

**OREGON EDUCATORS BENEFIT BOARD 2011-12 PLAN YEAR
SUMMARY OF MEDICAL AND PHARMACY BENEFITS**

	Med Plan 1	Med Plan 1A	Med Plan 2	Med Plan 2A	Med Plan 3	Med Plan 4	Med Plan 5	Med Plan 6	Med Plan 7	Med Plan 8	Med Plan 9
Medical Plans	Kaiser (HMO)	Kaiser (HMO)	Providence (POS)	Providence (POS)	ODS (PPO)	ODS (Limited Network)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS MAJOR MED (HSA-Compliant Plan)
Lifetime Maximum	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited	Unlimited
Deductible											
In-Network (Individual / Family)	None / None	\$100 / \$300	\$100 / \$300	\$300 / \$900	\$200 / \$600	\$300 / \$900	\$300 / \$900	\$400 / \$1,200	\$500 / \$1,500	\$1,000 / \$3,000	\$1,500 / \$3,000***
Out-of-Network (Individual / Family)	None / None	See EOC for details	Combined In/Out-of-Network								
Coinsurance											
In-Network	NA	20%	20%	20%	20%	20%	20%	20%	20%	20%	20%
Out-of-Network	NA	See EOC for details	50%	50%	50%	50%	50%	50%	50%	50%	50%
Maximum Out-of-Pocket costs per Plan Year											
In-Network (Individual / Family)	\$1,200 / \$2,400	\$2,000 / \$4,000	\$1,200 / \$3,600**	\$2,000 / \$6,000**	\$1,500 / \$4,500**	\$2,000 / \$6,000**	\$2,000 / \$6,000**	\$2,100 / \$6,300**	\$2,200 / \$6,600**	\$2,200 / \$6,600**	\$5,000 / \$10,000***
Out-of-Network (Individual / Family)	See EOC for details	See EOC for details	\$2,400 / \$7,200**	\$4,000 / \$12,000**	\$3,000 / \$9,000**	\$4,000 / \$12,000**	\$4,000 / \$12,000**	\$4,200 / \$12,600**	\$4,400 / \$13,200**	\$4,400 / \$13,200**	
The amount the Plan will pay after the Maximum Out-of-Pocket costs have been paid (except the Additional Cost Tier & Copayments still apply)	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%
Preventive Care Services (In-Network / Out-of-Network)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Adult, Well-child & Well-baby exams	\$0 / NA	\$0* / NA	\$0* / 50%	\$0* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Immunizations (In-Network / Out-of-Network)	\$0 / NA	\$0* / NA	\$0* / 50%	\$0* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Preventive Care Services as described in Plan Handbooks	\$0 / NA	\$0* / NA	\$0* / 50%	\$0* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%	0%* / 50%
Provider Services (In-Network / Out-of-Network)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Incentive Office Visits for asthma, heart conditions (CHF, cholesterol & high BP) & diabetes management	NA	NA	\$10* / 50%	\$10* / 50%	\$10* / 50%	\$10* / 50%	\$10* / 50%	\$10* / 50%	20%* / 50%	20% / 50%	20% / 50%
Primary Care Services as described in Plan Handbook	\$15 / NA	\$20* / NA	\$15* / 50%	\$25* / 50%	\$25* / 50%	\$25* / 50%	\$25* / 50%	\$25* / 50%	20% / 50%	20% / 50%	20% / 50%
Specialist Office Visits	\$25 / NA	\$30* / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Additional Cost Tier**	NA	NA	\$500 + 20% / \$500 + 50%	\$500 + 20% / \$500 + 50%	\$500 + 20% / \$500 + 50%	\$500 + 20% / \$500 + 50%	\$500 + 20% / \$500 + 50%	\$500 + 20% / \$500 + 50%	\$500 + 20% / \$500 + 50%	\$500 + 20% / \$500 + 50%	20% / 50%
Other Services (In-Network / Out-of-Network)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Laboratory / X-Ray	\$15 per visit / NA	\$20* per visit / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Imaging (CT, PET & MRI) **	\$15 / NA	\$20* / NA	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	20% / 50%
Sleep Studies**	\$15 / NA	\$20* / NA	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	20% / 50%
Upper Endoscopies**	\$75 / NA	20% / NA	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	\$100 + 20% / \$100 + 50%	20% / 50%
Durable Medical Equipment	20% / NA	20%* / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Hearing Aids (\$4000 maximum every 48 months)	10% / NA	10%* / NA	10% / 50%	10% / 50%	10% / 50%	10% / 50%	10% / 50%	10% / 50%	10% / 50%	10% / 50%	20% / 50%
Maternity (In-Network / Out-of-Network)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Outpatient Maternity Care	\$0 / NA	\$0* / NA	20% / 50%	20% / 50%	\$25* / 50%	\$25* / 50%	\$25* / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Delivery & Routine Newborn Nursery Care	\$100 per day, up to \$500 admission maximum / NA	20%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Mental Health & Chemical Dependency Services (In-Network / Out-of-Network)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Outpatient Services	\$15 / NA	\$20* / NA	\$15* / 50%	\$25* / 50%	\$25* / 50%	\$25* / 50%	\$25* / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Inpatient Services	\$100 per day, up to \$500 per admission / NA	20% / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Residential Services	\$100 per day, up to \$500 per admission / NA	20% / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Weight Loss Management (subscriber and covered dependents)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Up to four 13-week Weight Watchers Sessions per Plan Year (age restrictions may apply)	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
12 Health Coaching Sessions per Plan Year & Online Educational Resources	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge	No Charge
Hospital & Outpatient Services (In-Network / Out-of-Network)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Inpatient Care	\$100 per day, up to \$500 admission / See EOC for details	20% / See EOC for details	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Outpatient Surgery	\$75 / NA	20% / NA	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
Outpatient Rehabilitation (physical, occupational & speech therapy) - maximum visits apply both In-Network and Out-of-Network	\$25 per visit (max 20 visits per therapy per Plan Year) / NA	\$30 per visit* (max 20 visits per therapy per Plan Year) / NA	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)	20% / 50% (max 30 visits per Plan Year)
Ambulance	\$75	\$100*	20%	20%	20%	20%	20%	20%	20%	20%	20%
Emergency Room Copay (waived if admitted unless noted otherwise)	\$100 per visit	20% (not waived if admitted)	\$100 + 20% per visit	\$100 + 20% per visit	\$100 per visit then 20%	20%					
Urgent Care (In-Network / Out-of-Network)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Urgent Care Visit	\$35 / See EOC for details	\$40* / See EOC for details	\$50*	\$50*	\$50*	\$50*	\$50*	20%	20%	20%	20%
Tobacco Cessation Program (available to age 18 and over)	\$ and % shown is the Member Cost; \$ Amounts = Copayments										
Telephone Consults, Web-Coaching, Patches, Gum & Prescribed Medications	Unlimited calls to Free & Clear, maximum 5 calls from Free and Clear per Plan Year. Patches, gum & prescribed medications are subject to Rx copays. See Plan Handbook for details.										

