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February 28, 2013

TO: The Honorable Senator Alan Bates, Co-Chair
The Honorable Representative Nancy Nathanson, Co-Chair
Joint Ways and Means Human Services Subcommittee

FROM: Joan Kapowich, Administrator, Public Employees' Benefit Board

Subject: Public Employees' Benefits Board (PEBB) Follow-Up

DATE: February 28, 2013

During the Public Employees' Benefits Board (PEBB) and Oregon Educators Benefits Board (OEBB) Joint Ways and Means Subcommittee on Human Services presentation on February 14, 2013 you asked a number of questions regarding PEBB and OEBB operations and experience. Attached are several documents that answer the questions you raised.

First is a document that outlines several experience measures within PEBB and OEBB. Specifically, the document shows the PEBB per member per month (PMPM) allowed charges in 2011 and through the third quarter of 2012, including whether the charges increased or decreased between those years. The document also shows both the PEBB and OEBB medical/RX premium increases relative to trend between 2010 and 2013. Finally, the document shows the annual percentage change in the PEBB budget on a per employee per month basis (PEPM) between 2002 and 2013.

The next two documents included summarize and compare the different plan options in both PEBB and OEBB. These documents outline the benefits, deductibles, coinsurance/co-pays, and maximum out-of-pocket costs for each of the options in PEBB and OEBB.

Please let me know if you have any further questions. I am happy to provide additional information.

Cc: Sean Kolmer, Chair, Public Employees' Benefits Board
Courtney Thompson, Director of Legislative and Government Affairs, OHA Bill Coulombe, Budget Director, OHA
Linda Ames, Legislative Fiscal Office
Kate Nass, Department of Administrative Service

Public Employees' Benefit Board
Oregon Educators Benefit Board

Ways and Means Hearing Responses

Oregon Health Authority

PEBB Allowed Charges Per Member Per Month (PMPM)			
Providence Statewide Plan	Cost by Plan Year		
	2011	2012/Q3*	↓ / ↑
In patient facility	$94.28	$91.97	↓
In patient surgery prof	$6.60	$6.16	↓
Out Patient facility	$55.46	$48.67	↓
Out patient surgery prof	$19.68	$16.93	↓
Radiology	$33.43	$30.66	↓
Lab	$17.78	$17.69	↓
Primary care	$34.89	$34.28	↓
Specialty care	$23.42	$22.92	↓
Pharmacy	$52.27	$45.62	↓

