

## Preferred Health Plan - Individual Plan A

All Benefits are subject to the deductible being met prior to payment by Preferred Health Plan, unless otherwise stated.

| Individual Health Plan  |  | Plan A                                   |                               |
|---|--|--|-------------------------------|
| Benefits  | DEDUCTIBLE<br>INDIVIDUAL - FAMILY        |  | OOP MAXIMUM                   |
|   |  | \$500 - 1,500                            | \$3,000                       |
|   |  | \$1,000 - 3,000                          | \$5,000                       |
|   |  | \$2,500 - 7,500                          | \$5,000                       |
|   |  | \$5,000 - 15,000                         | \$5,000                       |
| Lifetime Maximum:   | \$2,000,000                              |  |                               |
| PREVENTATIVE/ROUTINE SERVICES   |  | PARTICIPATING<br>PROVIDER                | NON-PARTICIPATING<br>PROVIDER |
| Routine Physical Exams  | \$25 Copay † then 100% *                 |  | \$25 Copay † then 60% *       |
| Well-Baby Care  |  |  |                               |
| Routine Immunizations/Vaccinations                                    | 80% † *                                  |  | 60% † *                       |
| Women's Annual Exams  | \$25 Copay † then 100% *                 |  | \$25 Copay † then 60% *       |
| Routine Mammograms  | 80% † *                                  |  | 60% † *                       |
| PHYSICIAN/PROVIDER SERVICES   |  |  |                               |
| Office Visits & Urgent Care Facilities                                | \$25 Copay † then 100%                   |  | \$25 Copay † then 60%         |
| Surgery   | 80%                                      |  | 60%                           |
| Alternative Care – Chiropractic, Acupuncture or Naturopathic Services | \$25 Copay † then 80% to \$1,000 CYM     |  |                               |
| HOSPITAL SERVICES   |  |  |                               |
| Inpatient Room & Board  | 80%                                      |  | 60%                           |
| Outpatient Surgery  |  |  |                               |
| OUTPATIENT SERVICES   |  |  |                               |
| Outpatient Hospital/Facility  | 80%                                      |  | 60%                           |
| Lab, X-Ray, CT Scan, MRI  |  |  |                               |
| Emergency Room, \$100 Copay per visit                                 |  |  |                               |
| OTHER COVERED SERVICES  |  |  |                               |
| Prescription Drugs  | 50% to \$5,000 CYM (see benefit options) |  |                               |
| Accidental Injury – Medical (within 90 days of injury)                | 80% with DED waived for 1st \$500 only   | 60% with DED waived for 1st \$500 only   |                               |
| Accidental Injury – Dental (within 365 days of injury)                | 80% with DED waived, maximum of \$500    |  |                               |
| Ambulance   | 80% to \$5,000 CYM                       |  |                               |
| Allergy Injections  |  |  |                               |
| Durable Medical Equipment (\$5,000 CYM)                               |  |  |                               |
| Home Health (130 visits or \$10,000 CYM)                              |  |  |                               |
| Inpatient Mental Benefits (\$1,500 CYM)                               | 80%                                      |  | 60%                           |
| Inpatient Rehabilitation (60 days CYM)                                |  |  |                               |
| Maternity   |  |  |                               |
| Outpatient Rehabilitation (\$2,500 CYM)                               |  |  |                               |
| Skilled Nursing Facility (100 days CYM)                               |  |  |                               |
| Transplant Services (Lifetime Maximum of \$250,000)                   | 100%                                     | Lesser of 50% billed amount or \$250,000 |                               |

† Deductible Waived

\* Combined Calendar Year Maximum of \$125

Copay = The dollar amount or percentage of the covered service that you are responsible for paying.

CYM = Calendar Year Maximum

DED = Deductible

OOP = Out-of-Pocket

## Preferred Health Plan - Individual Plan B

All Benefits are subject to the deductible being met prior to payment by Preferred Health Plan, unless otherwise stated.

