



## ODS Medical and Pharmacy Plans and Rates - 2009

Note: All \$ and % shown are the Member's cost							
Plan Option	Med Plan 3	Med Plan 4	Med Plan 5	Med Plan 6	Med Plan 7	Med Plan 8	Med Plan 9
	PPO	PPO	PPO	PPO	PPO	PPO	Major Medical
Preventive Services							
In Network (no deductible)	None	None	None	None	None	None	None
Out of Network	30%	40%	40%	40%	40%	40%	40%
Deductible (Individual/Family)							
In Network / Out of Network	\$100/\$300	\$100/\$300	\$200/\$600	\$300/\$900	\$500/\$1,500	\$1,000/\$3,000	\$1,500/\$3,000
Annual Coinsurance Maximum (Individual/Family)							
In Network	\$500	\$1,000	\$1,000	\$1,500	\$2,000	\$2,000	\$5,000/\$10,000
Out of Network	\$1,500	\$2,000	\$2,000	\$3,000	\$4,000	\$4,000	\$5,000/\$10,000
Benefit Maximum							
In Network	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Out of Network	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000	\$2,000,000
Coinsurance							
In Network	10%	20%	20%	20%	20%	20%	20%
Out of Network	30%	40%	40%	40%	40%	40%	40%
Office Visit Copay							
In Network	\$10	\$15	\$20	\$20	20%	20%	20%
Out of Network	30%	40%	40%	40%	40%	40%	40%
Hospital Copay							
In Network	10%	20%	20%	20%	20%	20%	20%
Out of Network	30%	40%	40%	40%	40%	40%	40%
Emergency Room Copay							
In Network / Out of Network (waived if admitted)	\$100 per visit then 10%	\$100 per visit then 20%	20%				

Note: All \$ and % shown are the Member's cost			
Pharmacy Plans			
	Option A	Option B	Option C
Deductible	None	None	None
Annual Copay/ Coinsurance Maximum	\$1,000	\$1,000	\$1,000
Retail			
Generic	\$5	\$5	50%
Preferred	20%	\$25	50%
Non Preferred	50%	50%, \$50 max	50%
Mail			
Generic	\$10	\$10	50%
Preferred	20%	\$50	50%
Non Preferred	50%	50%, \$100 max	50%

For rates, see page 2.



## ODS Medical and Pharmacy Plans and Rates, cont. - 2009

**\*\*Notice:** Below are the revised rates reflecting the passage of 1 percent health insurance premium assessment.

Medical Plan Rates					
ODS Health Plans					
Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
<b>PPO</b>					
Plan 3/w Pharmacy Plan A	\$470.87	\$1,035.92	\$894.65	\$1,459.69	\$1,120.68
Plan 3/w Pharmacy Plan B	\$470.16	\$1,034.32	\$893.28	\$1,457.47	\$1,118.96
Plan 3/w Pharmacy Plan C	\$460.24	\$1,012.52	\$874.45	\$1,426.74	\$1,095.37
Plan 4/w Pharmacy Plan A	\$452.24	\$994.95	\$859.26	\$1,401.95	\$1,076.35
Plan 4/w Pharmacy Plan B	\$451.53	\$993.35	\$857.89	\$1,399.73	\$1,074.63
Plan 4/w Pharmacy Plan C	\$441.61	\$971.55	\$839.06	\$1,369.00	\$1,051.04
Plan 5/w Pharmacy Plan A	\$427.03	\$939.49	\$811.37	\$1,323.79	\$1,016.35
Plan 5/w Pharmacy Plan B	\$426.32	\$937.89	\$810.00	\$1,321.57	\$1,014.63
Plan 5/w Pharmacy Plan C	\$416.40	\$916.09	\$791.17	\$1,290.84	\$991.04
Plan 6/w Pharmacy Plan A	\$409.16	\$900.17	\$777.42	\$1,268.40	\$973.81
Plan 6/w Pharmacy Plan B	\$408.45	\$898.57	\$776.05	\$1,266.18	\$972.09
Plan 6/w Pharmacy Plan C	\$398.53	\$876.77	\$757.22	\$1,235.45	\$948.50
Plan 7/w Pharmacy Plan A	\$379.23	\$834.31	\$720.53	\$1,175.59	\$902.56
Plan 7/w Pharmacy Plan B	\$378.52	\$832.71	\$719.16	\$1,173.37	\$900.84
Plan 7/w Pharmacy Plan C	\$368.60	\$810.91	\$700.33	\$1,142.64	\$877.25
Plan 8/w Pharmacy Plan A	\$343.12	\$754.88	\$651.92	\$1,063.66	\$816.63
Plan 8/w Pharmacy Plan B	\$342.41	\$753.28	\$650.55	\$1,061.44	\$814.91
Plan 8/w Pharmacy Plan C	\$332.49	\$731.48	\$631.72	\$1,030.71	\$791.32
Plan 9*	\$259.14	\$570.12	\$492.37	\$803.34	\$616.75