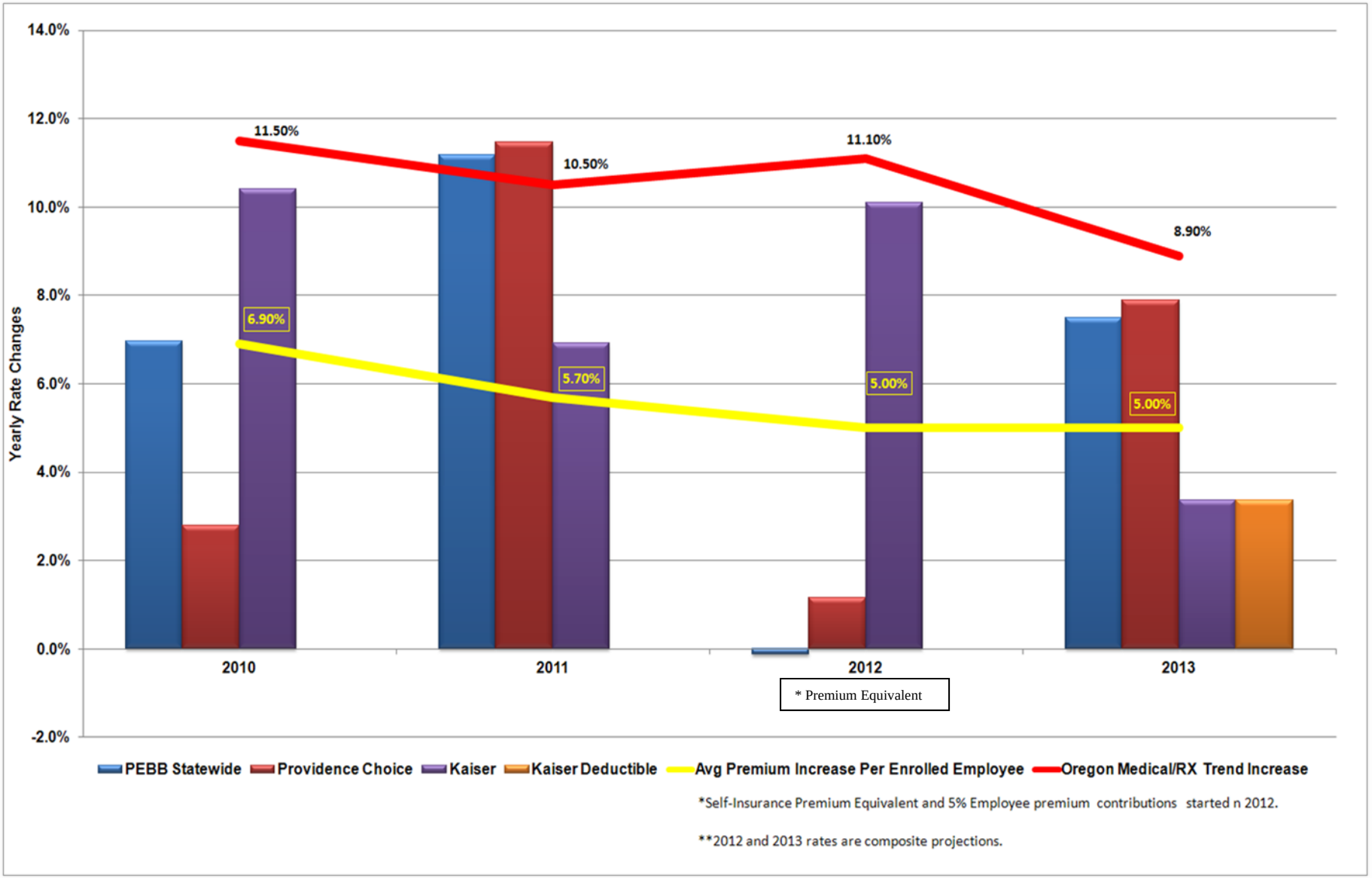
* all data is through 3rd quarter 2012 except pharmacy data which is through 4th qtr

Providence Choice Plan	Cost by Plan Year		
	2011	2012/Q3*	↓ / ↑
In patient facility	$80.37	$75.54	↓
In patient surgery prof	$5.22	$4.14	↓
Out Patient facility	$41.97	$40.58	↓
Out patient surgery prof fee	$15.68	$15.27	↓
Radiology	$22.14	$23.47	↑
Lab	$13.66	$13.88	↑
Primary care	$36.10	$37.11	↑
Specialty care	$23.42	$22.21	↓
Pharmacy	$39.03	$35.06	↓

