



**Evidence Based Value Plan
Preferred Provider Organization (PPO)**

DEDUCTIBLE & OUT OF POCKET MAXIMUM <i>(Deductible & Out of Pocket Maximums are separate for in and out of network benefits)</i>	Member Responsibility	
	In-Network Provider	Out-of-Network Provider ¹
Calendar Year Deductible: Individual Family	\$2,000 \$6,000	\$6,000 \$18,000
Calendar Year Out of Pocket Maximum: Individual Family	\$3,000 \$9,000	No Maximum
Essential Benefit Annual Maximum <i>(Medical & Rx)</i>	\$2,000,000	
CHRONIC & PREVENTIVE CARE MANAGEMENT		
Health Maintenance Testing Limited to the Following: -Cholesterol LDL-C (one per calendar year) -Diabetes HbA1C (one per calendar year) - Glucose Test -Urine Microalbumin (one per calendar year) - Kidney Function Urine Test	No copay *	40%
Imaging/Ancillary Limited to the Following: -Ejection Fraction Echocardiogram - Heart Scan -Spirometry Test (two per calendar year) - Lung Breathing Test	No copay *	40%
Immunizations	No copay*	40%
Routine Physicals / Well Baby Care	No copay *	40%
Routine Women's Exams / Men's Prostate Rectal Exam	No copay *	40%
PROFESSIONAL SERVICES		
Office and Home Visits	\$25 copay**	40%
Urgent Care Visits	\$25 copay**	40%
Physical / Speech / Occupational Therapy	\$25 copay**	40%
Acupuncture / Chiropractic / Naturopathic (\$1,500 Annual Maximum)	\$25 copay**	40%
MINIMALLY INVASIVE PROCEDURES (MIP) <i>Procedures listed below (surgical or otherwise) that are less invasive than open surgery used for the same purpose.</i>		
Laparoscopic Colectomy (colon removal)	20%	40%
Laparoscopic or Vaginal Hysterectomy (uterus removal)	20%	40%
Laparoscopic Gastric Fundoplication or Hiatal Hernia repair (repair for gastric reflux disease/heartburn)	20%	40%
Outpatient Laparoscopic Cholecystectomy (gall bladder removal)	20%	40%
Non-Emergent Laparoscopic Appendectomy (appendix removal)	20%	40%

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INPATIENT / OUTPATIENT SERVICES	In-Network Provider	Out-of-Network Provider ¹
Inpatient Hospital Care	30%	40%
Hospital Visits by Practitioner	30%	40%
Skilled Nursing Facility Care	30%	40%
Outpatient Hospital / Facility	30%	40%
Surgery (excludes minimally invasive surgeries)	30%	40%
Diagnostic X-Ray and Lab	30%*	40%
Imaging Services (MRI, CT, CAT, PET scans)	30%	40%
Allergy Injections	30%	40%
Durable Medical Equipment / Prosthetics / Orthotics / Implants	30%	40%
Home Health, Hospice, and Respite Care	30%	40%
Emergency Room Visit	30%	
Ambulance Service (\$5,000 annual max)	30%	
MEMBER PREFERENCE BENEFIT OPTIONS	In-Network Provider	Out-of-Network Provider ¹
Calendar Year Out of Pocket Maximum: Individual Family	\$6,000 \$18,000	No Maximum
Essential Benefit Annual Maximum (<i>Medical & Rx</i>)	\$2,000,000	
COVERED BENEFITS	Member Responsibility	
Outpatient Upper Endoscopy	50%	60%
Spine Surgery for Pain (Includes Injections)	50%	60%
Orthopedic joint procedures -Knee replacement -Hip replacement -Arthroscopies -Shoulder surgery for osteoarthritis	50%	60%
Colectomy (colon removal other than laparoscopic or robotic)	50%	60%
Hysterectomy (uterus removal other than laparoscopic, vaginal or robotic)	50%	60%
Fundoplication or Hiatal Hernia repair (repair for gastric reflux disease other than laparoscopic or robotic)	50%	60%
Outpatient Cholecystectomy (gall bladder removal other than laparoscopic)	50%	60%
Non-Emergent Appendectomy (appendix removal other than laparoscopic)	50%	60%

*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.

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SERVICE AREA

Illustrated in the ODS Provider Directory.

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

* 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 inpatient admissions and outpatient imaging services 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 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: 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 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 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.

* 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 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.
- * Services or supplies related to sex change procedures or sexual dysfunction unless delivered by a mental health provider.
- * 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.

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

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