\*Pharmacy is included in this plan as any other covered medical expense. Rx's are applied to the deductible and then once the deductible is met they are paid at the same level as other covered medical expenses.

\*\*Revised 6/30/2009



## ODS Dental and Orthodontia Plans and Rates - 2009

	Dental Plan 1	Dental Plan 2	Dental Plan 3	Dental Plan 4	Dental Plan 5	Dental Plan 6
Deductible	None	None	None	\$25	\$50	\$50
Annual Maximum	\$2,200	\$1,500	\$1,500	\$1,500	\$1,500	\$1,000
Preventive Care	70%+10% year	70%+10% year	70%+10% year	100%	100%	100%
Restorative Services	70%+10% year	70%+10% year	70%+10% year	80%	80%	80%
Major Services	70%+10% year	70%+10% year	70%+10% year	80%	50%	50%
Prosthodontics	70%+10% year	70%+10% year	50%	50%	50%	50%

Dental Plan Rates					
ODS Health Plans					
Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
Plan 1	\$57.09	\$113.04	\$114.75	\$175.27	\$131.26
Plan 2	\$50.92	\$100.81	\$102.34	\$156.31	\$117.06
Plan 3	\$49.79	\$98.58	\$100.07	\$152.85	\$114.46
Plan 4	\$45.82	\$90.72	\$92.10	\$140.66	\$105.35
Plan 5	\$41.86	\$82.89	\$84.14	\$128.52	\$96.25
Plan 6	\$35.05	\$69.39	\$70.44	\$107.59	\$80.58

Orthodontia Plan Rates					
Oregon Dental Service					
Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
ODS Ortho Option	\$1.05	\$2.10	\$14.18	\$15.23	\$10.73



## ODS Vision Plans and Rates - 2009

Plan Option	Vision Plan 1	Vision Plan 2	Vision Plan 3	Vision Plan 4	Vision Plan 5
<b>Plan Maximum</b>	\$250	\$350	\$450	\$600	See allowances
<b>Routine Eye Exam</b>	\$10 copay	100%	100%	100%	100% up to \$64.50
<b>Exam Frequency</b>	12 months				
<b>Lenses</b>	Either one pair of lenses or contacts				
<b>Single Vision</b>	100%	100%	100%	100%	100% up to \$58.50 / year
<b>Bifocal</b>	100%	100%	100%	100%	100% up to \$86.00 / year
<b>Lenticular</b>	100%	100%	100%	100%	100% up to \$86.00 / year
<b>Trifocal</b>	100%	100%	100%	100%	100% up to \$109.00 / year
<b>Contact Lenses</b>	100%	100%	100%	100%	100% up to \$192.50 / year
<b>Lens Frequency</b>	12 months				
<b>Frames</b>	100%	100%	100%	100%	100% up to \$75.00 / year
<b>Frame Frequency</b>	child: 12 months, adult: 24 months				