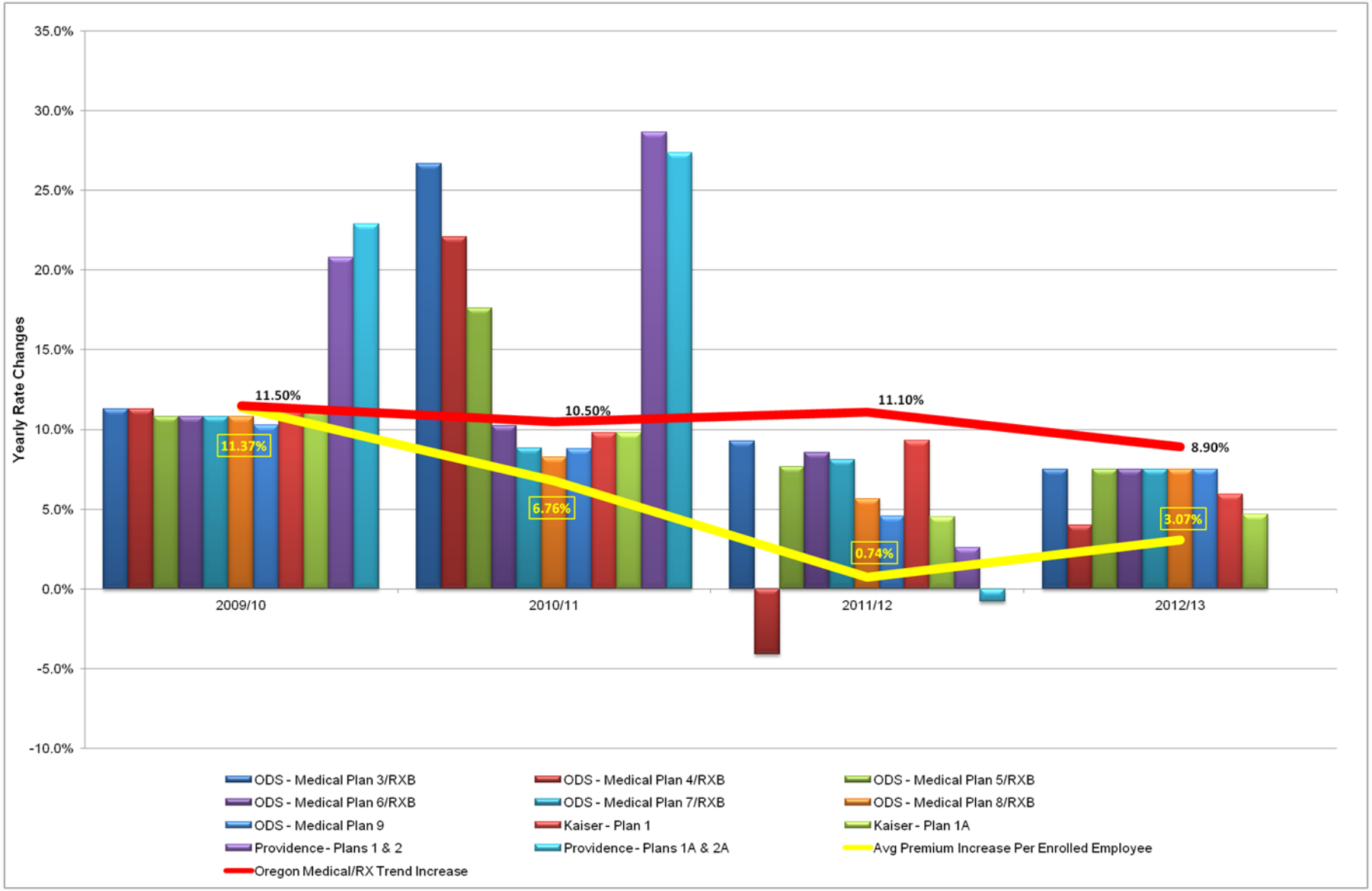
* all data is through 3rd quarter 2012 except pharmacy data which is through 4th qtr

