Medical Plan 9
Oregon Educators Benefit Board

Plan Year: October 1 - September 30	In-Network Provider	Out-of-Network Provider [2]
	Member Responsibility	
EMPLOYEE ONLY	Applies if employee is enrolling with no other family members.	
Plan Year Deductible (applies to out-of-pocket max)	$1,500	
Plan Year Out-of-Pocket Maximum	$5,000	
EMPLOYEE AND ONE OR MORE DEPENDENT(S)	Family deductible can be met by one or more family members. This deductible must be met before benefits will be paid.	
Plan Year Deductible (applies to out-of-pocket max)	$3,000	
Plan Year Out-of-Pocket Maximum	$10,000	
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	20%	40%
PROFESSIONAL SERVICES		
Office and Home Visits	20%	40%
Specialist Visits	20%	40%
Outpatient Rehabilitation (Physical, Occupational and Speech Therapy)	20%	40%
MATERNITY CARE		
Physican, Practitioner and Midwife Services	20%	40%
Hospital and Birthing Center	20%	40%
OUTPATIENT AND HOSPITAL SERVICES		
Additional Cost Tier	20%	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	20%	40%
EMERGENCY CARE		
Ambulance Service	20%	
Emergency Room Visits	20%	
Urgent Care Visits	20%	
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	20%	40%
All Other Services (e.g., labs, diagnostics, etc.)	20%	40%
PRESCRIPTION DRUG COVERAGE		
Covered under major medical benefits	30%	

*Deductible waived.

[1] Fixed dollar copayments and disallowed charges do not apply to the plan year deductible or 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.

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Visit ODS' web site at www.odscompanies.com

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
* Services and supplies associated with orthognathic surgery.

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