



**PPO Copay Deductible Plan
PPO500_10E1**

Standard PPO Plan	In-Network Provider	Out-of-Network Provider ²
Annual Deductible (Individual / Family)	\$500 Individual / \$1,500 Family	
Annual Out-of-Pocket Maximum (Individual / Family)	\$3,500 Individual / \$10,500 Family	\$10,500 Individual / \$31,500 Family
PREVENTIVE CARE		
Routine Physicals / Well Baby Care	No co-pay*	Not covered
Routine Women's Exams / Men's Prostate Rectal Exam (PRE)	No co-pay*	50%
Immunizations	No co-pay*	Not covered
PROFESSIONAL SERVICES		
Office and Home Visits	\$30 co-pay* ¹	50%
Surgery	20%	50%
Acupuncture	\$30 co-pay* ¹ (\$1,500 Annual Maximum)	
Chiropractic		
Naturopathic		
MATERNITY CARE		
Practitioner Services	\$200 co-pay* ³	50%
Hospital Stay	20%	50%
HOSPITAL INPATIENT / OUTPATIENT SERVICES		
Inpatient Care	20%	50%
Skilled Nursing Facility Care	20%	50%
Outpatient Hospital / Facility	20%	50%
Outpatient Diagnostic X-Ray and Lab	20%*	50%
Specified Imaging (MRI, CT, CAT, PET scans)	20%	50%
EMERGENCY CARE		
Emergency Room Visits	\$100 co-pay* ¹	
Urgent Care Visits	\$30 co-pay* ¹	50%
Ambulance Service (\$5,000 annual max)	20%	
OTHER COVERED SERVICES		
Physical Therapy	\$30 co-pay* ¹	50%
Allergy Injections	20%	50%
Durable Medical Equipment / Prosthetics	20%	50%
Home Health, Hospice, and Respite Care	20%	50%

*Deductible waived.

¹ Fixed dollar co-pays, prescription drug co-pays, and disallowed charges do not apply to the annual deductible or to the out-of-pocket maximum. Expenses applied toward the annual deductible do not apply to the out-of-pocket maximum.

² Out-of-network coverage co-payments are based on the maximum plan allowance for those services.

³ \$200 maternity co-pay does not apply to the annual deductible, but does apply to the out-of-pocket maximum.

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SERVICE AREA

Illustrated in the ODS Provider Directory.

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.

OUT-OF-AREA DEPENDENT CHILDREN COVERAGE

If your enrolled dependent child(ren) resides outside the service area, we will extend benefits for treatment of an illness or injury, and preventive healthcare and maternity services, as if care were rendered by an in-network physician or provider. Out-of-area dependents must access benefits within a 30 mile radius of their residence, in order for the in-network benefit level to apply.

LIMITATIONS

* Pre-existing conditions for members age 19 and older even if they worsen or reoccur.

Note: *Your plan's six month pre-existing exclusion period will be shortened one day for each day you had "creditable coverage" under another health plan, provided you do not have a 63 day lapse (or longer) in coverage immediately prior to your enrollment date in our plan, or, if earlier, the first day of the waiting period for such enrollment.*

* All medical and surgical admissions must be authorized by ODS.

* Mental illness / chemical dependency (including alcoholism) will be treated the same as other medical conditions except for mental health residential treatment that has a 45-day limit per calendar year.

* When a member has more than one group plan, combined benefits for both group plans will be provided up to, but not exceeding, the maximum plan allowance for all covered services.

* Inpatient rehabilitation benefits are limited to 30 days per calendar year (prior authorization needed for up to 60 days for head and spinal cord injuries); outpatient rehabilitation benefits are limited to 30 sessions per calendar year (prior authorization needed for up to 60 sessions for head and spinal cord injuries).

* Transplant benefits are limited to an aggregate annual maximum benefit of \$750,000.

* Hospice benefits are limited to \$20,000 for home care; 12 days of inpatient care; Respite care is limited to 170 hours.

EXCLUSIONS

* Services provided by members or their relatives. Relatives, for the purpose of this exclusion, include a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.

* 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.

* 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 Gender Identity Disorders, for members age nineteen and older.

* Services or supplies related to sex change procedures or sexual dysfunction unless delivered by a mental health provider.

* 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.

* Services and supplies associated with orthognathic surgery.

This is a benefit summary only.

For a complete description of benefits, limitations and exclusions refer to your member handbook.

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