

ODS Medical Plans Summary:

Type of Plan :	Plan 3 – PPO Plan		Plan 5 – PPO Plan		Plan 7 – PPO Plan		Plan 8 – PPO Plan	
General Information:								
Reimbursement:	Member Responsibility		Member Responsibility		Member Responsibility		Member Responsibility	
	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network	In-Network	Out of Network
Individual Deductible (plan year)	\$100	\$100	\$200	\$200	\$500	\$500	\$1,000	\$1,000
Family Deductible (plan year)	\$300	\$300	\$600	\$600	\$1,500	\$1,500	\$3,000	\$3,000
Individual Coinsurance Maximum (plan year)	\$500	\$1,500	\$1,000	\$2,000	\$2,000	\$4,000	\$2,000	\$4,000
Family Coinsurance Maximum (plan year)	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Lifetime Benefit Maximum	\$2,000,000		\$2,000,000		\$2,000,000		\$2,000,000	
Member Coinsurance	10%	30%	20%	40%	20%	40%	20%	40%
Covered Services:								
Hospital Benefit								
Inpatient Hospital Coinsurance Service authorization required	10%	30%	20%	40%	20%	40%	20%	40%
Service Authorization Penalty Inpatient & Residential	50% up to \$2,500	50% up to \$2,500	50% up to \$2,500	50% up to \$2,500	50% up to \$2,500	50% up to \$2,500	50% up to \$2,500	50% up to \$2,500
Inpatient Days Covered	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited	unlimited
Pre-admission Testing	10%	30%	20%	40%	20%	40%	20%	40%
Inpatient Rehabilitative Hospital Care (30/60 days per calendar year)	10%	30%	20%	40%	20%	40%	20%	40%
Emergency & Urgent Care								
Emergency Care (waived if admitted)	\$100 copayment per visit		\$100 copayment per visit		\$100 copayment per visit		\$100 copayment per visit	
RN Advice for minor illnesses & injuries	eDoc		eDoc		eDoc		eDoc	
Urgent Care Visits	\$10 copayment		\$20 copayment		20%		20%	
Ambulance Transportation (\$5,000 annual maximum)	10% (ground or air ambulance)		20% (ground or air ambulance)		20% (ground or air ambulance)		20% (ground or air ambulance)	
Skilled Nursing Facility								
Skilled Nursing Facility 60 per calendar year	10%	30%	20%	40%	20%	40%	20%	40%

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Physician & Professional Services								
Office, Home or Hospital visit	\$10 copayment	30%	\$20 copayment	40%	20%	40%	20%	40%
Outpatient Rehabilitation (physical, occupational and speech therapy - 30/60 days per calendar year)	\$10 copayment	30%	\$20 copayment	40%	20%	40%	20%	40%
Anesthesiologist	10%	30%	20%	40%	20%	40%	20%	40%
Ambulatory & Outpatient Hospital Services								
Outpatient Surgery	10%	30%	20%	40%	20%	40%	20%	40%
Diagnostic X-rays & Laboratory Tests	10%	30%	20%	40%	20%	40%	20%	40%
Chemotherapy	10%	30%	20%	40%	20%	40%	20%	40%
Radium, Radioisotopic, X-Ray Therapy and Kidney Dialysis	10%	30%	20%	40%	20%	40%	20%	40%
Imaging Procedures	10%	30%	20%	40%	20%	40%	20%	40%
Preventive Healthcare								
Well Child Exams Newborn through age 17	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Childhood Immunizations	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Adult Immunizations (flu and others as indicated)	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Routine Adult Physical Exams Age 18 and above	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Routine Mammograms subject to schedule	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Pap Smear	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Prostate Screening - Age 50 and over	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Colon Cancer Screenings Age 50 and over subject to schedule	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Cardiovascular screenings	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%
Hearing Evaluations	\$0 deductible waived	30%	\$0 deductible waived	40%	\$0 deductible waived	40%	\$0 deductible waived	40%

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Family Planning								
Tubal ligation	10%	30%	20%	40%	20%	40%	20%	40%
Vasectomy	10%	30%	20%	40%	20%	40%	20%	40%
Contraceptive Devices	10%	30%	20%	40%	20%	40%	20%	40%
Maternity/Newborn Care								
Outpatient Maternity Care	10%	30%	20%	40%	20%	40%	20%	40%
Midwife Delivery (only if also a licensed nurse practitioner)	10%	30%	20%	40%	20%	40%	20%	40%
Inpatient Delivery	10%	30%	20%	40%	20%	40%	20%	40%
Newborn Circumcision	10%	30%	20%	40%	20%	40%	20%	40%
Newborn Nursery Care	10%	30%	20%	40%	20%	40%	20%	40%
Other Care/Treatments								
Allergy Testing	10%	30%	20%	40%	20%	40%	20%	40%
Allergy Injections	10%	30%	20%	40%	20%	40%	20%	40%
Therapeutic Injections	10%	30%	20%	40%	20%	40%	20%	40%
Injectable Medication (administered in provider's office)	10%	30%	20%	40%	20%	40%	20%	40%
Biofeedback Therapy	10%	30%	20%	40%	20%	40%	20%	40%
10 visits per lifetime	10%	30%	20%	40%	20%	40%	20%	40%
Inborn Errors of Metabolism	10%	30%	20%	40%	20%	40%	20%	40%
Cochlear Implants service authorization required	10%	30%	20%	40%	20%	40%	20%	40%
Cosmetic and Reconstructive Surgery (medically necessary - service authorization required)	10%	30%	20%	40%	20%	40%	20%	40%
Maxillofacial Prosthetic Services (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%
Temporomandibular Joint Syndrome (\$3,000 lifetime maximum)	10%	30%	20%	40%	20%	40%	20%	40%
Special Dental Care (injury to natural teeth or jaw)	10%	30%	20%	40%	20%	40%	20%	40%
Transplants (service authorization required)	\$0	30%	\$0	40%	\$0	40%	\$0	40%
Therapeutic Abortions	10%	30%	20%	40%	20%	40%	20%	40%
Podiatry Services (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%

