



Beneficial Value 1000

Standard PPO Plan	In-Network Provider	Out-of-Network Provider
Member Responsibility		
Plan Year Deductible, individual (family deductible is 3x the individual)	\$1,000	
Out-of-Pocket Maximum, per person (after deductible)	\$5,000	\$10,000
PREVENTIVE CARE		
Annual women's exam - pap, pelvic, breast	\$25*	50%
Women's routine mammogram	\$25*	50%
Well-baby care	\$25*	Not covered
Routine physical exams	\$25*	Not covered
Immunizations	\$0*	Not covered
PROFESSIONAL SERVICES		
Office Visits	First 3 at \$25**	50%
Alternative Care (\$1,000 per plan year limit) Chiropractic, Naturopathic, and Acupuncture	First 3 at \$25**	50%
FACILITY AND ANCILLARY SERVICES		
Hospital - Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	30%	50%
Maternity - All pre/post office visits and doctor delivery; hospital charges	30%	50%
Mental Health (\$2,500 maximum in a 12-month period) Inpatient, outpatient, residential combined	30%	50%
Lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	30%	50%
EMERGENCY SERVICES		
Urgent care	First 3 at \$25**	50%
Emergency room (deductible applies)	30% after \$100 copay	
Ambulance	30%	
OTHER BENEFITS		
Prescription services	Optional***	
Lifetime maximum	\$2,000,000 (\$250,000 out-of-network)	
Accident benefit	Deductible waived for treatment completed within 90 days of accident; \$10,000 per person per year maximum	

* Deductible waived.

** Beneficial plans pay first three office visits with a copayment, which may be used for either office visits or urgent care for illness or injury. Alternative care includes an additional three visits with a copayment. Thereafter, the deductible and coinsurance apply for additional office visits and alternative care.

*** Can purchase a prescription rider separately; benefit is \$15 generic or 50% brand, \$2,000 maximum benefit; deductible waived

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SERVICE AREA

Illustrated in the ODS Provider Directory.

DEPENDENT ELIGIBILITY

Dependents are a lawful spouse or partner pursuant to the Oregon Family Fairness Act and eligible children to age 26.

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, women's routine healthcare (or preventive healthcare if available in the plan) and maternity services as if care were rendered by a participating physician or provider. Out-of-area dependents must access benefits within a 30-mile radius of their residence in order for the PPO benefit level to apply.

LIMITATIONS

Six-month exclusion period applies to the following:

- * Myringotomy with tubes
- * Removal of tonsils or adenoids
- * Allergies
- * Sterilization
- * Elective procedures (procedures that can be reasonably postponed for the exclusion period)
- * Pre-existing conditions 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 paid up to a \$2,500 maximum or 20 outpatient visits in a 12-month period for inpatient/outpatient/residential services, combined.
- * Alcohol treatment up to a \$4,500 maximum in a 24-month period for inpatient/outpatient/residential services combined.
- * A 24-month exclusion period for transplants.
- * ODS will not pay benefits for covered expenses to the extent that you have any other coverage for those expenses.
- * Inpatient rehabilitation benefits are limited to 30 days per plan year; outpatient rehabilitation benefits are limited to 30 sessions per plan year. Prior authorization is needed for up to 60 days inpatient, or 60 sessions outpatient, rehabilitation for head and spinal cord injuries.
- * Transplant benefits are limited to an aggregate lifetime maximum benefit of \$250,000.
- * Hospice benefits are limited to \$20,000 for home care; 12 days of inpatient care; 170 hours/three months respite care.

EXCLUSIONS

- * Services provided by the patient or a member of the patient's immediate family.
- * 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.**
- * Services or supplies for the treatment of sexual dysfunction or inadequacy, or those related to sex change procedures.
- * Treatment of personality disorders
- * 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.
- * Drugs for treatment of mental illness
- * Chemical dependency treatment, except for alcohol treatment

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This is a benefit summary only. For a complete description of benefits, limitations and exclusions refer to your member handbook.