

Lane Community College
Faculty Plan Comparisons | Plan Year October 1, 2014 - September 30, 2015

		Med Plan A	Med Plan B	Med Plan C	Med Plan E	Med Plan G
Medical Plans <i>no lifetime maximum on any medical plans</i>		Moda Health/ ODS (PPO)	Moda Health/ ODS (PPO)	Moda Health/ ODS (PPO)	Moda Health/ ODS (PPO)	Moda Health/ ODS (PPO)
Deductible (Individual / Family)	In-Network Out-of-Network	\$200 / \$600	\$350 / \$1050	\$500 / \$1500	\$1000 / \$3000	\$1500 / \$4500
Coinsurance	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
All plans will pay 100% after the Maximum Out-of-Pocket costs have been paid (except the Additional Cost Tier).						
Copayments and co-insurance for all non-pharmacy services, as well as deductibles will accrue toward the medical Maximum Out-of-Pocket on all plans.						
Maximum Out-of-Pocket Costs per Plan Year (Individual / Family)	In-Network	\$2400 / \$7200	\$2950 / \$8850	\$3300 / \$9900	\$4250 / \$12,700	\$6350 / \$12,700
	Out-of-Network	\$4800 / \$14,400	\$5900 / \$17,700	\$6600 / \$19,800	\$8500 / \$25,400	\$12,700 / \$25,400
Preventive Care Services \$ and % shown is the Member Cost; \$ Amounts = Copayments						
Adult, Well-child & Well-baby Exams; Immunizations; and Preventive Care Services as described in the Plan Handbooks	In-Network	\$0	\$0	\$0	\$0	\$0
	Out-of-Network	50%	50%	50%	50%	50%
Provider Services \$ and % shown is the Member Cost; \$ Amounts = Copayments						
Incentive Office Visits for asthma, heart conditions (CHF, cholesterol & high BP) & diabetes management	In-Network	20%*	20%*	20%*	20%*	20%*
	Out-of-Network	50%	50%	50%	50%	50%
Primary Care Services as described in the Plan Handbook	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Specialist Office Visits	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Additional Cost Tier** as described in Plan Handbook	In-Network	\$500 + 20%	\$500 + 20%	\$500 + 20%	\$500 + 20%	\$500 + 20%
	Out-of-Network	\$500 + 50%	\$500 + 50%	\$500 + 50%	\$500 + 50%	\$500 + 50%
Hospital & Outpatient Services \$ and % shown is the Member Cost; \$ Amounts = Copayments						
Inpatient Care	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Outpatient Surgery	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Outpatient Rehabilitation (physical, occupational & speech therapy) Max 30 visits per Plan Year	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Ambulance		20%	20%	20%	20%	20%
Emergency Room (copay \$ amounts listed are waived if admitted)		\$100 per visit then 20%	\$100 per visit then 20%	\$100 per visit then 20%	\$100 per visit then 20%	\$100 per visit then 20%
Urgent Care \$ and % shown is the Member Cost; \$ Amounts = Copayments						
Urgent Care Visit	In-Network	\$50*	\$50*	\$50*	\$50*	\$50*
	Out-of-Network					
Other Services \$ and % shown is the Member Cost; \$ Amounts = Copayments						
Laboratory / X-Ray	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Imaging (CT, PET & MRI), Lumbar Discographies & Sleep Studies**	In-Network	\$100 + 20%	\$100 + 20%	\$100 + 20%	\$100 + 20%	\$100 + 20%
	Out-of-Network	\$100 + 50%	\$100 + 50%	\$100 + 50%	\$100 + 50%	\$100 + 50%

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Medical Plans		Moda Health/	Moda Health/	Moda Health/	Moda Health/	Moda Health/
<i>no lifetime maximum on any medical plans</i>		ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)
Viscosupplementation**	In-Network	\$100 + 20%	\$100 + 20%	\$100 + 20%	\$100 + 20%	\$100 + 20%
	Out-of-Network	\$100 + 50%	\$100 + 50%	\$100 + 50%	\$100 + 50%	\$100 + 50%
Upper Endoscopies**	In-Network	\$100 + 20%	\$100 + 20%	\$100 + 20%	\$100 + 20%	\$100 + 20%
	Out-of-Network	\$100 + 50%	\$100 + 50%	\$100 + 50%	\$100 + 50%	\$100 + 50%
Durable Medical Equipment	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Hearing Aids (\$4000 benefit every 48 months) as described in Plan Handbook	In-Network	10%	10%	10%	10%	10%
	Out-of-Network	50%	50%	50%	50%	50%
Alternative Care Services						
\$ and % shown is the Member Cost; \$ Amounts = Copayments						
Acupuncture, Chiropractic & Naturopathic Services \$2000 Maximum Combined Benefit (cost of lab, x-rays, supplies & procedures performed in Provider's office applies to benefit maximum)	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Tobacco Cessation Program						
(available to age 18 and over)						
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications		See footnote\$	See footnote\$	See footnote\$	See footnote\$	See footnote\$
Maternity						
\$ and % shown is the Member Cost; \$ Amounts = Copayments						
Outpatient Maternity Care	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Delivery & Routine Newborn Nursery Care	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Weight Management (subscriber and covered dependents unless noted otherwise)						
\$ and % shown is the Member Cost; \$ Amounts = Copayments						
Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply)		\$0	\$0	\$0	\$0	\$0
12 Health Coaching Sessions per Plan Year & Online Educational Resources		\$0	\$0	\$0	\$0	\$0
Bariatric Surgery** (subscribers only, not covered for dependents) See Plan Handbook for specific criteria.	Approved Providers Only - see criteria	\$500 + 20%	\$500 + 20%	\$500 + 20%	\$500 + 20%	\$500 + 20%
Mental Health & Chemical Dependency Services						
\$ and % shown is the Member Cost; \$ Amounts = Copayments						
Mental Health Outpatient Services	In-Network	\$20*	\$20*	\$20*	\$30*	\$30*
	Out-of-Network	50%	50%	50%	50%	50%
Mental Health Inpatient & Residential Services	In-Network	20%	20%	20%	20%	20%
	Out-of-Network	50%	50%	50%	50%	50%
Substance Abuse Outpatient, Inpatient & Residential Services	In-Network	\$0	\$0	\$0	\$0	\$0
	Out-of-Network	50%	50%	50%	50%	50%

