



**Medical Plan 3**  
**Oregon Educators Benefit Board**

Effective October 1, 2011

Plan Year: October 1 - September 30	In-Network Provider	Out-of-Network Provider <sup>2</sup>
<b>Member Responsibility</b>		
Plan Year Deductible: Individual	\$200	
Family	\$600	
Plan Year Out-of-Pocket Maximum: Individual	\$1,500	\$3,000
Family	\$4,500	\$9,000
<b>PREVENTIVE CARE</b>		
Routine Physicals / Well Baby Care	0%*	50%
Routine Women's Exams, Men's Prostate Rectal Exam (PRE), Annual Obesity Screening	0%*	50%
Routine Immunizations	0%*	50%
<b>INCENTIVE SERVICES<sup>3</sup></b>		
Office and Home Visits	\$10 copay * <sup>1</sup>	50%
<b>PROFESSIONAL SERVICES</b>		
Office and Home Visits: Primary Care and Maternity	\$25 copay* <sup>1</sup>	50%
Specialist and Hospital Visits	20%	50%
Outpatient Mental Health and Chemical Dependency	\$25 copay* <sup>1</sup>	50%
Outpatient Rehabilitation (30 visits per plan year/60 for head spinal cord injury)	20%	50%
<b>MATERNITY CARE</b>		
Physician, or Midwife Services and Hospital Stay	20%	50%
<b>OUTPATIENT AND HOSPITAL SERVICES</b>		
Outpatient and Inpatient Hospital / Facility Care	20%	50%
Skilled Nursing Facility Care (60 days per plan year)	20%	50%
Surgery	20%	50%
Specified Imaging (MRI, CT, PET), and Sleep Studies	\$100 copay <sup>1</sup> + 20%	\$100 copay <sup>1</sup> + 50%
Outpatient Upper Endoscopy and Spinal Injections	\$100 copay <sup>1</sup> + 20%	\$100 copay <sup>1</sup> + 50%
Additional Cost Tier <sup>3</sup>	\$500 copay <sup>1</sup> + 20%	\$500 copay <sup>1</sup> + 50%
<b>EMERGENCY CARE</b>		
Urgent Care Visits	\$50 copay* <sup>1</sup>	
Emergency Room Visits (copay waived if admitted)	\$100 copay <sup>1</sup> + 20%	
Ambulance Service	20%	
<b>OTHER COVERED SERVICES</b>		
Hearing Aids (\$4,000 max/48 months) <sup>4</sup>	10%	50%
Allergy Injections	20%	50%
Diagnostic X-Ray and Lab	20%	50%
Durable Medical Equipment / Prosthetics	20%	50%
<b>ALTERNATIVE CARE (combined maximum benefit of \$2,000 per plan year)</b>		
Acupuncture, Chiropractic, and Naturopathic Visits	\$25 copay* <sup>1</sup>	50%
All Other Services (e.g., labs, diagnostics, etc.)	20%	50%

\*Deductible waived.

<sup>1</sup> 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.

<sup>2</sup> Out-of-network coverage copayments are based on the maximum plan allowance for those services.

<sup>3</sup> See reverse for a list of incentive services and Additional Cost Tier procedures.

<sup>4</sup> Hearing aid coverage is subject to a 48-month maximum that is adjusted annually as required by Oregon statute.

**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.odskompanies.com/oebb](http://www.odskompanies.com/oebb)**

See back for additional information

INCENTIVE SERVICES	ADDITIONAL COST TIER
<ul style="list-style-type: none"> <li>* Asthma</li> <li>* Heart Conditions (including CHF)</li> <li>* Cholesterol</li> <li>* High Blood Pressure</li> <li>* Diabetes</li> </ul>	<ul style="list-style-type: none"> <li>* Spine Surgery</li> <li>* Knee Replacement</li> <li>* Hip Replacement</li> <li>* Knee Arthroscopy</li> <li>* Shoulder Arthroscopy</li> </ul>

**NETWORK INFORMATION**

Members may choose a provider from the network directory, which is available at [www.odscompanies.com/oebb](http://www.odscompanies.com/oebb) under "Find Care" or by contacting ODS' Medical Customer Service Department for assistance.

**DEPENDENT ELIGIBILITY**

Dependents are lawful spouse, Oregon registered domestic partners and eligible children to age 26, including children an employee is required to enroll due to a court or administrative order. Additional information on dependent eligibility can be found at [www.oregon.gov/OHA/OEBB/DEVReq.shtml](http://www.oregon.gov/OHA/OEBB/DEVReq.shtml)

**OUT-OF-AREA CHILDREN COVERAGE**

Enrolled children residing outside the service area may receive the in-network benefit level by using a travel network provider. If a travel network provider is not available, plan benefits will be extended to such enrolled dependents residing outside the primary service area for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by in-network providers. Services will be paid at the in-network benefit level, subject to maximum plan allowance, if provided within a 30-mile radius of the dependent child's residence or at the closest appropriate facility.

**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.
- \* All x-ray and lab work relating to Acupuncture/Chiropractic/Naturopathic services are subject to the \$2,000 plan year benefit maximum.
- \* 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 up to 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.
- \* 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, except for those rated A or B by the U.S. Preventive Services Taskforce.
- \* 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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