Maximizer 5000

Standard PPO Plan	In-Network Provider	Out-of-Network Provider[1]
	Member Responsibility	
Plan Year Deductible, Per Member (Family deductible is 3x)	$5,000	
Out-of-Pocket Maximum, Per Member (After Deductible)	$5,000	$10,000
Plan Year Essential Benefit Maximum *(Medical & Rx)*	$2,000,000	
PREVENTIVE CARE		
Routine Physical Exam	No co-pay*	Not covered
Routine Women's Exams (including pap test, pelvic exam, breast exam and mammogram)	No co-pay*	50%
Immunizations	No co-pay*	Not covered
PROFESSIONAL SERVICES		
Urgent Care, Home or Office Visits	First 6 at $20**[2]	50%
Alternative Care ($1,000 aggregate plan year maximum) Chiropractic, Naturopathic, and Acupuncture	$20*[2]	50%
FACILITY AND ANCILLARY SERVICES		
Hospital - Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	30%	50%
Maternity - All pre/post office visits and doctor delivery; hospital charges	30%	50%
Alcohol / Mental Health Treatment - Inpatient, outpatient, residential combined	30%	50%
Lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	30%	50%
EMERGENCY SERVICES		
Emergency room (deductible applies)	30% after $100 copay[2]	
Ambulance ($5,000 maximum per plan year)	30%	
OTHER BENEFITS		
Prescription services	$2 value tier, $15 generics or 50% brand*[2]	
Accident benefit	Deductible waived for treatment completed within 90 days of accident	

* Deductible waived

** Deductible waived for first six medical home, office or urgent care visits per plan year. First six in-network visits do not include home or office visits for mental health, alcohol treatment, family planning or biofeedback. Subsequent visits are subject to the deductible and co-insurance.

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

[2]Fixed dollar copayments, prescription drug out-of-pocket expenses, and disallowed charges do not apply toward the plan year deductible or to the out-of-pocket maximum. Expenses applied toward the 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 a lawful spouse or registered domestic partner pursuant to the Oregon Family Fairness Act and children up to age 26.

OUT-OF-AREA DEPENDENT CHILDREN COVERAGE

If your enrolled 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 may receive the in-network benefit level by using the travel network. If a travel network provider is not available, the services will be paid at the in-network benefit level if provided within a 30-mile radius of the child's residence or at the closest appropriate facility. Fees charged by out-of-area providers will be reimbursed at the maximum plan allowance for those services.

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EXCLUSION PERIODS

Six-month exclusion period applies to:

* 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 recur, unless the insured is under the age of 19.

Note: Your plan's exclusion period will be shortened one day for each day you had "credible 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.

LIMITATIONS

* All medical and surgical admissions must be authorized by ODS.
* Mental health treatment for inpatient or residential care limited to 10 days per plan year. Outpatient care limited to 20 visits per plan year.
* Alcohol treatment for inpatient or residential care limited to 10 days per plan year. Outpatient care is limited to 20 visits per plan year.
* Hearing aid coverage limited to members under the age of 26 with a maximum benefit of up to $4,100 every 48 months.
* Inpatient rehabilitation benefits are limited to 15 days per plan year. Outpatient rehabilitation benefits are limited to 15 sessions per plan year.
* Transplant benefits are limited to an aggregate lifetime maximum benefit of $750,000 *(24-month exclusion period applies)*
* Hospice benefits are limited to 12 days of inpatient care and up to 170 hours/three months respite care.
* ODS will not pay benefits for covered expenses to the extent that you have any other coverage for those expenses.

EXCLUSIONS

* Services provided by 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.
* Services or supplies available in whole, or in part under any city, county, state, or federal law, except Medicaid.
* Charges above those considered 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. (Those exempt from state and federal workers' compensation law will have 24 hour coverage.)
* 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.

These benefits are subject to change per health care reform

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