Changes and Reminders for 2015-16

Moda Health Plans A-G – NEW Affordable Care Act (ACA) Maximum Cost Share

This plan year limit includes your pharmacy copays and coinsurances and your Additional Cost Tier (ACT) copays, as well as the eligible medical expenses that accrue toward your in-network medical out-of-pocket maximum. The medical maximum out-of-pocket will remain the same for plans A-G.

For additional information, call Moda Health Customer Service at 866-923-0409 or visit the Moda Health website at www.modahealth.com/oebb.

HSAs and OEBB Medical Plans

If you are interested in pairing a Health Savings Account (HSA) with your medical plan, you must enroll in either Moda Health Medical Plan H (where pairing with an HSA is required). To learn more about HSAs, see *page 40*.

You and Your Family

- If you enroll in a Moda Statewide plan, you don't have to identify your primary care provider and you have access to the more extensive Connexus Network to qualify for the in-network benefit level.
- OEBB provides a Plan Comparison Tool within the MyOEBB system to help you estimate and compare costs (monthly premiums and healthcare expenses combined) of the various plans available to you. Learn more about this tool on *pages 53 - 56*.

The Coordinated Care Model (CCM)

Through the coordinated care model, Oregonians are experiencing improved, more integrated care. With a focus on primary care and prevention, health plans using the coordinated care model are able to better manage chronic conditions and keep people healthy and out of the emergency department.

Key elements of the coordinated care model include:

- Best practices to manage and coordinate care;
- Shared responsibility for health;
- Performance is measured;
- Paying for outcomes and health;
- Transparency and clear information; and
- Maintain costs at a sustainable rate of growth.

OEBB works diligently to incorporate these elements into all OEBB medical plans.

Learn more about the Coordinated Care Model and Oregon's efforts in this area on the Oregon Health Policy Board website: www.oregon.gov/oha/OHPB/Pages/health-reform/ccos.aspx.

Dental Plans

Changes and Reminders for 2015-16

The only change to OEBB dental plans for 2015-16 is the addition of a Chronic Condition Dental Management program on Willamette Dental Group Dental Plan 8. Members with chronic conditions can learn more about this program by contacting Willamette Dental Group directly.

Below are reminders of important things to consider when choosing dental coverage.

Incentive Plans vs. Non-Incentive Plans

Moda Health/ODS Dental Plans 1, 2 and 3 are "incentive plans," meaning as long as you visit the dentist at least once during the year the level of benefit for certain services will increase the following year (up to a maximum of 100 percent). If you switch to one of the other "non-incentive" plans (Willamette Dental Group Plan 8, and Moda Health/ODS Dental Plans 4 and 6), you will not retain any higher benefit level you previously earned. If you switch back to an incentive plan in the future, your benefit will start over at 70 percent.

Maximum Benefit on Plans 1 – 6

Moda Health/ODS Dental Plans 1 – 6 are structured with a benefit maximum (maximum possible amount the insurance will pay in a given plan year). If you anticipate needing costly dental work, note the benefit maximum on the plan you choose and be prepared to pay 100% of any remaining costs after reaching that benefit maximum.

Willamette Dental Group Dental Plan 8 does not have a benefit maximum. The plan and the member will continue to share the costs of all covered services as shown in the summary of benefits for the entire plan year, regardless of the accrued amount paid by either party.

Provider Networks

Willamette Dental Group requires you to use their facilities and providers to have nonemergency services covered. If you are currently covered by a different carrier and change to this plan, you will need to change providers.

Late Enrollment Penalty/12-Month Waiting Period

If you didn't enroll yourself or a dependent in dental coverage when initially eligible, then choose to enroll during an Open Enrollment period, whoever is being added to coverage will be considered a "late enrollee." Late enrollees are subject to a 12-month waiting period on all dental plans, meaning only diagnostic and preventive care will be covered for the first full 12 months of coverage.

Why is this waiting period in place?

Dental coverage is most often totally voluntary. That combined with the fact that dental services can often be delayed, as they tend to be less urgent than medical services, opens the plans up to "adverse selection." Basically, if individuals only enroll once they know they need costly services, the premiums for these coverages would need to be much higher for everyone than they are today in order to bring in enough premiums to pay the claims. The waiting period helps control costs, maintaining a balance between premiums coming in and claims being paid out.

Vision Plans

Reminders for 2015-16

There are no changes to OEBB vision plans for 2015-16. However, here are some reminders of important things to consider when choosing vision coverage.

Maximum Benefit on Plans 1 – 4

Moda Health Vision Plans 1 – 4 are structured with a benefit maximum (maximum possible amount the insurance will pay in a given plan year). If you anticipate needing vision services, note the benefit maximum on the plan you choose and be prepared to pay 100% of any remaining costs after the plan has paid that benefit maximum.

Note that all the vision plans have a "frequency schedule" for exams, lenses, and frames, meaning these services are only allowed once within a specified timeframe. See the Vision Plans Summary of Benefits on *page 29* for allowed amounts and frequency schedules.

Late Enrollment Penalty/12-Month Waiting Period

If you didn't enroll yourself or a dependent in vision coverage when initially eligible, then choose to enroll during an Open Enrollment period, whoever is being added to coverage will be considered a "late enrollee." Late enrollees are subject to a 12-month waiting period on all vision plans, meaning only routine eye exams will be covered for the first full 12 months of coverage – no lenses or frames.

Why is this waiting period in place?

Vision coverage is most often totally voluntary. That combined with the fact that vision services can often be delayed, as they tend to be less urgent than medical services, opens the plans up to "adverse selection." Basically, if individuals only enroll once they know they need costly services, the premiums for these coverages would need to be much higher for everyone than they are today in order to bring in enough premiums to pay the claims. The waiting period helps control costs, maintaining a balance between premiums coming in and claims being paid out.