OEBB Medical PPO Plan Comparisons

Type of Plan :	Plan 3 – PPO Plan		Plan 4 – PPO Plan		Plan 5 – PPO Plan		Plan 6 – PPO Plan		Plan 7 – PPO		Plan 8 – PPO Plan		Plan 9 – HSA Compatible PPO Plan	
General Information:														
Reimbursement:	**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Individual Deductible (plan year)	$100		$100		$200		$300		$500		$1,000		$1,500*	
Family Deductible (plan year)	$300		$300		$600		$900		$1,500		$3,000		$3,000**	
Individual Out of Pocket Maximum (plan year)	$500	$1,500	$1,000	$2,000	$1,000	$2,000	$1,500	$3,000	$2,000	$4000	$2,000	$4,000	$5,000	
Family Out of Pocket Maximum (plan year)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	$10,000	
Lifetime Benefit Maximum	$2,000,000		$2,000,000		$2,000,000		$2,000,000		$2,000,000		$2,000,000		$2,000,000	
Member Coinsurance	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Covered Services														
Hospital Benefit														
Inpatient Hospital Coinsurance Service authorization required	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Inpatient Days Covered	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited
Pre-admission Testing	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Inpatient Rehabilitative Hospital Care (30/60 days per plan year)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Emergency & Urgent Care														
Emergency Room (copayment waived if admitted)	$100 copayment per visit then 10%		$100 copayment per visit then 20%		$100 copayment per visit then 20%		$100 copayment per visit then 20%		$100 copayment per visit then 20%		$100 copayment per visit then 20%		20%	
RN Advice for minor illnesses & injuries	eDoc		eDoc		eDoc		eDoc		eDoc		eDoc		eDoc	
Urgent Care Visits	$10 copayment		$15 copayment		$20 copayment		$20 copayment		20%		20%		20%	
Ambulance Transportation	10%		20%		20%		20%		20%		20%		20%	
Skilled Nursing Facility														
Skilled Nursing Facility 60 days per plan year	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%

OEBB Medical PPO Plan Comparisons

Type of Plan :	Plan 3 – PPO Plan (continued)		Plan 4 – PPO Plan (continued)		Plan 5 – PPO Plan (continued)		Plan 6 – PPO Plan (continued)		Plan 7 – PPO (continued)		Plan 8 – PPO Plan (continued)		Plan 9 – HSA Compatible PPO Plan (continued)	
Reimbursement:	**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Physician & Professional Services														
Office, Home or Hospital visit	$10 copayment	30%	$15 copayment	40%	$20 copayment	40%	$20 copayment	40%	20%	40%	20%	40%	20%	40%
Outpatient Rehabilitation (physical, occupational and speech therapy - 30/60 days per plan year)	$10 copayment	30%	$15 copayment	40%	$20 copayment	40%	$20 copayment	40%	20%	40%	20%	40%	20%	40%
Anesthesiologist	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Ambulatory & Outpatient Hospital Services														
Outpatient Surgery	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Diagnostic X-rays & Laboratory Tests	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Chemotherapy	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Radium, Radioisotopic, X-Ray Therapy and Kidney Dialysis	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Imaging Procedures	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Preventive Healthcare														
Well Child Exams Newborn through age 17	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Childhood Immunizations	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Adult Immunizations (flu and others as indicated)	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Routine Adult Physical Exams Age 18 and above	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Routine Mammograms subject to schedule	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Pap Smear	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Prostate Screening Age 50 and over	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Colon Cancer Screenings Age 50 and over subject to schedule	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%