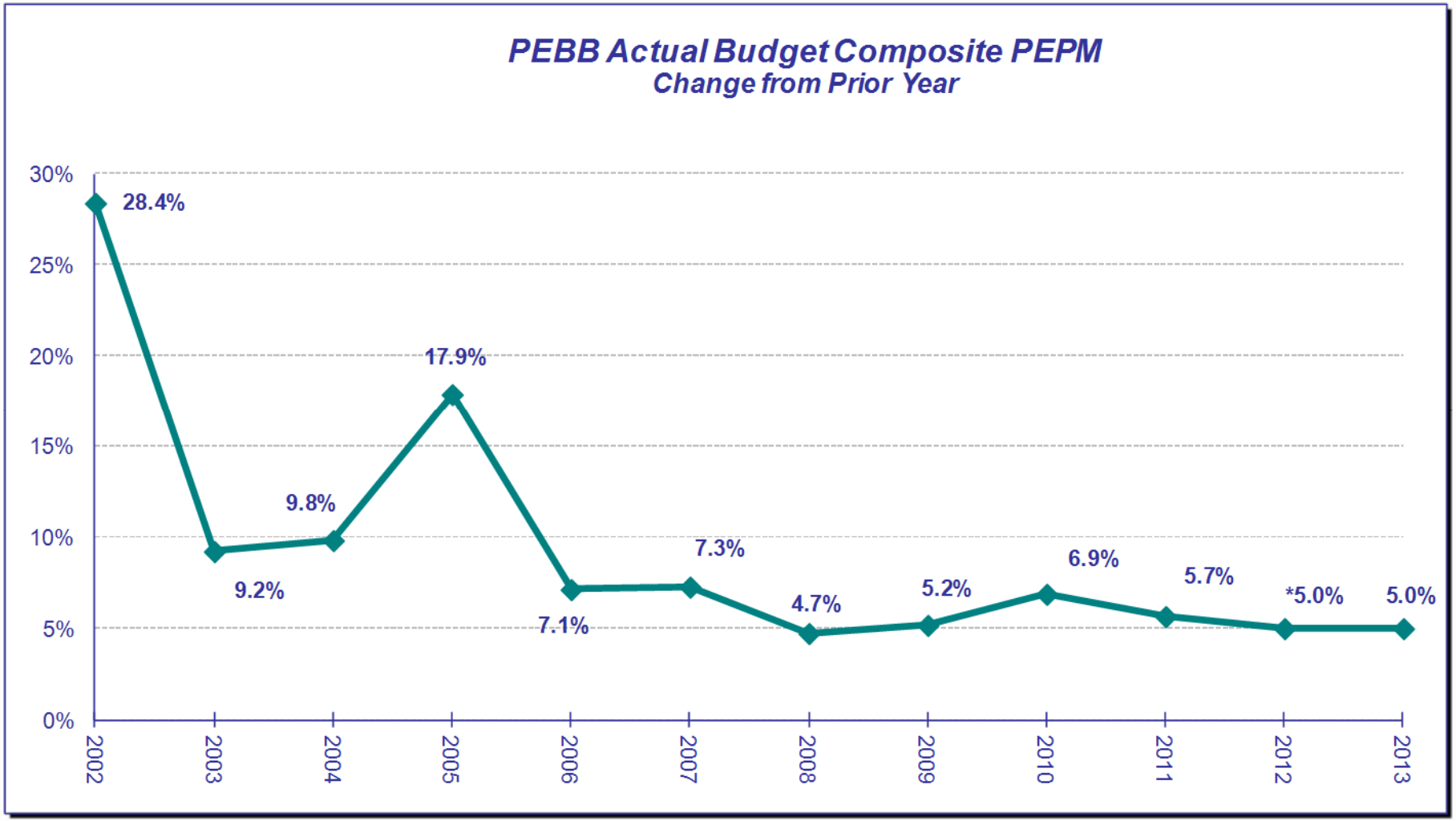
Oregon Health Authority

Public Employees' Benefit Board (PEBB) Medical/RX Premium Increases Relative to Trend



Oregon Educators Benefit Board (OEBB) Medical/RX Premium Increases Relative to Trend





*Self-Insurance Premium Equivalent and 5% Employee premium contributions started in 2012.

**2012 and 2013 rates are composite projections.

PUBLIC EMPLOYEES' PEBB BENEFIT BOARD

2013 Full Time Health Plans Comparisons

Full Time Medical Plans

(Available to both full time and part time PEBB-eligible employees)

This is a summary only. See plan documents for details.

