Medical Plan 5
Oregon Educators Benefit Board

Plan Year: October 1 - September 30	In-Network Provider	Out-of-Network Provider [2]
	Member Responsibility	
Plan Year Deductible (Individual/Family)	$200/$600	
Plan Year Out-of-Pocket Maximum (Individual)	$1,800	$3,600
PREVENTIVE CARE		
Routine Physicals / Well Baby Care	0%*	40%
Routine Women's Exams / Men's Prostate Rectal Exam (PRE)	0%*	40%
Immunizations	0%*	40%
INCENTIVE SERVICES		
Office and Home Visits	$10 copay *[1]	40%
PROFESSIONAL SERVICES		
Office and Home Visits	$25 copay*[1]	40%
Specialist Visits	$25 copay*[1]	40%
Outpatient Rehabilitation (Physical, Occupational and Speech Therapy)	$25 copay*[1]	40%
MATERNITY CARE		
Physican, Practitioner and Midwife Services	20%	40%
Hospital and Birthing Center	20%	40%
OUTPATIENT AND HOSPITAL SERVICES		
Additional Cost Tier	$500 copay[1] + 20%	$500 copay[1] + 40%
Outpatient and Inpatient Hospital / Facility Care	20%	40%
Surgery	20%	40%
Skilled Nursing Facility Care (60 days per plan year)	20%	40%
Diagnostic X-Ray and Lab	20%	40%
Specified Imaging (MRI, CT, PET) and Sleep Studies	$100 copay[1] + 20%	$100 copay[1] + 40%
EMERGENCY CARE		
Ambulance Service	20%	
Emergency Room Visits (copay waived if admitted)	$100 copay[1] + 20%	
Urgent Care Visits	$25 copay*[1]	
OTHER COVERED SERVICES		
Allergy Injections	20%	40%
Durable Medical Equipment / Prosthetics	20%	40%
Home Health, Hospice, and Respite Care	20%	40%
ALTERNATIVE CARE (combined maximum benefit of $2,000 per plan year)		
Acupuncture, Chiropractic, and Naturopathic Office Visits	$25 copay*[1]	40%
All Other Services (e.g., labs, diagnostics, etc.)	20%	40%

*Deductible waived.

[1] Fixed dollar copayments and disallowed charges do not apply to the plan year deductible or to the out-of-pocket maximum. Expenses applied toward the plan year deductible do not apply to the out-of-pocket maximum.

[2] Out-of-network coverage copayments are based on the maximum plan allowance for those services.

MEMBER SERVICES

This is a benefit summary only. Any errors or omissions are unintentional.
For a more detailed description of benefits, refer to your member handbook.

Visit ODS' web site at www.odscompanies.com

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See back for additional information

Preventive Care includes:
Routine women's exams
Routine mammography
Immunizations
Well-baby exams
Periodic physical exam
Colorectal cancer screening

Incentive Services - for the management of:
Asthma
Heart conditions (including CHF)
Cholesterol
High blood pressure
Diabetes

The Additional Cost Tier applies to the following conditions:

- Outpatient upper endoscopy
- Spine surgery for pain
- Knee and hip replacement
- Arthroscopies (knee and shoulder)

SERVICE AREA

Illustrated in the ODS Provider Directory.

LIMITATIONS

* All medical and surgical inpatient hospital admissions and some outpatient procedures must be authorized by ODS.
* Mental illness / chemical dependency (including alcoholism) will be treated the same as other medical conditions except for mental health residential treatment that has a 60 day limit per plan year.
* When a member has more than one group plan, combined benefits for both group plans will be provided up to 100% of the total allowable charges.
* Inpatient rehabilitation benefits are limited to 30 days per plan year (prior authorization needed for up to 60 days for head and spinal cord injuries; outpatient rehabilitation benefits are limited to 30 sessions per plan year (prior authorization needed for u pto 60 sessions for head and spinal cord injuries).
* Transplant benefits are subject to specific limitations. Please reference your member handbook for details.
* Biofeedback therapy is limited to treatment of tension or migraine headaches. Plan will pay for no more than 10 visits.
* Hospice benefits are limited to $20,000 for home care; 12 days of inpatient care; Respite care is limited to 170 hours.
* Podiatry services: Paring/cutting of corns/calluses, trimming of dystrophic and non-dystrophic nails, debridement of nails by any method are not covered unless required by the patient's medical condition (e.g. diabetes).

EXCLUSIONS

* Services provided by the patient or a member of the patient's immediate family.
* Services or supplies which are not medically necessary.
* Services and supplies for reversal of sterilization or infertility.
* Services and supplies for obesity, including complications arising out of such treatment.
* Surgery to alter the refractive character of the eye.
* Dental examinations and treatment, except as specifically listed.
* Massage or massage therapy.
* Medical services or supplies for the treatment of sexual dysfunctions or inadequacies, except when delivered by a mental health provider as defined in this plan.
* Services or supplies related to sex change procedures.
* Services or supplies related to Gender Identity Disorders for members age 19 and over.
* Experimental or investigational treatment.
* Services or supplies available in whole, or in part under any city, county, state, or federal law, except Medicaid.
* Charges above the maximum plan allowance.
* Services or supplies for which an employer is required by law to provide benefits even if you choose not to accept those benefits.
* Instruction programs, including, but not limited to, those to learn to self-administer drugs or nutrition, except as specifically provided for under the outpatient diabetic instruction benefit of this plan.
* Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education.
* Cosmetic / reconstructive services and supplies (except for surgery related to breast reconstruction following a mastectomy in accordance with Women's Health and Cancer rights).
* Services and supplies associated with orthognathic surgery.

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