| Individual Health Plan  |  | Plan B                                 |                            |
|---|--|--|----------------------------|
| Benefits  | DEDUCTIBLE<br>INDIVIDUAL - FAMILY        |  | OOP MAXIMUM                |
|   |  | \$1,000 - 3,000                        | \$5,000                    |
|   |  | \$2,500 - 7,500                        | \$7,500                    |
|   |  | \$5,000 - 15,000                       | \$10,000                   |
|   |  | \$7,500 - 22,500                       | \$12,500                   |
|   |  | \$10,000 - 30,000                      | \$15,000                   |
| Lifetime Maximum:   | \$2,000,000                              |  |                            |
| PREVENTATIVE/ROUTINE SERVICES   |  | PARTICIPATING PROVIDER                 | NON-PARTICIPATING PROVIDER |
| Routine Physical Exams  | 80% *                                    | 60% *                                  |                            |
| Well-Baby Care  |  |  |                            |
| Routine Immunizations/Vaccinations                                    |  |  |                            |
| Women's Annual Exams  |  |  |                            |
| Routine Mammograms  |  |  |                            |
| PHYSICIAN/PROVIDER SERVICES   |  |  |                            |
| Office Visits & Urgent Care Facilities                                | 80%                                      | 60%                                    |                            |
| Surgery   |  |  |                            |
| Alternative Care – Chiropractic, Acupuncture or Naturopathic Services | 80% to \$1,000 CYM                       |  |                            |
| HOSPITAL SERVICES   |  |  |                            |
| Inpatient Room & Board  | 80%                                      | 60%                                    |                            |
| Outpatient Surgery  |  |  |                            |
| OUTPATIENT SERVICES   |  |  |                            |
| Outpatient Hospital/Facility  | 80%                                      | 60%                                    |                            |
| Lab, X-Ray, CT Scan, MRI  |  |  |                            |
| Emergency Room, \$100 Copay per visit                                 |  |  |                            |
| OTHER COVERED SERVICES  |  |  |                            |
| Prescription Drugs  | 50% to \$5,000 CYM (see benefit options) |  |                            |
| Accidental Injury – Medical (within 90 days of injury)                | 80% with DED waived for 1st \$500 only   | 60% with DED waived for 1st \$500 only |                            |
| Accidental Injury – Dental (within 365 days of injury)                | 80% with DED waived, maximum of \$500    |  |                            |
| Ambulance   | 80% to \$5,000 CYM                       |  |                            |
| Allergy Injections  | 80%                                      | 60%                                    |                            |
| Durable Medical Equipment (\$5,000 CYM)                               |  |  |                            |
| Home Health (130 visits or \$10,000 CYM)                              |  |  |                            |
| Inpatient Mental Benefits (\$1,500 CYM)                               |  |  |                            |
| Inpatient Rehabilitation (60 days CYM)                                |  |  |                            |
| Maternity   |  |  |                            |
| Outpatient Rehabilitation (\$2,500 CYM)                               |  |  |                            |
| Skilled Nursing Facility (100 days CYM)                               |  |  |                            |
| Transplant Services (Lifetime Maximum of \$250,000)                   |  |  | 100%                       |

† Deductible Waived

\* Combined Calendar Year Maximum of \$125

CYM = Calendar Year Maximum

DED = Deductible

OOP = Out-of-Pocket

## Preferred Health Plan - Individual Plan C

All Benefits are subject to the deductible being met prior to payment by Preferred Health Plan, unless otherwise stated.

| Individual Health Plan  |  | Plan C                                 |                            |
|---|--|--|----------------------------|
| Benefits  | DEDUCTIBLE<br>INDIVIDUAL - FAMILY        |  | OOP MAXIMUM                |
|   |  | \$1,000 - 3,000                        | \$5,000                    |
|   |  | \$2,500 - 7,500                        | \$7,500                    |
|   |  | \$5,000 - 15,000                       | \$10,000                   |
|   |  | \$7,500 - 22,500                       | \$12,500                   |
|   |  | \$10,000 - 30,000                      | \$15,000                   |
| Lifetime Maximum:   | \$2,000,000                              |  |                            |
| PREVENTATIVE/ROUTINE SERVICES   |  | PARTICIPATING PROVIDER                 | NON-PARTICIPATING PROVIDER |
| Routine Physical Exams  | 70% *                                    | 50% *                                  |                            |
| Well-Baby Care  |  |  |                            |
| Routine Immunizations/Vaccinations                                    |  |  |                            |
| Women's Annual Exams  |  |  |                            |
| Routine Mammograms  |  |  |                            |
| PHYSICIAN/PROVIDER SERVICES   |  |  |                            |
| Office Visits & Urgent Care Facilities                                | 70%                                      | 50%                                    |                            |
| Surgery   |  |  |                            |
| Alternative Care – Chiropractic, Acupuncture or Naturopathic Services | 70% to \$1,000 CYM                       |  |                            |
| HOSPITAL SERVICES   |  |  |                            |
| Inpatient Room & Board  | 70%                                      | 50%                                    |                            |
| Outpatient Surgery  |  |  |                            |
| OUTPATIENT SERVICES   |  |  |                            |
| Outpatient Hospital/Facility  | 70%                                      | 50%                                    |                            |
| Lab, X-Ray, CT Scan, MRI  |  |  |                            |
| Emergency Room, \$100 Copay per visit                                 |  |  |                            |
| OTHER COVERED SERVICES  |  |  |                            |
| Prescription Drugs  | 50% to \$5,000 CYM (see benefit options) |  |                            |
| Accidental Injury – Medical (within 90 days of injury)                | 70% with DED waived for 1st \$500 only   | 50% with DED waived for 1st \$500 only |                            |
| Accidental Injury – Dental (within 365 days of injury)                | 70% with DED waived, maximum of \$500    |  |                            |
| Ambulance   | 70% to \$5,000 CYM                       |  |                            |
| Allergy Injections  | 70%                                      | 50%                                    |                            |
| Durable Medical Equipment (\$5,000 CYM)                               |  |  |                            |
| Home Health (130 visits or \$10,000 CYM)                              |  |  |                            |
| Inpatient Mental Benefits (\$1,500 CYM)                               |  |  |                            |
| Inpatient Rehabilitation (60 days CYM)                                |  |  |                            |
| Maternity   |  |  |                            |
| Outpatient Rehabilitation (\$2,500 CYM)                               |  |  |                            |
| Skilled Nursing Facility (100 days CYM)                               |  |  |                            |
| Transplant Services (Lifetime Maximum of \$250,000)                   |  |  | 100%                       |

