

Oregon School Boards Association

Preferred Provider Plan



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	Preferred Provider Benefit	Non-Preferred Provider Benefit
Lifetime maximum benefit	\$2,000,000	
Individual deductible per calendar year (separate from prescription medications)	\$100	\$200
Maximum family deductible per calendar year	\$300	\$600
We pay 90% or 70% of covered expenses up to this amount after the deductible	\$5,000	
Your maximum medical out-of-pocket per person per calendar year (10% or 30% coinsurance) including deductible	\$600	\$1,700
After your maximum medical out-of-pocket is met each calendar year, we pay	100% after applicable copayment	
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 Services¹	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	90%	70%
Lab and X-ray services	90%	70%
Allergy shots and other therapeutic injections	90%	70%
Outpatient mental illness/chemical dependency ¹	90%	70%
Maternity care	90%	70%
Surgery	90%	70%
Hospital Services		
Inpatient hospital stay including rehabilitation or mental illness/chemical dependency ¹	90%	70%
Maternity hospital stay	90%	70%
Intensive Care Unit	90%	70%
Outpatient day surgery	90%	70%
Emergency room care (copayment waived if admitted)	90% after \$100 copay	70% after \$100 copay
Other Services		
Ambulance	80%	
Rehabilitation including Occupational, Speech, and Physical Therapy ¹	80%	
Additional accident (deductible waived for 90 days from injury date)	90%	70%
Outpatient Durable Medical Equipment and Supplies	90%	70%
Dental Services (Maximum \$1,500 per calendar year)		
Preventive services (no deductible)	100%	
Restorative services	80%	
Major services	50%	
Prescription Medications – Retail and Mail Order¹	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%	

¹Limits 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 Medical Benefits Are Limited

- Residential care treatment for mental health conditions is limited to 45 days per calendar year per enrollee.
- Mental health treatment for parent-child relational problems, neglect or abuse of child, and bereavement is limited to children five years of age or younger.
- 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.

These Dental Benefits Are Limited

- When there is more than one method treatment for a dental condition, we may limit payment to the treatment method with the lesser charge.
- Periodontal scaling and root planing are limited to once every 24 months, per quadrant.
- Replacement of an existing denture or crown is covered only when five or more years have passed since the date of the most recent placement.

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 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.
- Mental health treatment for conditions and diagnosis that describe relational problems, problems related to abuse or neglect or other issues that may be the focus of assessment or treatment. This would include, but is not limited to, such issues as occupational or academic problems.
- Services and supplies (including medications) for or in connection with sexual dysfunction regardless of cause, except for counseling services provided by covered, licensed mental health practitioners.
- Treatment, surgery, or counseling services for sexual reassignment.
- Mental health treatment for paraphilia for all ages.
- 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).

These Dental Benefits are Not Covered

- Services that are not necessary dental care.
- Temporary dentures.
- Appliances or restorations used for periodontal splinting, to increase vertical dimensions, restore the occlusion (bite), or correct habits such as tongue thrusting.
- Orthodontic services, except extractions for orthodontic purpose.
- Cosmetic dental services including complications arising out of such services.
- Local anesthesia charged separately with fillings.
- General anesthesia, except when necessary for complex oral surgery or due to the existence of a concurrent medical condition.
- Treatment(s), procedures, equipment, medications, devices, and supplies that are experimental or investigational even when provided by foreign providers.
- Temporomandibular (jaw joint) and related problems.
- Replacement of teeth missing when this coverage begins.
- Implants and attachment devices.



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