OEBB Medical PPO Plan Comparisons

Type of Plan :	Plan 3 – PPO Plan (continued)		Plan 4 – PPO Plan (continued)		Plan 5 – PPO Plan (continued)		Plan 6 – PPO Plan (continued)		Plan 7 – PPO (continued)		Plan 8 – PPO Plan (continued)		Plan 9 – HSA Compatible PPO Plan (continued)	
Reimbursement:	**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Preventive Healthcare (continued)														
Cardiovascular screenings	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Hearing Evaluations	$0 deductible waived	30%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%	$0 deductible waived	40%
Family Planning														
Tubal ligation	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Vasectomy	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Contraceptive Devices (Includes contraceptives and devices which cannot be legally dispensed without a prescription)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Maternity/Newborn Care														
Outpatient Maternity Care	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Midwife Delivery (only if also a licensed nurse practitioner)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Inpatient Delivery	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Newborn Circumcision	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Newborn Nursery Care	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Other Care/Treatments														
Allergy Testing	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Allergy Injections	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Therapeutic Injections	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Injectable Medication (administered in provider's office)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Biofeedback Therapy 10 visits per lifetime	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Inborn Errors of Metabolism	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Cochlear Implants service authorization required	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Maxillofacial Prosthetic Services (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Temporomandibular Joint Syndrome (TMJ)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Special Dental Care (injury to natural teeth or jaw)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Transplants (requires service authorization)	$0	30%	$0	40%	$0	40%	$0	40%	$0	40%	$0	40%	20%	40%

OEBB Medical PPO Plan Comparisons

Type of Plan :	Plan 3 – PPO Plan (continued)		Plan 4 – PPO Plan (continued)		Plan 5 – PPO Plan (continued)		Plan 6 – PPO Plan (continued)		Plan 7 – PPO (continued)		Plan 8 – PPO Plan (continued)		Plan 9 – HSA Compatible PPO Plan (continued)	
Reimbursement:	**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Other Care/Treatments (continued)														
Therapeutic Abortions	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Podiatry Services (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Hospice Care (maximum benefit of $20,000)														
Hospice Home Care	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Hospice Inpatient Care	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Other Services														
Home Healthcare (daily limitations/140 visits per year)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Respite Care (limited to 170 hours of care in three months)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Infusion Therapy (service authorization required)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Prosthetic & Orthotic Appliances (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Non-prescription Enteral Formula for Home Use (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Supplies, Appliances and Durable Medical Equipment (subject to limitations)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Benefits for Chemical Dependency														
Detoxification	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Inpatient Treatment	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Outpatient Office Visits	$10 copayment	30%	$15 copayment	40%	$20 copayment	40%	$20 copayment	40%	20%	40%	20%	40%	20%	40%
Treatment for Mental Illness														
Inpatient Treatment	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Outpatient Office Visits	$10 copayment	30%	$15 copayment	40%	$20 copayment	40%	$20 copayment	40%	20%	40%	20%	40%	20%	40%
Group Therapy	$10 copayment	30%	$15 copayment	40%	$20 copayment	40%	$20 copayment	40%	20%	40%	20%	40%	20%	40%
Mental Health Residential Care (45 days per plan year)	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%

OEBB Medical PPO Plan Comparisons

Type of Plan :	Plan 3 – PPO Plan (continued)		Plan 4 – PPO Plan (continued)		Plan 5 – PPO Plan (continued)		Plan 6 – PPO Plan (continued)		Plan 7 – PPO (continued)		Plan 8 – PPO Plan (continued)		Plan 9 – HSA Compatible PPO Plan (continued)	
Reimbursement:	**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**		**Member Responsibility**	
	In-Network	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**	**In-Network**	**Out of Network**
Alternative Care - Chiropractic, Acupuncture/Acupressure, Naturopath Services (Combined maximum plan year benefit of $2,500)* **														
Office Visit	$10 copayment	30%	$15 copayment	40%	$20 copayment	40%	$20 copayment	40%	20%	40%	20%	40%	20%	40%
All Other Services	10%	30%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%	20%	40%
Health & Wellness														
Online Health & Lifestyle Information - Reference eDoc and myODS.														
Prescription Drugs	See Pharmacy Benefit		See Pharmacy Benefit		See Pharmacy Benefit		See Pharmacy Benefit		See Pharmacy Benefit		See Pharmacy Benefit		20%	

*Individual deductible applies if employee is enrolling with no other family members.
**Family deductible can be met by one or more family members. This deductible must be met before benefits will be paid.
***Services will be covered the same as any other benefit would be under the plan, up to a plan year combined benefit maximum of $2,500.

OEBB Medical Plan Comparison
tm: 8/15/2008