	PEBB Statewide		Providence Choice		Kaiser HMO	Kaiser Deductible
Plan's service Area	Statewide and Nationwide		Clackamas, Clark, Curry, Deschutes, Jefferson, Lane, Linn-Benton, Marion-Polk, Multnomah, Washington and Yamhill counties		Zip codes in Benton, Clackamas, Clark, Columbia, Hood River, Linn, Marion, Multnomah, Polk, Washington and Yamhill counties	
Lifetime max	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Services	**In Network**	**Out of Network**	**In Medical Home[1]**	**Out of Medical Home[1]**	**Kaiser HMO**	**Kaiser HMO**
Standard plan deductible[2]	$250/individual $750/family Four primary care visits not subject	$500/individual $1500/family Four primary care visits not subject	$250/individual $750/family Four primary care visits not subject	$500/individual $1500/family Four primary care visits not subject	$0	$250/individual $750/family. Office visits, some services not subject
Added deductible for HEM Non-Participants[3]	$100/individual $300 family	$100/individual $300 family	$100/individual $300 family	$100/individual $300 family	$100/individual $300 family	$100/individual $300 family
Out-of-pocket max (deductibles, copays and some services don't apply)	$1500/individual $4500/family	$2500/individual $7500/family	$1500/individual $4500/family	$2500/individual $7500/family	$600/individual $1200/family	$1500/individual $4500/family
Primary care visit	15% or 10%[4]	30%	$5	30%	$5	$5
Chronic care visit[5]	0%	30%	$0	30%	$5	$5
Specialty care visit	15%	30%	$5	30%	$5	$5
Mental health care	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services	Cost as for physical health services
Maternity & childbirth provider services	15%	30%	$0	30%	$0/prenatal Delivery services included in inpatient hospital	$0/prenatal not subject to deductible Delivery services included in inpatient hospital.
Preventive	$0	30%	$0	30%	$0	$0
Lab & X-ray	15%	30%	$0	30%	$0	$15
Inpatient hospital	15%	30%	$50/day to $250	30%	$50/day up to $250 max/admission	$50/day to $250 max/admission after deductible
Emergency dept.[6]	15% + $100	15% + $100	$100	$100	$75	$75 after deductible
Durable medical equipment	15%	30%	15%	30%	$0	15%
Insulin and diabetic supplies	$0	$0	$0	$0	$0	$0
Additional Cost Tier diagnostics[7]	15% +$100	30% +$100	$100	30% +$100	$100 copay[8]	$100 copay
Additional Cost Tier procedures[9]	15% +$500	30%+$500	$500	30%+$500	Copay same as other conditions	Copay same as other conditions
Chiropractic, acupuncture, naturopathic	30% coinsurance. 60 visits/yr max		$10 copay; limited to lesser of $1000 or 60 visits/yr		$10 up to $1000/yr	$10 up to $1000/yr
Prescription Drugs	**In Network**	**Out of Network**	**In network**	**Out of Network**	**Kaiser HMO**	**Kaiser HMO**
	$50 deductible[10] $1000 out-of-pocket maximum[11] Retail: $0 Value (not subject to deductible)[12] $10 generic $30 preferred brand $100 specialty. Copay x 2.5 for 90-day	Urgent, emergent and out-of country. In-network deductible, out-of-pocket maximum apply. Reimbursed as if filled in network; member pays difference between network & billed amount	$50 deductible[10] $1000 out-of-pocket maximum[11] $0 Value (not subject to deductible)[12] $10 generic $30 preferred brand $100 specialty. Copay x 2.5 for 90-day	Urgent, emergent and out-of country. In-network deductible, out-of-pocket maximum apply. Reimbursed as if filled in network; member pays difference between network & billed amount	No deductible No out-of-pocket maximum $5 generic $25 brand Maintenance (31-90 day) $5 generic $25 brand	No deductible No out-of-pocket maximum $5 generic $25 brand Maintenance (31-90 day) $5 generic $25 brand 50% to $100 for exception-approved non-formulary

Full Time Medical Plans (cont.)

	PEBB Statewide		Providence Choice		Kaiser HMO	Kaiser Deductible
Vision	**VSP Provider**	**Non-VSP Provider**	**VSP Provider**	**Non-VPS Provider**	$5 exam copay. $200 hardware allowance max/24 months.	$5 exam copay. $200 hardware allowance max/24 months.
	Annual benefit $10 exam copay. $25 frame copay. $150 retail frame allowance. Single and lined bifocal and trifocal lenses covered in full. Progressive lenses available at 35-40% discount Or $200 allowance for contacts and contacts fitting/evaluation.	Annual benefit Exam reimbursement up To $50 after $10 copay. Frame reimbursement up to $70 after $25 copay. Reimbursement of $50 to $100 for single and lined bifocal and trifocal lenses. Or reimbursement up to $105 for contacts.	Annual benefit $10 exam copay. $25 frame copay. $150 retail frame allowance. Single and lined bifocal and trifocal lenses covered in full. Progressive lenses available at 35-40% discount. Or $200 allowance for contacts and contacts fitting/evaluation.	Annual benefit Exam reimbursement up To $50 after $10 copay. Frame reimbursement up to $70 after $25 copay. Reimbursement of $50 to $100 for single and lined bifocal and trifocal lenses. Or reimbursement up to $105 for contacts.		

[1] To receive Medical Home benefits, members must choose a medical home in the plan, notify Providence of their choice, and receive care through providers from that medical home (*In Medical Home*) or from providers referred by their medical home. Otherwise, benefits are *Out of Medical Home* with higher costs.

[2] All plans have a standard plan deductible. This is the amount a member must pay for covered services before the plan begins to pay its share for covered services. Deductibles apply per individual, based on the employee's choice of coverage tier. The maximum number of individuals in a family who must meet the deductible is three. Payments toward the deductible accumulate separately for services In Network and Out of Network, and In Medical Home and Out of Medical Home (see [1] above). These are not subject to the deductible: first four visits per individual to a primary care provider; insulin and diabetic supplies; in plan visits for care of asthma, diabetes, cardiovascular disease or congestive heart failure; and preventive services.