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Hospice Care (maximum benefit of \$20,000)								
Hospice Home Care	10%	30%	20%	40%	20%	40%	20%	40%
Hospice Inpatient Care	10%	30%	20%	40%	20%	40%	20%	40%
Other Services								
Home Healthcare (daily limitations/140 visits per year)	\$10 copayment	30%	\$20 copayment	40%	20%	40%	20%	40%
Respite Care (limited to 170 hours of care in three months)	10%	30%	20%	40%	20%	40%	20%	40%
Infusion Therapy (service authorization required)	10%	30%	20%	40%	20%	40%	20%	40%
Prosthetic & Orthotic Appliances (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%
Non-prescription Enteral Formula for Home Use (medically necessary)	10%	30%	20%	40%	20%	40%	20%	40%
Supplies, Appliances and Durable Medical Equipment (subject to limitations)	10%	30%	20%	40%	20%	40%	20%	40%
Benefits for Chemical Dependency								
Deductible per Confinement	10%	30%	20%	40%	20%	40%	20%	40%
Deductible per Day	10%	30%	20%	40%	20%	40%	20%	40%
Detoxification	10%	30%	20%	40%	20%	40%	20%	40%
Inpatient Treatment	10%	30%	20%	40%	20%	40%	20%	40%
Outpatient Office Visits	\$10 copayment	30%	\$20 copayment	40%	20%	40%	20%	40%
Treatment for Mental Illness								
Deductible per Confinement	10%	30%	20%	40%	20%	40%	20%	40%
Deductible per Day	10%	30%	20%	40%	20%	40%	20%	40%
Inpatient Treatment	10%	30%	20%	40%	20%	40%	20%	40%
Outpatient Office Visits	\$10 copayment	30%	\$20 copayment	40%	20%	40%	20%	40%
Group Therapy	\$10 copayment	30%	\$20 copayment	40%	20%	40%	20%	40%
Mental Health Residential Care (45 days per calendar year)	10%	30%	20%	40%	20%	40%	20%	40%

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Alternative Care (Combined maximum benefit of \$2,500)								
Chiropractic Care	10%	30%	20%	40%	20%	40%	20%	40%
Acupuncture/Acupressure	10%	30%	20%	40%	20%	40%	20%	40%
Naturopath	10%	30%	20%	40%	20%	40%	20%	40%
Health & Wellness								
Online Health & Lifestyle Information - Reference eDoc and MyOEBC.org								

ODS Pharmacy Plan Summary:

Deductible: None	Annual Copay / Coinsurance Maximum: \$1,000		
	Generic	Preferred	Non-Preferred
Retail (31 day supply)	\$5.00	\$25.00	50%, \$50.00 max
Mail Order (90 day supply)	\$10.00	\$50.00	50%, \$100.00 max

GENERAL EXCLUSIONS FOR ODS MEDICAL PLANS:

Behavior Modification	Orthopedic Shoes
Benefits Not Stated	Orthognathic Surgery
Charges Over the Maximum Plan Allowance	Paraphilia
Comfort and First-Aid Supplies	Pastoral and Spiritual Counseling
Cosmetic/Reconstructive Surgery	Personality Disorders
Counseling or Treatment in the Absence of Illness	Physical Examinations for employment, licensing or insurance
Custodial Care	Physical Exercise Programs
Dental Examinations and Treatment; Orthodontia	Private Nursing Services
Dental implants	Reports and Records
Experimental or Investigational Procedures	Services Otherwise Available
Faith Healing	Services Provided by a Member of Your Immediate Family
Family Planning (In-vitro, etc.)	Services Provided by Volunteer Workers
Financial Counseling Services	Service Related Conditions (armed forces of any country or from an
Food Services	Services Required As A Condition Of Maintaining A Valid Drivers
Gender Changes	Services and Supplies Provided for Obesity or Weight Reduction
Genetic Engineering	Sexual Disorders
Growth Hormones	Support Education (e.g. AA, anger management, etc.)
Guest Meals in a Hospital or Skilled Nursing Facility	Supportive Environment Materials (e.g. handrails, ramps, benches, etc.)
Hearing Aids	Surgery to Alter Refractive Character of the Eye (e.g. LASIK)
Homemaker or Housekeeping Services	Taxes
Non-terminal Hospice Services	TeleHealth and TeleMedicine
Immunizations (for travel)	Telephone Visits or Consultations, and Telephone Psychotherapy
Infertility	Telephones and Televisions in a Hospital or Skilled Nursing Facility
Inmates	Therapies related to developmental delay etc.
Legal Counseling	Third Party Liability
Massage or Massage Therapy	Transportation-non-emergent
Mental Examination and Psychological Testing and Evaluations	Treatment After Coverage Terminates
Mental Retardation/Learning Disabilities	Treatment for Admissions Prior to Coverage
Missed Appointments	Treatment not Medically Necessary
Motor Vehicle Coverage and Other Insurance Liability	Treatment Prior to Enrollment
Necessities of Living	Wigs, Toupees, Hair Transplants
Nutritional Counseling	Work-Related Conditions
Over the counter medications, vitamins and minerals	