Vision Plan Rates					
ODS Health Plans					
Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
Plan 1	\$8.63	\$19.00	\$16.40	\$26.76	\$19.72
Plan 2	\$11.34	\$24.95	\$21.54	\$35.16	\$25.90
Plan 3	\$12.79	\$28.13	\$24.30	\$39.63	\$29.20
Plan 4	\$14.96	\$32.91	\$28.42	\$46.38	\$34.16
Plan 5	\$8.19	\$18.02	\$15.56	\$25.39	\$18.71



## Providence Medical and Pharmacy Plans and Rates - 2009

Note: All \$ and % shown are the Member's cost			
Plan Option	Med Plan 1	Med Plan 1A	Med Plan 2
	POS	POS	POS
Preventive Services			
In Network (no deductible)	None	None	None
Out of Network	50%	50%	50%
Deductible (Individual/Family)			
In Network	None	None	None
Out of Network	\$300/\$900	\$300/\$900	\$300/\$900
Annual Coinsurance Maximum (Individual/Family)			
In Network	\$1000/\$2,000	\$1,500/\$3,000	\$600/\$1,200
Out of Network	\$2,000/\$4,000	\$3,000/\$6,000	\$2,000/\$4,000
Benefit Maximum			
In Network	\$2,000,000	\$2,000,000	\$2,000,000
Out of Network			
Coinsurance			
In Network	None	None	None
Out of Network	50%	50%	50%
Office Visit Copay <sup>(3)</sup>			
In Network	\$10	\$25	\$5
Out of Network	50%	50%	50%
Hospital Copay		\$200 per day, \$1,000 max	No charge
In Network	\$100 per day		
Out of Network	50%	50%	50%
Emergency Room Copay			
In Network / Out of Network (waived if admitted)	\$100 per visit	\$100 per visit	\$100 per visit

Rx Plan 1	
In Network Only	
Deductible	None
Annual Copay/Coinsurance Maximum	\$1,000
Retail	
Generic	\$5
Preferred	\$15
Non Preferred	50%
Mail	
Generic	\$10
Preferred	\$30
Non Preferred	50%

**\*\*Notice: Below are the revised rates reflecting the passage of HB 2116.**

Medical Plan Rates					
Providence Health Plan					
OEBB Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
<b>POS</b>					
Plan 1 w/Pharmacy	\$488.44	\$1,074.58	\$928.04	\$1,514.19	\$1,167.38
Plan 1A w/Pharmacy	\$480.44	\$1,056.95	\$912.82	\$1,489.34	\$1,148.22
Plan 2 w/Pharmacy	\$500.66	\$1,101.45	\$951.25	\$1,552.06	\$1,196.57

**\*\*Revised 6/30/2009**



## Kaiser Medical and Pharmacy Plans and Rates - 2009

Note: All \$ and % shown are the Member's cost			
Plan Option	Med Plan 1	Med Plan 1A	Med Plan 2
	HMO	HMO	HMO
Preventive Services			
In Network (no deductible)	None	None	None
Out of Network	-	-	-
Deductible (Individual/Family)			
In Network / Out of Network	None	None	None
Annual Coinsurance Maximum (Individual/Family)			
In Network	\$1,000/\$2,000	\$1,500/\$3,000	\$600/\$1,200
Out of Network	-	-	-
Benefit Maximum			
In Network	unlimited	unlimited	unlimited
Out of Network	-	-	-
Coinsurance			
In Network	None	None	None
Out of Network	-	-	-
Office Visit Copay			
In Network	\$10	\$25	\$5
Out of Network	-	-	-
Hospital Copay			
In Network	\$100 per day, \$500 max	\$200 per day, \$1,000 max	No charge
Out of Network	-	-	-
Emergency Room Copay			
In Network / Out of Network (waived if admitted)	\$100 per visit	\$100 per visit	\$100 per visit

