Beneficial PPO Plan
BEN7500_11A1

Beneficial PPO Plan	**In-Network Provider**	**Out-of-Network Provider [1]**
Annual Deductible (Individual / Family)	$7,500 Individual / $22,500 Family	
Annual Out-of-Pocket Maximum (Individual / Family)	$5,000 / $15,000	$15,000 / $45,000
Essential Benefit Annual Maximum *(Medical & Rx)*	$2,000,000	
PREVENTIVE CARE		
Periodic Health Exams	No copay*	Not covered
Routine Women's Exams (including pap test, pelvic exam & breast exam)	No copay*	50%
Immunizations	No copay*	Not covered
PROFESSIONAL SERVICES		
Office, Home & Urgent Care Visits	$25 copay*[2][3]	50%
Surgery	30%	50%
Acupuncture	$25 copay*[2] ($1,500 Annual Maximum)	
Chiropractic		
Naturopathic		
MATERNITY		
Practitioner Services	30%	50%
Hospital Stay	30%	50%
HOSPITAL INPATIENT / OUTPATIENT SERVICES		
Inpatient Care	30%	50%
Skilled Nursing Facility Care	30%	50%
Outpatient Hospital/Facility	30%	50%
Outpatient Diagnostic X-Ray and Lab	30%	50%
Specified Imaging (MRI, CT, CAT, PET scans)	30%	50%
EMERGENCY CARE		
Emergency Room Visits	30%	
Ambulance Service ($5,000 annual maximum)	30%	
OTHER COVERED SERVICES		
Physical Therapy	30%	50%
Allergy Injections	30%	50%
Durable Medical Equipment/Prosthetics	30%	50%
Home Health, Hospice, and Respite Care	30%	50%

* Deductible waived.

[1] Out-of-network coverage coinsurance is based on the maximum plan allowance for these services.

[2] Copayments 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.

[3] Deductible waived for the first five medical office, home, or urgent care visits per calendar year. First five in-network visits do not include services for physical therapy, occupational therapy, or speech therapy. Subsequent home, office and urgent care visits are subject to the deductible, then coinsurance applies.

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NETWORK INFORMATION

Members may choose a provider from the network directory, which is available at www.odscompanies.com under “Find Care” or by contacting ODS’ Medical Customer Service Department for assistance.

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 CHILDREN COVERAGE

Enrolled children residing outside the service area may receive the in-network benefit level by using a travel network provider. If a travel network provider is not available, plan benefits will be extended to such enrolled dependents residing outside the primary service area for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by in-network providers. Services will be paid at the in-network benefit level if provided within a 30-mile radius of the dependent child's residence or at the closest appropriate facility.

LIMITATIONS

* 6-month exclusion period for 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.
* 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 accrues 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 those 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; home health; laboratory tests; home, office and hospital visits; covered preventive and wellness services and chronic disease management; pediatric services including oral and vision care, if any.
* Mental illness / chemical dependency (including alcoholism) will be treated the same as other medical conditions.
* 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 for up to 60 days for head and spinal cord injuries); outpatient rehabilitation benefits are limited to 30 sessions per calendar year (prior authorization for up to 60 sessions for head and spinal cord injuries). Medically necessary outpatient services for mental health and chemical dependency are not subject to these limits.
* Transplant benefits are limited to an aggregate lifetime maximum benefit of $250,000. Donor costs are limited to a $25,000 per transplant maximum.
* Hospice benefits are limited to 12 days of inpatient care and 170 hours of 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, except for those rated A or B by the U.S. Preventive Services Taskforce.
* 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 related to sex change procedures or 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.
* 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. Exceptions are provided for reconstructive surgery following a mastectomy.
* 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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