[3]The goal of the Health Engagement Model (HEM) program is to engage as many people as possible in improving their health, which can help to contain health care costs over time. A $100-per-person HEM Non-Participant deductible will be added to their plan's standard deductible for members who choose not to sign up for the HEM program or who sign up but don't participate by completing their health assessment by Oct. 1, 2012. This deductible works the same as the standard plan deductible, as described in [2] above.

[4] Members whose provider has been certified by the Oregon Health Authority as a Patient-Centered Primary Care Home will have the lower, 10% coinsurance.

[5] These are visits for care of asthma, diabetes, cardiovascular disease and congestive heart failure. Not subject to deductible.

[6] Copay and coinsurance amounts for a use of a hospital emergency department are waived if the member is admitted to the hospital for inpatient treatment. This does not include inpatient admittance for observation.

[7] These diagnostic procedures are MRI, CT, PET and SPECT scans; sleep studies; and upper endoscopy. These procedures may be overused compared with their risks and benefits. Additional copay does not apply to cancer-related procedures.

[8] Upper endoscopy is not on the Additional Cost Tier in Kaiser plans.

[9] These are surgical procedures for hip or knee replacement or resurfacing; knee or shoulder arthroscopy; bariatric surgery; spine procedures; and sinus surgery. Spine injections for pain are also on this tier, but with a $100 copay. Additional copay does not apply to cancer-related procedures. These procedures may have alternatives that provide equal or better outcomes with lower risks and costs.

[10] The prescription-drug deductible is $50 per person, with a family (three-person) maximum of $150. It applies separately from any other deductible and accumulates separately for prescriptions filled by In Network and Out of Network providers.

[11] The $1,000 out-of-pocket maximum for prescription drugs applies per person in the plan, with a family (three-person) maximum of $3,000.

[12] All plans have formularies that list covered drugs. Value drugs in Providence's formulary typically are generic drugs that are used in treating most common chronic conditions.

Full Time Dental Plans

(Available to both full time and part time PEBB-eligible employees)

Plan	**ODS Preferred[1]**		**ODS Traditional[1]**	**Willamette**	**Kaiser**
Provider	**In-Network**	**Out-of-Network**	**Participating**	**Willamette**	**Kaiser**
Annual maximum coverage	$1,750	$1,750	$1,750	None	$1,750
Deductible per person /family	$50/$150	$50/$150	$50/$150	None	None
Diagnostic, preventive	0%	10%	0%	$5	0%[2]
Basic, maintenance	20%	30%	20%	0%	20%
Crowns	50%	50%	50%	$190	25%
Implants	50%	50%	50%	Varies	50%
Dentures	50%	50%	50%	$190	50%
Orthodontia	50%	50%	50%	$1500[3]	50% to $1500

[1]You have higher savings in the Preferred plan than in the Traditional plan. Preferred plan dentists accept ODS-contracted fees as full payment for services, so you usually pay less for each visit and are protected from balance billing. Plus, your coinsurance for basic services drops from 20% to 10% to 0% over three years when you see a dentist in the Preferred plan at least once a year.

[2]Not applied to annual maximum coverage.

[3]Total out of pocket cost.

