



AK HSA 1200

| Standard HSA Plan | In-Network Provider | Out-of-Network Provider ² |
|--|--|--------------------------------------|
| EMPLOYEE ONLY | Applies only if employee is enrolling in plan with no other family members. | |
| Annual Deductible | \$1,200** ¹ | |
| Annual Out-of-Pocket Maximum | \$3,800** ¹ | No Maximum** ² |
| EMPLOYEE ONLY W/ ONE OR MORE DEPENDENT(S) | Applies to employees enrolling in plan with 1 or more dependents. Family deductible can be met by 1 or more family members. The family deductible is an aggregate deductible and must be met before benefits will be paid. | |
| Annual Deductible | \$2,400** ¹ | |
| Annual Out-of-Pocket Maximum | \$7,600** ¹ | No Maximum** ² |
| PREVENTIVE CARE | | |
| Routine Physicals / Well Baby Care | 20%* | 40% |
| Routine Women's Exams / Men's Rectal Exam (PRE) | 20%* | 40% |
| Immunizations | 20%* | 40% |
| PROFESSIONAL SERVICES | | |
| Office and Home Visits | 20% | 40% |
| Surgery | 20% | 40% |
| Acupuncture | 20% | |
| Chiropractic | (\$2,000 Annual Maximum) | |
| Naturopathic | | |
| MATERNITY CARE | | |
| Practitioner Services | 20% | 40% |
| Hospital Stay | 20% | 40% |
| HOSPITAL INPATIENT / OUTPATIENT SERVICES | | |
| Inpatient Care | 20% | 40% |
| Skilled Nursing Facility Care | 20% | 40% |
| Outpatient Hospital/Facility | 20% | 40% |
| Diagnostic X-Ray and Lab | 20% | 40% |
| Specified Imaging (MRI, CT, CAT, PET scans) | 20% | 40% |
| HOSPITAL INPATIENT / OUTPATIENT SERVICES | | |
| Emergency Room Visits | 20% | 40% |
| Urgent Care Visits | 20% | 40% |
| Ambulance Service | 20% | |
| OTHER COVERED SERVICES | | |
| Physical Therapy | 20% | 40% |
| Allergy Injections | 20% | 40% |
| Durable Medical Equipment | 20% | 40% |
| Home Health, Hospice, and Respite Care | 20% | 40% |
| PRESCRIPTION DRUG (Show your ODS ID card to access discounts at participating pharmacies.) | 20% | |
| MAXIMUM LIFETIME BENEFIT | \$2,000,000 (\$250,000 can be accessed out-of-network) | |

*Deductible waived.

** Separate in and out of network out of pocket maximums.

¹ Expenses applied toward the annual deductible do not apply to the out-of-pocket maximum. Expenses for transplants performed at out-of-network transplant facilities 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. All hospital and professional services, except out-of-network hospital services, provided in the state of Alaska will be paid at the in-network benefit level, subject to the in-network deductible and accrue toward the in-network out-of-pocket maximum. There are exceptions when in-network hospitals are not accessible. Please see the details in the member handbook.

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SERVICE AREA

Illustrated in the ODS Alaska Provider Directory.

DEPENDENT ELIGIBILITY

Dependents are lawful spouse and unmarried children to age 25, including children an employee is required to enroll due to a court or administrative order.

OUT-OF-STATE AND OUT-OF-AREA DEPENDENT CHILDREN COVERAGE

If your enrolled dependent child(ren) resides outside of Alaska and outside of the ODS network 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 a participating physician or provider. Out-of-state and out-of-area dependents must access benefits within a 50 mile radius of their residence, in order for the in-network benefit level to apply.

LIMITATIONS

* Pre-existing conditions even if they worsen or reoccur.

Note: *Your plan's 12 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 90 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) paid up to state mandated limits.
- * 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 lifetime maximum benefit of \$250,000.
- * Hospice benefits are limited to \$20,000 for home care; 12 days of inpatient care; Respite care is limited to 170 hours.
- * If you receive outpatient supplies, appliances and durable medical equipment from out-of-network physicians or providers in states outside of Alaska or from out-of-network hospitals in Alaska, these services will be reimbursed at the out-of-network rate.

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
- * Appliances or equipment primarily for comfort, convenience, cosmetics, environmental control, or education.
- * Cosmetic / reconstructive services and supplies.
- * Services and supplies associated with orthognathic surgery.

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

"Subject to approval of the health benefit plans by the Alaska insurance division."