* Deductible waived

\$ Unlimited calls to Alere Wellbeing, maximum 5 calls from Alere Wellbeing per Plan Year. Patches, gum & prescribed medications are subject to Rx copays. See Plan Handbook for details.

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Pharmacy Services		Moda Health/	Moda Health/	Moda Health/	Moda Health/	Moda Health/
\$ and % shown is the Member Cost; \$ Amounts = Copayment		ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)
Pharmacy Out-of-Pocket Maximum (per person)		NA	NA	NA	NA	NA
Retail						
Value (up to 90-day supply)		\$0	\$0	\$0	\$0	\$0
Select Generic	30/31-day supply	\$8	\$8	\$8	\$8	\$8
Preferred	30/31-day supply	25% up to \$50	25% up to \$50	25% up to \$50	25% up to \$50	25% up to \$50
Non-Preferred	30/31-day supply	50% up to \$150	50% up to \$150	50% up to \$150	50% up to \$150	50% up to \$150
Mail						
Value		90-day supply	\$0	\$0	\$0	\$0
Select Generic	90-day supply	\$16	\$16	\$16	\$16	\$16
Preferred	90-day supply	25% up to \$100	25% up to \$100	25% up to \$100	25% up to \$100	25% up to \$100
Non-Preferred	90-day supply	50% up to \$300	50% up to \$300	50% up to \$300	50% up to \$300	50% up to \$300
Specialty						
Select Generic	30/31-day supply	\$16	\$16	\$16	\$16	\$16
Preferred	30/31-day supply	25% up to \$100	25% up to \$100	25% up to \$100	25% up to \$100	25% up to \$100
Non-Preferred	30/31-day supply	50% up to \$300	50% up to \$300	50% up to \$300	50% up to \$300	50% up to \$300

Vision Plan 4	
Vision Plan	
Moda Health (ODS)	
Plan Year Maximum	
\$600*	
Exams	
Exam Frequency	
Once per Plan Year	
Routine Eye Exam	
100%	
Lenses	
Lens Frequency	
Once per Plan Year	
Lenses	
Either one pair of lenses or contacts	
Single Vision	
100%	
Bifocal	
100%	
Lenticular	
100%	
Trifocal	
100%	
Contact Lenses	
100%	
Frames	
Frame Frequency	
Child: once per Plan Year	
Adult: once every two Plan Years	
Frames	
100%	

* Exam and hardware charges all apply to the Plan Year maximum.

	Dental Plan 1 ♦	Dental Plan 4	Dental Plan 8 ‡
Dental Plans	Moda Health (ODS)	Moda Health (ODS)	Willamette Dental
Dental Office Visit Copayment	NA	NA	\$20*
Benefit Maximum	\$2,200	\$1,500	NA
Deductible	\$50	\$50	NA
Plan Year Maximum	\$2,200	\$1,500	NA
Preventive and Diagnostic Services*	Deductible Waived for Preventive & Diagnostic Services on		
Oral exams, X-rays, cleaning (prophylaxis), fluoride treatments, and space maintainers	70% + 10% each Plan Year	100%	100%*
Restorative Services*			
Routine fillings, inlays and stainless steel crowns	70% + 10% ¹ each Plan Year	80% ¹	100% ^{2*}
Simple Extraction*			
Simple tooth extractions	70% + 10% each Plan Year	80%	100%*
Oral Surgery*			
Surgical tooth extractions, including diagnosis and evaluation	70% + 10% each Plan Year	80%	100%*
Periodontics*			
Diagnosis, evaluation, and treatment of gum disease including scaling and root planing	70% + 10% each Plan Year	80%	100%*
Endodontics*			
Root canal and related therapy including diagnosis and evaluation	70% + 10% each Plan Year	80%	100%*
Major Restorative Services*			
Gold or porcelain crowns and onlays	70% + 10% each Plan Year	80%	100%*
Implants	70% + 10% each Plan Year	50%	See Certificate of Coverage for copays
Fixed and Removable Prosthetic Services*			
Full and partial dentures, relines, rebases	70% + 10% each Plan Year	50%	100%*
Bridge retainers and pontics	70% + 10% each Plan Year	50%	100%*
Orthodontics * (All plans except ODS Dental Plan 6)			
Orthodontic Treatment	80% to \$1,800 lifetime max	80% to \$1,800 lifetime max	\$1,500 copay + \$20 per visit**

♦ Under ODS Plans 1, 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 plan 3 and non-incentive plans (4 and 8) will have an effect on benefit level.

‡ Under Willamette Dental Plan 8, services must be provided by a Willamette Dental contracted provider in order for benefits to be payable. See handbook for details.

* For Willamette Dental Plan 8: Office visit copayment applies at each visit, in addition to any plan copayments for