OREGON EDUCATORS BENEFIT BOARD 2012-13 PLAN YEAR
SUMMARY OF MEDICAL AND PHARMACY BENEFITS

	Med Plan 1	Med Plan 1A	Med Plan 3	Med Plan 4	Med Plan 5	Med Plan 6	Med Plan 7	Med Plan 8	Med Plan 9
Medical Plans	**Kaiser (HMO)**	**Kaiser (HMO)**	**ODS (PPO)**	**ODS (Community Care Plan)**	**ODS (PPO)**	**ODS (PPO)**	**ODS (PPO)**	**ODS (PPO)**	**ODS MAJOR MED (HSA-Compliant Plan)**
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Deductible									
In-Network (Individual / Family)	None / None	$150 / $450	$200 / $600	$300 / $900	$300 / $900	$400 / $1,200	$500 / $1,500	$1,000 / $3,000	$1,500 / $3,000***
Out-of-Network (Individual / Family)	None / None	See Plan Handbook for details	Combined In/Out-of-Network	Combined In/Out-of-Network	Combined In/Out-of-Network	Combined In/Out-of-Network	Combined In/Out-of-Network	Combined In/Out-of-Network	Combined In/Out-of-Network
Coinsurance									
In-Network	NA	20%	20%	20%	20%	20%	20%	20%	20%
Out-of-Network	NA	See Plan Handbook for details	50%	50%	50%	50%	50%	50%	50%
Maximum Out-of-Pocket costs per Plan Year									
In-Network (Individual / Family)	$1,200 / $2,400	$2,000 / $4,000	$1,500 / $4,500**	$2,000 / $6,000**	$2,000 / $6,000**	$2,100 / $6,300**	$2,200 / $6,600**	$2,200 / $6,600**	$5,000 / $10,000***
Out-of-Network (Individual / Family)	See Plan Handbook for details	See Plan Handbook for details	$3,000 / $9,000**	$4,000 / $12,000**	$4,000 / $12,000**	$4,200 / $12,600**	$4,400 / $13,200**	$4,400 / $13,200**	
The amount the Plan will pay after the Maximum Out-of-Pocket costs have been paid (except the Additional Cost Tier & Copayments still apply)‡	100%	100%	100%	100%	100%	100%	100%	100%	100%
Preventive Care Services (In-Network / Out-of-Network)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Adult, Well-child & Well-baby exams	$0 / NA	$0* / NA	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Immunizations (In-Network / Out-of-Network)	$0 / NA	$0* / NA	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Preventive Care Services as described in Plan Handbooks	$0 / NA	$0* / NA	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Provider Services (In-Network / Out-of-Network)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Incentive Office Visits for asthma, heart conditions (CHF, cholesterol & high BP) & diabetes management	NA	NA	$10* / 50%	$10* / 50%	$10* / 50%	20%* / 50%	20% / 50%	20% / 50%	20% / 50%
Primary Care Services as described in Plan Handbook	$15 / NA	$20* / NA	$25* / 50%	$25* / 50%	$25* / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Specialist Office Visits	$25 / NA	$30* / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Additional Cost Tier** as described in Plan Handbook	NA	NA	$500 + 20% / $500 +50%	$500 + 20% / $500 + 50%	$500 + 20% / $500 + 50%	$500 + 20% / $500 + 50%	$500 + 20% / $500 + 50%	$500 + 20% / $500 + 50%	20% / 50%
Other Services (In-Network / Out-of-Network)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Laboratory / X-Ray	$15 per visit / NA	$20* per visit / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Imaging (CT, PET & MRI) **	$15 / NA	$20* / NA	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	20% / 50%
Sleep Studies**	$15 / NA	$20* / NA	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	20% / 50%
Upper Endoscopies**	$75 / NA	20% / NA	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	$100 + 20% / $100 + 50%	20% / 50%
Durable Medical Equipment	20% / NA	20%* / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Hearing Aids ($4000 benefit every 48 months) as described in Plan Handbook	10% / NA	10%* / NA	10% / 50%	10% / 50%	10% / 50%	10% / 50%	10% / 50%	10% / 50%	20% / 50%
Maternity (In-Network / Out-of-Network)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Outpatient Maternity Care	$0 / NA	$0* / NA	$25* / 50%	$25* / 50%	$25* / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Delivery & Routine Newborn Nursery Care	$100 per day, up to $500 admission maximum / NA	20%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Mental Health & Chemical Dependency Services (In-Network / Out-of-Network)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Outpatient Services	$15 / NA	$20* / NA	$25* / 50%	$25* / 50%	$25* / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Inpatient Services	$100 per day, up to $500 per admission / NA	20% / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Residential Services	$100 per day, up to $500 per admission / NA	20% / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%

