This plan sponsored by:

OREGON SCHOOL BOARDS ASSOCIATION

Oregon School Boards Association Medical Plan A-100

This chart is a brief summary of your benefits under this plan. Your benefit booklet will give you a more complete description of your plan. A copy of this is available from your school district's group administrator. A special feature of your coverage is its "hold harmless" clause. Basically, this clause guarantees you that participating providers (available on our web site) will not charge you beyond the fee upon which we base our payment. Of course, any applicable deductible and coinsurance will continue to apply. Providers who are not participating, however, may bill you for any balances over our payment level. All services and supplies described below must be medically necessary and all payments are based on eligible charges for such services and supplies.

Benefit Features	
Lifetime maximum benefit	$2,000,000
Individual deductible per calendar year (separate from prescription medications)	$100
Maximum family deductible per calendar year	$300
We pay 80% of covered expenses up to this amount after the deductible	$5,000
Your maximum medical out-of-pocket per person per calendar year (20% coinsurance) including deductible	$1,100
Your family maximum medical out-of-pocket (2 times individual medical out-of-pocket + family maximum deductible)	$2,300
After your maximum medical out-of-pocket is met each calendar year, we pay	100%

Please note: Covered expenses paid at 100% and copayments do not accumulate towards your maximum out-of-pocket. Copayments will continue to be collected after your maximum out-of-pocket has been reached.

Preventive Care Services[1]	**Deductible Waived - We Pay**
Well-baby care to age 2	100%
Immunizations all ages	100%
Routine physical exams including related lab and X-ray (up to $500 per calendar year)	100%
Annual women's exams including Pap and mammogram	100%
Professional Services	**After Deductible - We Pay**
Office visits	80%
Lab and X-ray services	80%
Allergy shots and other therapeutic injections	80%
Outpatient Mental Illness/Chemical Dependency[1]	80%
Maternity care	80%
Surgery	80%
Hospital Services	
Inpatient hospital stay including rehabilitation or mental illness/chemical dependency[1]	80%
Maternity hospital stay	80%
Intensive Care Unit	80%
Outpatient day surgery	80%
Emergency room care for medical emergency (copayment waived if admitted)	80% after $100 copayment
Other Services	
Ambulance	80%
Additional accident (deductible waived for 90 days from injury date)	80%
Rehabilitation including Occupational, Speech, and Physical Therapy[1]	80%
Outpatient Durable Medical Equipment and Supplies	80%

Prescription Medications – Retail and Mail Order[1]	**No Deductible**
Generic Medications	$10 Copay (retail) / $30 Copay (mail order)
Preferred Brand Medications	80% (retail and mail order)
Non-Preferred Brand Medications	50% (retail and mail order)
Individual prescription medication out-of-pocket limit per calendar year	$1,000 (separate from medical)
After your maximum out-of-pocket is met each calendar year, we pay	100%

[1]Limits may apply, please refer to the **Limitations And Exclusions** on page 2.

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Limitations and Exclusions

This is a benefit summary only. For a complete list of benefits and the limitations and exclusions that apply to them, please refer to the benefits booklet.

Preventive Care Schedule	
Well-baby Care	
Newborn	Nursery care, including initial exam
First two years	7 well-baby exams
Immunizations (Not covered for travel or passport purposes)	
All ages	As recommended by provider
Physical Exams (up to $500 per calendar year)	
Age 2-6	Every year
Age 7-18	Every 2 years
Age 19-34	Every 4 years
Age 35+	Every 2 years
Women's Exams	
Annual breast & pelvic	Every year
Mammograms	
Age 35-40	Once during this time
Age 40+	Every year

These Pharmacy Benefits Are Limited

- The maximum quantity for pharmacy purchased medications is 34-day supply at retail pharmacy, 90-day supply through mail order. Some medications may be limited by quantity rather than day supply.
- Some medications may require preauthorization by the health plan.
- Compound medications are only covered when one ingredient is a federal legend or state restricted medication.

These Pharmacy Benefits are Not Covered

- Oral and injectable impotence medications, infertility medications, and experimental/investigational medications.
- Medications prescribed for cosmetic purposes (including, but not limited to Retin-A for anyone over 25 years of age, Renova, Lamisil, Sporanox, and topical minoxidil).

These Medical Benefits Are Limited

- We provide transplant coverage only to those who have been covered by us, or another insurer with similar transplant coverage, for a total of at least 12 months (or since birth), providing there is no lapse between the two coverages. Benefits are based on the recipient's eligibility, not the donor's.
- Inpatient rehabilitation benefits are limited to 30 inpatient days per calendar year. Inpatient rehabilitation benefits for head and spinal cord injuries or stroke are increased to 60 inpatient days per calendar year.
- Outpatient rehabilitation benefits are limited to 30 sessions per calendar year. Benefits are increased to 60 sessions per calendar year, for head and spinal cord injuries or stroke. Physical exercise programs are not included.
- Skilled Nursing Facility care is limited to 14 days. If authorized by the health plan, the benefit may be increased to 100 days.
- Home health care is limited to 180 visits per calendar year.
- Dental care is limited to the treatment of an accidental injury to natural teeth or a fractured jaw. Diagnoses must be made within 6 months and treatment within 12 months after the injury.

Mental Illness and Chemical Dependency Schedule*		
Mental Illness Treatment Setting	**Adults**	**Children Up to 18**
Inpatient Care	15 Days	16 Days
Residential/partial-hospitalization	17 Days	20 Days
Outpatient Care	34 Visits	34 Visits
Chemical Dependency Treatment Setting	**Adults**	**Children Up to 18**
Inpatient Care	13 Days	27 Days
Residential/partial-hospitalization	19 Days	26 Days
Outpatient Care	25 Visits	36 Visits

*Per 24 consecutive calendar months and subject to limitations designated under state and federal law.

These Medical Benefits Are Not Covered

- Services provided by a member of the patient's immediate family.
- Charges in excess of the amount allowed according to the terms of the contract.
- Services or supplies that are not medically necessary.
- Naturopathy, faith healing services, and homeopathy, even when provided by participating providers.
- Services related to or supporting infertility, reversal of sterilization procedures, and impotence medications.
- Orthognathic surgery.
- Custodial care, personal hygiene, and other forms of supervised self-care.
- Services and supplies provided for obesity or weight reduction, including complications arising from such treatment.
- Chronic or long-term psychotherapy (defined as services provided in excess of crisis intervention or short-term therapy).
- Services or supplies for the treatment of personality disorders, paraphilia, or other gender identity disorders.
- Cosmetic/reconstructive services and supplies, including complications arising from such services, except for breast reconstruction following a mastectomy necessary due to illness or injury.
- Treatment(s), procedures, equipment, medications, devices, and supplies that are experimental or investigational.
- Appliances or equipment primarily for personal comfort or convenience, and therapeutic devices including eyeglasses and hearing aids.
- Services and supplies available in whole or in part under any city, county, state, or federal law.
- Routine physical, mental, eye, hearing examinations or eye exercises (except where specifically listed).
- Surgery to alter the refractive character of the eye.
- Self-help training or instructional programs (except where specifically listed).

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Toll-free, all areas 1 (800) 228-0978
TDD Line for people with hearing impairments 1 (800) 382-1003
www.or.regence.com