Medford SCHOOL DISTRICT

Regence

Effective 10/1/2022-9/30/2023	$800 PPO		$1,200 PPO		Plan $1,600 without HSA		Plan $1,600 with HSA	
Medical - Administered by Regence BlueCross BlueShield of Oregon								
Benefit Category	**Preferred Providers**	**Out-of-Network Providers**	**Preferred Providers**	**Out-of-Network Providers**	**Preferred Providers**	**Out-of-Network Providers**	**Preferred Providers**	**Out-of-Network Providers**
Annual Deductible								
Individual	$800	$1,600	$1,200	$2,400	$1,600	$3,200	$1,600*	$3,200
Family	$2,400	$4,800	$3,600	$7,200	$3,200	$6,400	$3,200*	$6,400
Annual Out-of-Pocket Maximum	*Includes deductible, coinsurance & medical & pharmacy copayments*		*Includes deductible, coinsurance & medical & pharmacy copayments*		*Includes deductible, coinsurance & medical & pharmacy coinsurance*		*Includes deductible, coinsurance & medical & pharmacy coinsurance*	
Individual	$4,000	$8,000	$5,000	$10,000	$6,550	$13,100	$6,550**	$13,100***
Family	$12,000	$24,000	$13,700	$27,400	$13,100	$26,200	$13,100	$26,200
Preventive Care- *according to ACA guidelines*	no cost	50% (deductible Waived)	no cost	50% (deductible Waived)	no cost	50% (deductible Waived)	no cost	50% (deductible Waived)
Physician Office Visit *including outpatient mental health substance and naturopath visits*	20%	50%	20%	50%	20%	50%	20%	50%
In/Outpatient Facility including mental health	20%	50%	20%	50%	20%	50%	20%	50%
Home Health Care: *180 visits per benefit year*	20%	50%	20%	50%	20%	50%	20%	50%
Hospice: *limited to 183 days per lifetime*	20%	50%	20%	50%	20%	50%	20%	50%
In/Outpatient Professional including mental health	20%	50%	20%	50%	20%	50%	20%	50%
Lab/X-Ray	20%	50%	20%	50%	20%	50%	20%	50%
Complex Imaging - *CT, PET Scans, MRIs etc.*	$100 copay then 20% coinsurance after deductible	$100 copay then 50% coinsurance after deductible	$100 copay then 20% coinsurance after deductible	$100 copay then 50% coinsurance after deductible	20%	50%	20%	50%
Ambulance - Ground & Air	20%		20%		20%		20%	
Emergency Room	$100 copay then 20% coinsurance after deductible		$100 copay then 20% coinsurance after deductible		20% after deductible		20% after deductible	
Rehabliltave Care including: **Physical Therapy** **Speech Therapy** **Occupational Therapy** **Massage Therapy** *30 combined Outpatient visits shared with Neurodevelopmental therapy. Inpatient limited to 30 days per benefit year up to 60 days for head & spinal cord injuries*	20%	50%	20%	50%	20%	50%	20%	50%
Alternative Care(Spinal manipulations & Acupuncture): *limited to 25 visits per service, per benefit year*	20%	50%	20%	50%	20%	50%	20%	50%
Skilled Nursing Facilities: *limited to 60 days per benefit year*	20%	50%	20%	50%	20%	50%	20%	50%
Telehealth MD Live	10%	No Benefit	10%	No Benefit	10%	No Benefit	10%	No Benefit
Durable Medical Equipment	20%	50%	20%	50%	20%	50%	20%	50%
Prescription Drug (Rx) A1								
Generic Rx	$15 copay for 30-day retail supply $30 copay for 90-day supply at mail order		$15 copay for 30-day retail supply $30 copay for 90-day supply at mail order		$15 copay for 30-day retail supply $30 copay for 90-day supply at mail order		20% after annual deductible	
Brand-Formulary Rx *(as defined by Prime Therapeutics)*	$30 copay for 30-day retail supply $60 copay for 90-day supply at mail order		$30 copay for 30-day retail supply $60 copay for 90-day supply at mail order		$30 copay for 30-day retail supply $60 copay for 90-day supply at mail order		20% after annual deductible	
Non-Brand Formulary Rx *(as defined by Prime Therapeutics)*	$50 copay for 30-day supply $100 copay for 90-day supply at mail order		$50 copay for 30-day supply $100 copay for 90-day supply at mail order		$50 copay for 30-day supply $100 copay for 90-day supply at mail order		20% after annual deductible	
Specialty medication *(as defined by Prime Therapeutics)*	20% coinsurance to a maximum of $80 per fill		20% coinsurance to a maximum of $80 per fill		20% coinsurance to a maximum of $80 per fill		20% after annual deductible	

% = co-insurance (amount you pay)

* If enrolled as a single, the deductible is $1,600. If enrolled in any other tier, then the family deductible of $3,200 must be met before plan pays. This can be met by a combination of family

** Embedded out-of-pocket max of $6,550 per family member. If one family member reaches the Individual OOPM, their claims will pay at 100%.

*** Embedded out-of-pocket max of $13,100 per family member. If one family member reaches the Individual OOPM, their claims will pay at 100%.

For more in-depth benefits please contact customer service or review your SPD