Rx Plan 1	
Deductible	None
Annual Copay/Coinsurance Maximum	\$1,000
Retail	
Generic	\$5
Preferred	\$15
Non Preferred	N/A
Mail	
Generic	\$10
Preferred	\$30
Non Preferred	N/A

**\*\*Notice: Below are the revised rates reflecting the passage of HB 2116.**

Medical Plan Rates					
Kaiser Permanente OEBB Rates 2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
<u>HMO</u>					
Plan 1 w/Pharmacy	\$397.14	\$873.72	\$754.58	\$1,231.15	\$945.20
Plan 1A w/ Pharmacy	\$384.96	\$846.92	\$731.44	\$1,193.39	\$916.21
Plan 2 w/Pharmacy	\$415.60	\$914.29	\$789.62	\$1,288.33	\$989.10

**\*\*Revised 6/30/2009**

## Kaiser Dental and Orthodontia Plans and Rates - 2009



	Dental Plan 7	Dental Plan 8
Deductible	None	None
Annual Maximum	None	None
Preventive Care	100% (\$5 per visit)	100% (\$10 per visit)
Restorative Services	100% (\$5 per visit)	100% (\$10 per visit)
Major Services	\$45	100%
Prosthodontics	\$95 partial denture, \$65 full denture, \$25 reline	100%

Dental Plan Rates					
Kaiser Permanente					
Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Groups
					Unit
<u>DHMO</u>					
Plan 7	\$62.85	\$138.28	\$119.42	\$194.85	\$149.59
Plan 8	\$62.60	\$137.73	\$118.95	\$194.08	\$149.00

Orthodontia Plan Rates					
Kaiser Permanente					
OEBB Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Groups
					Unit
<u>DHMO</u>					
Kaiser Ortho Option A - 50% to \$2,000	\$3.01	\$6.62	\$5.71	\$9.32	\$7.16
Kaiser Ortho Option B - \$1,500 copay + \$10	\$4.24	\$9.35	\$8.07	\$13.16	\$10.11



## Kaiser Vision Plan and Rates - 2009

Plan Option	Vision Plan 5
Plan Maximum	See allowances
Routine Eye Exam	100% up to \$64.50 (\$5 office visit)
Exam Frequency	12 months
Lenses	Either one pair of lenses or contacts
Single Vision	100% up to \$58.50 / year
Bifocal	100% up to \$86.00 / year
Lenticular	100% up to \$86.00 / year
Trifocal	100% up to \$109.00 / year
Contact Lenses	100% up to \$192.50 / year
Lens Frequency	12 months
Frames	100% up to \$75.00 / year
Frame Frequency	child: 12 months, adult: 24 months

Vision Plan Rates					
Kaiser Permanente Rates 2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
Vision Plan 5	\$7.59	\$16.71	\$14.43	\$23.53	\$18.07

## Willamette Dental Plans and Rates - 2009



	Dental Plan 7	Dental Plan 8
Deductible	None	None
Annual Maximum	None	None
Preventive Care	100% (\$5 per visit)	100% (\$10 per visit)
Restorative Services	100% (\$5 per visit)	100% (\$10 per visit)
Major Services	\$45	100%
Prosthodontics	\$95 partial denture, \$65 full denture, \$25 reline	100%
Orthodontia built into plan	\$1,500 co-pay + \$10 office visit	\$1,500 co-pay + \$10 office visit

Dental Plan Rates					
Willamette Dental					
Rates					
2009 Contract Year (effective October 1, 2009)					
OEBB Plan	Tier-Rated Groups				Composite-Rated Groups
	Employee Only	Employee + Spouse	Employee + Child(ren)	Family	Unit
<u>DHMO</u>					
Plan 7 w/Ortho	\$42.90	\$84.95	\$90.30	\$135.78	\$109.08
Plan 8 w/ Ortho	\$42.30	\$83.74	\$89.09	\$133.91	\$107.56