



Standard PPO Plan	In-Network	Out-of-Network ²
Annual Deductible (Individual/Family)	\$5,000 Individual / \$15,000 Family ¹	
Annual Out-of-Pocket Maximum (Individual/Family) <i>Includes deductible</i>	\$7,500 Individual / \$22,500 Family** ¹	No Maximum**
Essential Benefit Annual Maximum (Medical & Rx)	\$2,000,000	
IN-NETWORK SERVICES IN ALASKA		
<i>EVERY licensed professional provider in Alaska is covered at the In-Network benefit level.</i>		
<i>In-network copay or coinsurance and 50% out-of-network coinsurance applies to MOST services outside Alaska.</i>		
PREVENTIVE CARE	In-Network	
Periodic Health Exams	No copay*	
Routine Women's Exams (including pap test, pelvic exam, breast exam & mammogram)	No copay*	
Immunizations	No copay*	
PROFESSIONAL SERVICES		
Office and Home Visits	\$25 copay* ¹	
Surgery	30%	
Acupuncture	\$25 copay* ¹ (\$2,000 Annual Maximum)	
Chiropractic		
Naturopathic		
EMERGENCY CARE		
Emergency Room Visits	\$100 copay* ¹	
Urgent Care Visits	\$50 copay* ¹	
Ambulance Service	30%	
OTHER COVERED SERVICES		
Physical Therapy	\$25 copay* ¹	
Allergy Injections	30%	
Durable Medical Equipment	30%	
Home Health, Hospice, and Respite Care	30%	
IN-NETWORK & OUT-OF-NETWORK SERVICES IN ALASKA		
	In-Network	Out-of-Network ²
HOSPITAL INPATIENT / OUTPATIENT SERVICES		
Inpatient Care (<i>Includes Maternity Care</i>)	30%	50%
Skilled Nursing Facility Care	30%	50%
Outpatient Hospital/Facility	30%	50%
Diagnostic X-Ray and Lab	30%*	50%
Specified Imaging (MRI, CT, CAT, PET scans)	30%	50%

*Deductible waived.

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

¹ Copayments (including prescription drug copays), out-of-pocket expenses from an out-of-network transplant facility and disallowed charges do not apply to the annual deductible or to the out-of-pocket maximum. Expenses applied toward the annual deductible do apply to the out-of-pocket maximum.

² Out-of-Network coverage coinsurance are based on the maximum plan allowance for those services. In Alaska, hospital and professional services, except out-of-network hospitals located within 50 miles of an in-network hospital, 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.

SERVICE AREA

Visit www.odsalaska.com to search for ODS providers.

DEPENDENT ELIGIBILITY

Dependents are lawful spouse and eligible children to age 26, including children an employee is required to enroll due to a court or administrative order.

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

If your enrolled child(ren) resides outside of Alaska and outside of 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-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. Benefits are covered up the maximum plan allowance and do not apply to the out-of-pocket maximum.

LIMITATIONS

* Pre-existing conditions for members age 19 or older 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 Alaska.
- * The plan has a calendar year maximum of \$2,000,000 on all essential benefits. In-network and out-of-network benefits for such covered expenses accrue toward the calendar year maximum for each member. Once the maximum is met, coverage for all essential benefits will cease until the next calendar year. Essential benefits include the following categories: ambulatory services; emergency services; hospitalization including skilled nursing facility; maternity and newborn care; mental health and chemical dependency service; prescription drugs including prescribed drugs administered in a professional provider's office, urgent care center, facility or in conjunction with home health care; covered rehabilitative and habilitative services and devices; hospice care; laboratory tests; covered preventive and wellness services and chronic disease management; pediatric services including oral and vision care, if any.
- * Mental health benefits are limited to 6 days inpatient stay per calendar year (2 days of residential, day treatment, or partial hospitalization equals one inpatient day). Outpatient mental health benefits are limited to 12 visits per calendar year.
- * Chemical dependency benefits (including alcoholism) are limited to 2 days of inpatient detoxification; 12 residential days; 5 day treatments/partial hospitalization; and up to 24 outpatient visits/tests (per calendar year).
- * When a member has other health coverage, group or individual, combined benefits for this plan and the other 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. Donor costs are limited to a \$25,000 per transplant maximum.

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, except for those rated A or B by the U.S. Preventive Services Task Force.
- * 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, except when covered under mandated cancer clinical trials.
- * 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.

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