ODS

OREGON EDUCATORS OEBB BENEFIT BOARD

Medical Plan 4: Community Care Plan
Oregon Educators Benefit Board

Effective October 1, 2012

Plan Year: October 1 - September 30		In-Network Provider	Out-of-Network Provider [2]
		Member Responsibility	
Plan Year Deductible:	Individual	$300	
	Family	$900	
Plan Year Out-of-Pocket Maximum:	Individual	$2,000	$4,000
	Family	$6,000	$12,000
PREVENTIVE CARE			
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%
INCENTIVE SERVICES[3]			
Office and Home Visits		$10 copay *[1]	50%
PROFESSIONAL SERVICES			
Office and Home Visits: Primary Care and Maternity		$25 copay*[1]	50%
Specialist and Hospital Visits		20%	50%
Outpatient Mental Health and Chemical Dependency		$25 copay*[1]	50%
Outpatient Rehabilitation (30 visits per plan year/60 for head spinal cord injury)		20%	50%
MATERNITY CARE			
Physician, or Midwife Services and Hospital Stay		20%	50%
OUTPATIENT AND HOSPITAL SERVICES			
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[1] + 20%	$100 copay[1] + 50%
Outpatient Upper Endoscopy and Spinal Injections		$100 copay[1] + 20%	$100 copay[1] + 50%
Gastric Bypass Surgery (Roux-en-Y)[5]		$500 copay[1] + 20%	N/A
Additional Cost Tier[3]		$500 copay[1] + 20%	$500 copay[1] + 50%
EMERGENCY CARE			
Urgent Care Visits		$50 copay*[1]	
Emergency Room Visits (copay waived if admitted)		$100 copay[1] + 20%	
Ambulance Service		20%	
OTHER COVERED SERVICES			
Hearing Aids ($4,000 max/48 months)[4]		10%	50%
Allergy Injections		20%	50%
Diagnostic X-Ray and Lab		20%	50%
Durable Medical Equipment / Prosthetics		20%	50%
ALTERNATIVE CARE (combined maximum benefit of $2,000 per plan year)			
Acupuncture, Chiropractic, and Naturopathic Visits		$25 copay*[1]	50%
All Other Services (e.g., labs, diagnostics, etc.)		20%	50%

*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.

[3] See reverse for a list of incentive services and Additional Cost Tier procedures.

[4] Hearing aid coverage is subject to a 48-month maximum. The amount is adjusted annually for children as required by Oregon statute.

[5] Subscriber only coverage. Pre-surgery requirements must be met, and services performed at a Center of Excellence.

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

Visit ODS' web site at www.odscompanies.com/oebb

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See back for additional information

INCENTIVE SERVICES	ADDITIONAL COST TIER
* Asthma	* Spine Surgery
* Heart Conditions (including CHF)	* Knee Replacement
* Cholesterol	* Hip Replacement
* High Blood Pressure	* Knee Arthroscopy
* Diabetes	* Shoulder Arthroscopy

NETWORK INFORMATION

Members who live or work in the Community Care Network Service area may choose to enroll in this plan. A provider can be chosen from the Community Care Network directory, which is available at www.odscompanies.com/oebb under "Find Care" or by contacting ODS' Medical Customer Service Department.

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 eligibiltiy can be found at 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.
* 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.

www.odscompanies.com/oebb

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