prescription sunglasses, in lieu of prescription glasses or contacts. Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details	OEBB members can use their frame allowance to pay for non-prescription sunglasses, in lieu of prescription glasses or contacts. Coverage with a participating retail chain may be different. Once your benefit is effective, visit vsp.com for details

*Exam and hardware charges all apply to the plan year maximum on Moda Plans

**Must be enrolled in a Kaiser Medical Plan to enroll in the Kaiser Vision Plan

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Optional Insurance Premiums – Employee Self Pay

Life Insurance (optional)

2018-19 open enrollment offering of $200,000 without medical exam

The Standard
Optional Life Insurance Plans and Rates
2018-19 Plan Year

Optional Employee Life Plans and Rates $10,000 - $500,000 Maximum Benefit		
Age as of Each October 1st	Monthly Rate Per Each $10,000 of Benefit	
	If employee HAS NOT used tobacco in the past 12 months	If employee HAS used tobacco in the past 12 months
Under 25	$0.340	$0.500
25 – 29	$0.383	$0.600
30 – 34	$0.425	$0.800
35 – 39	$0.595	$0.900
40 – 44	$0.850	$1.216
45 – 49	$1.275	$1.802
50 – 54	$1.955	$2.754
55 – 59	$3.655	$5.041
60 – 64	$5.610	$7.684
65 – 69	$10.795	$14.467
70 – 74	$12.580	$20.600
75+	$17.510	$22.440

Optional Spouse Life Plans and Rates $10,000 - $500,000 Maximum Benefit		
Age as of Each October 1st	Monthly Rate Per Each $10,000 of Benefit	
	If spouse HAS NOT used tobacco in the past 12 months	If spouse HAS used tobacco in the past 12 months
Under 25	$0.468	$0.675
25 – 29	$0.558	$0.801
30 – 34	$0.747	$1.071
35 – 39	$0.846	$1.224
40 – 44	$1.000	$1.494
45 – 49	$1.500	$2.268
50 – 54	$2.300	$3.339
55 – 59	$4.250	$5.877
60 – 64	$6.420	$8.802
65 – 69	$12.270	$16.461
70 – 74	$14.710	$20.600
75+	$20.600	$43.542

Optional Child Life Plan and Rate $2,000 - $10,000 Maximum Benefit	
Monthly Rate for $2,000 of Benefit	$0.100

AD&D – Accidental Death & Dismemberment (optional)

The Standard
Accidental Death and Dismemberment Basic and Optional Plans and Rates
2018-19 Plan Year
(No change from 2017-18)

Basic Accidental Death and Dismemberment (AD&D) Plans		
Plan Design	Benefit Level	Rate Per $1,000 of Benefit
Plan 1	$5,000	$0.015
Plan 2	$7,500	$0.015
Plan 3	$10,000	$0.015
Plan 4	$15,000	$0.015
Plan 5	$20,000	$0.015
Plan 6	$25,000	$0.015
Plan 7	$30,000	$0.015
Plan 8	$35,000	$0.015
Plan 9	$40,000	$0.015
Plan 10	$50,000	$0.015
Plan 11	$100,000	$0.015
Plan 12	$110,000	$0.015
Plan 13	$200,000	$0.015
Plan 14	$300,000	$0.015
Plan 15	1 Times Annual Pay Max $300,000	$0.015
Plan 16	2 Times Annual Pay Max $300,000	$0.015
Plan 18	$150,000	$0.015

Optional Employee AD&D Plan	
$10,000 - $500,000 Maximum Benefit	
Rate per $10,000 of benefit	$0.200

Optional Spouse AD&D Plan	
$10,000 - $500,000 Maximum Benefit	
Rate per $10,000 of benefit	$0.200

Optional Child AD&D Plan	
$2,000 - $10,000 Maximum Benefit	
Rate per $2,000 of benefit	$0.040

Short Term Disability (optional)

New offering at Oregon Coast Community College - Plan 14 circled in red

What will your premium be? See monthly Premium

The Standard

Short Term Disability Plans and Rates

2018-19 Plan Year

VOLUNTARY ENROLLMENT - EMPLOYEE PAID PLANS

Allows each employee to choose whether or not they wish to enroll. Premiums must be paid by the employee.

	Voluntary Enrollment - Employee Paid								
	Plan 1	Plan 2	Plan 3	Plan 4	Plan 5	Plan 6	Plan 7	Plan 8	Plan 9
Benefit Waiting Period (Days)	7	7	7	14	14	14	30	30	30
Benefit Duration (Days)	60	60	60	60	60	60	60	60	60
Maximum Weekly Benefit	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500
Benefit Percentage	60%	66 ⅔%	70%	60%	66 ⅔%	70%	60%	66 ⅔%	70%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings*)	0.00593	0.00658	0.00691	0.00458	0.00508	0.00534	0.00307	0.00343	0.00361

	Plan 10	Plan 11	Plan 12	Plan 13	Plan 14	Plan 16	Plan 17
Benefit Waiting Period (Days)	7	7	7	14	14	30	30
Benefit Duration (Days)	90	90	90	90	90	90	90
Maximum Weekly Benefit	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500	$1,500
Benefit Percentage	60%	66 ⅔%	70%	60%	66 ⅔%	60%	66 ⅔%
Monthly Premium = Employee's Average Monthly Wage Multipled By This Rate (Not to exceed Maximum Monthly Pre-disability Earnings*)	0.00686	0.00762	0.00799	0.00539	0.00598	0.00374	0.00415

*** Maximum Monthly Pre-disability Earnings:**

For 60% Plan: The first $10,833 of employee's monthly pre-disability earnings

For 66 ⅔% Plan: The first $9,750 of employee's monthly pre-disability earnings

For 70% Plan: The first $9,286 of employee's monthly pre-disability earnings

**** Plan 15 will be discontinued**

This change, as well as the addition of two plans on LTD, will be done by amendment.