



**HSA 3000**

<b>Standard HSA Plan</b>	<b>In-Network Provider</b>	<b>Out-of-Network Provider</b>
Plan Year Deductible	\$3,000 (Individual) / \$6,000 (Family)	
Plan Year Out-of-Pocket Maximum for Services Other Than Preventive Care	\$0	No Maximum
Plan Year Out-of-Pocket Maximum for Preventive Care Services Only	\$2,000 (Individual) / \$4,000 (Family)	No Maximum
<b>PREVENTIVE CARE</b>		
Annual women's exam - pap, pelvic, breast	50%*	50%
Women's routine mammogram	50%*	50%
Well-baby care	50%*	50%
Routine physical exams	50%*	50%
Immunizations	50%*	50%
<b>PROFESSIONAL SERVICES</b>		
Office Visits	0%	50%
Alternative Care (\$1,000 per plan year limit) Chiropractic, Naturopathic, and Acupuncture	0%	50%
<b>FACILITY AND ANCILLARY SERVICES</b>		
Hospital - Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	0%	50%
Maternity - All pre/post office visits and doctor delivery; hospital charges	0%	50%
Mental Health (\$2,500 maximum in a 12-month period) Inpatient, outpatient, residential combined	0%	50%
Lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	0%	50%
<b>EMERGENCY SERVICES</b>		
Urgent care	0%	50%
Emergency room (deductible applies)	0%	
Ambulance (\$5,000 per plan year limit)	0%	
<b>OTHER BENEFITS</b>		
Prescription services	0%	
Lifetime maximum	\$2,000,000 (\$250,000 out-of-network)	
Accident benefit	Paid as any other illness subject to deductible/coinsurance	

\* 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.**