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Medical Plans	Kaiser (HMO)	Kaiser (HMO)	Providence (POS)	Providence (POS)	ODS (PPO)	ODS (Limited Network)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS (PPO)	ODS MAJOR MED (HSA-Compliant Plan)
Alternative Care Services (In-Network/Out-of-Network)	\$2,000 Maximum Combined Benefit* \$ and % shown is the Member Cost; \$ Amounts = Copayment					ODS Copayments do not apply to Out-Of-Pocket Maximums					
Acupuncture, Chiropractic & Naturopathic Services	\$15 / NA	\$20* / NA	\$15* / NA	\$25* / NA	\$25* / 50%	\$25* / 50%	\$25* / 50%	20% / 50%	20% / 50%	20% / 50%	20% / 50%
♦ Cost of lab, x-rays, supplies & procedures performed in Alternative Care Provider's office applies to Benefit Maximum											
Pharmacy Services	\$ and % shown is the Member Cost; \$ Amounts = Copayment					ODS Rx Benefit: ODS Rx Plans can be combined with any of the above Medical Plans (3 - 8) which will result in a different premium for that Plan.					
	Kaiser Rx Plan		Providence Rx Plan		ODS Rx Option A	ODS Rx Option B	ODS Rx Option C				
Out-of-Pocket Maximum (per person)	\$1,100		\$1,100		\$1,100	\$1,100	\$1,100				
Retail	(Up to a 30-day supply)		(Up to a 31-day supply)		(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)				
Value	NA		\$4		\$4	\$4	\$4				
Generic	\$5		\$8		\$8	\$8	50%				
Preferred	\$25		\$25		20%	\$25	50%				
Non-preferred	\$25 if criteria met		50%		50%	50%	50%				
Mail	(Up to a 90-day supply)		(Up to a 90-day supply)		(Up to a 90-day supply)	(Up to a 90-day supply)	(Up to a 90-day supply)				
Value	NA		\$8		\$8	\$8	\$8				
Generic	\$10		\$16		\$16	\$16	50%				
Preferred	\$50		\$50		20%	\$50	50%				
Non-preferred	\$50 if criteria met		50%		50%	50%	50%				
Specialty	(Up to a 30-day supply)		(Up to a 30-day supply)		(Up to a 31-day supply)	(Up to a 31-day supply)	(Up to a 31-day supply)				
Generic	NA		\$8		\$16	\$16	50%				
Preferred	NA		\$25		20%	\$50	50%				
Non-preferred	NA		50%		50%	50%	50%				

EOC = Evidence of Coverage

* Deductible Waived

** Additional Cost Tier copayments and \$100 Imaging/Sleep Studies/Upper Endoscopies copayments do not count toward Deductible or Out-of-Pocket Maximum.

*** ODS Plan 9 individual Deductible and Out-of-Pocket applies for Member only. Family applies for Plan with two or more members. This Deductible must be met before benefits will be paid.

This document is for comparison purposes only and is not intended to fully describe the benefits of each Plan. Refer to your member handbook for more details of benefit coverage. In the case of a conflict between this comparison and your member handbook, the member handbook will prevail.