OREGON EDUCATORS BENEFIT BOARD 2012-13 PLAN YEAR
SUMMARY OF MEDICAL AND PHARMACY BENEFITS

	Med Plan 1	Med Plan 1A	Med Plan 3	Med Plan 4	Med Plan 5	Med Plan 6	Med Plan 7	Med Plan 8	Med Plan 9
Medical Plans	**Kaiser (HMO)**	**Kaiser (HMO)**	**ODS (PPO)**	**ODS (Community Care Plan)**	**ODS (PPO)**	**ODS (PPO)**	**ODS (PPO)**	**ODS (PPO)**	**ODS MAJOR MED (HSA-Compliant Plan)**
Weight Management (subscriber and covered dependents)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
12 Health Coaching Sessions per Plan Year & Online Educational Resources	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Bariatric Surgery** (subscribers only, not covered for dependents) See Plan Handbook for specific criteria.	$500 + Inpatient Care costs / NA	$500 + 20% / NA	$500 + 20% / NA	$500 + 20% / NA	$500 + 20% / NA	$500 + 20% / NA	$500 + 20% / NA	$500 + 20% / NA	$500‡ + 20% / NA
Hospital & Outpatient Services (In-Network / Out-of-Network)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Inpatient Care	$100 per day, up to $500 per admission / See Plan Handbook for details	20% / See Plan Handbook for details	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Outpatient Surgery	$75 / NA	20% / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Outpatient Rehabilitation (physical, occupational & speech therapy) - *maximum visits apply both In-Network and Out-of-Network*	$25 per visit (max 20 visits per therapy per Plan Year) / NA	$30 per visit* (max 20 visits per therapy per Plan Year) / NA	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)
Ambulance	$75	$100*	20%	20%	20%	20%	20%	20%	20%
Emergency Room Copay (waived if admitted unless noted otherwise)	$100 per visit	20% (not 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%	$100 per visit then 20%	20%
Urgent Care (In-Network / Out-of-Network)	**$ and % shown is the Member Cost; $ Amounts = Copayments**								
Urgent Care Visit	$35 / See Plan Handbook for details	$40* / See Plan Handbook for details	$50*	$50*	$50*	20%	20%	20%	20%
Tobacco Cessation Program (available to age 18 and over)									
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications	Unlimited calls to Alere Wellbeing (formerly Free & Clear, Inc.), maximum 5 calls from Alere Wellbeing per Plan Year. Patches, gum & prescribed medications are subject to Rx copays. See Plan Handbook for details.								
Alternative Care Services (In-Network/Out-of-Network)	**$2,000 Maximum Combined Benefit♦ $ and % shown is the Member Cost; $ Amounts = Copayment**		**ODS Copayments do not apply to Out-Of-Pocket Maximums**						
Acupuncture, Chiropractic & Naturopathic Services	$15 / NA	$20* / NA	$25* / 50%	$25* / 50%	$25* / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
♦ Cost of lab, x-rays, supplies & procedures performed in Alternative Care Provider's office applies to Benefit Maximum									
Pharmacy Services	**$ and % shown is the Member Cost; $ Amounts = Copayment**								
Out-of-Pocket Maximum (per person)	$1,100	$1,100	$1,100	$1,100	$1,100	$1,100	$1,100	$1,100	NA
Retail	(Up to a 30-day supply)	(Up to a 30-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)
Value	NA	NA	$4	$4	$4	$4	$4	$4	$4*†‡
Generic	$5	$5	$8	$8	$8	$8	$8	$8	20% / 50%
Preferred	$25	$25	$25	$25	$25	$25	$25	$25	20% / 50%
Non-preferred	$25 if criteria met	$25 if criteria met	50%	50%	50%	50%	50%	50%	20% / 50%
Mail	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)
Value	NA	NA	$8	$8	$8	$8	$8	$8	$8*†‡
Generic	$10	$10	$16	$16	$16	$16	$16	$16	20% / 50%
Preferred	$50	$50	$50	$50	$50	$50	$50	$50	20% / 50%
Non-preferred	$50 if criteria met	$50 if criteria met	50%	50%	50%	50%	50%	50%	20% / 50%
Specialty			(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)	
Generic	NA	NA	$16	$16	$16	$16	$16	$16	20% / 50%
Preferred	NA	NA	$50	$50	$50	$50	$50	$50	20% / 50%
Non-preferred	NA	NA	50%	50%	50%	50%	50%	50%	20% / 50%

NA = not applicable

*** Deductible Waived**

**** Additional Cost Tier copayments, $100 Imaging/Sleep Studies/Upper Endoscopies copayments, and $500 Bariatric Surgery copayments do not count toward Deductible or Out-of-Pocket Maximum on Plans 1 - 8.**

***** ODS Plan 9 individual Deductible and Out-of-Pocket Maximum apply to single coverage only. Family Deductible and Out-of-Pocket Maximum apply when two or more individuals are covered on the Plan. This Deductible must be met before benefits will be paid (except where * indicates Deductible Waived). On Plan 9, the Deductible applies toward the Out-of-Pocket Maximum.**

† In order to remain HSA compliant, certain conditions are not included in the Plan 9 value tier. See Plan Handbook for details.

‡ On Plan 9, after Out-of-Pocket Maximum has been met, fixed dollar copays no longer apply.

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.