\* Combined Calendar Year Maximum of \$125

CYM = Calendar Year Maximum

DED = Deductible

OOP = Out-of-Pocket

## Preferred Health Plan - Individual Plan D

All Benefits are subject to the deductible being met prior to payment by Preferred Health Plan, unless otherwise stated.

| Individual Health Plan  |  | Plan D                                   |                               |
|---|--|--|-------------------------------|
| Benefits  | DEDUCTIBLE<br>INDIVIDUAL - FAMILY        |  | OOP MAXIMUM                   |
|   |  | \$1,000 - 3,000                          | \$5,000                       |
|   |  | \$2,500 - 7,500                          | \$7,500                       |
|   |  | \$5,000 - 15,000                         | \$10,000                      |
|   |  | \$7,500 - 22,500                         | \$12,500                      |
|   |  | \$10,000 - 30,000                        | \$15,000                      |
|   |  | \$15,000 - 45,000                        | \$20,000                      |
| Lifetime Maximum:   | \$2,000,000                              |  |                               |
| PREVENTATIVE/ROUTINE SERVICES   |  | PARTICIPATING<br>PROVIDER                | NON-PARTICIPATING<br>PROVIDER |
| Routine Physical Exams  | Not Covered                              |  |                               |
| Well-Baby Care  |  |  |                               |
| Routine Immunizations/Vaccinations                                    |  |  |                               |
| Women's Annual Exams  | 75%*                                     | 50%*                                     |                               |
| Routine Mammograms  |  |  |                               |
| PHYSICIAN/PROVIDER SERVICES   |  |  |                               |
| Office Visits & Urgent Care Facilities                                | 75%                                      | 50%                                      |                               |
| Surgery   |  |  |                               |
| Alternative Care – Chiropractic, Acupuncture or Naturopathic Services | Not Covered                              |  |                               |
| HOSPITAL SERVICES   |  |  |                               |
| Inpatient Room & Board  | 75%                                      | 50%                                      |                               |
| Outpatient Surgery  |  |  |                               |
| OUTPATIENT SERVICES   |  |  |                               |
| Outpatient Hospital/Facility  | 75%                                      | 50%                                      |                               |
| Lab, X-Ray, CT Scan, MRI  |  |  |                               |
| Emergency Room, \$100 Copay per visit                                 |  |  |                               |
| OTHER COVERED SERVICES  |  |  |                               |
| Prescription Drugs  | 50% to \$5,000 CYM (see benefit options) |  |                               |
| Accidental Injury – Medical (within 90 days of injury)                | 75%                                      | 50%                                      |                               |
| Accidental Injury – Dental (within 365 days of injury)                | Not Covered                              |  |                               |
| Ambulance   | 75% to \$5,000 CYM                       |  |                               |
| Allergy Injections  | 75%                                      | 50%                                      |                               |
| Durable Medical Equipment (\$5,000 CYM)                               |  |  |                               |
| Home Health (130 visits or \$10,000 CYM)                              |  |  |                               |
| Inpatient Mental Benefits (\$1,500 CYM)                               |  |  |                               |
| Inpatient Rehabilitation (60 days CYM)                                |  |  |                               |
| Maternity   |  |  |                               |
| Outpatient Rehabilitation (\$2,500 CYM)                               |  |  |                               |
| Skilled Nursing Facility (100 days CYM)                               |  |  |                               |
| Transplant Services (Lifetime Maximum of \$250,000)                   | 100%                                     | Lesser of 50% billed amount or \$250,000 |                               |

\* Combined Calendar Year Maximum of \$125

CYM = Calendar Year Maximum

OOP = Out-of-Pocket

## Preferred Health Plan - Individual Plan H

All Benefits are subject to the deductible being met prior to payment by Preferred Health Plan, unless otherwise stated.

| Individual Health Plan  |   | Plan H                 |                            |
|---|---|------------------------|----------------------------|
| Benefits  | DEDUCTIBLE<br>INDIVIDUAL - FAMILY   |                        | OOP MAXIMUM                |
|   | Note: The individual deductible applies only if policyholder enrolls without dependents. If the policyholder and one or more dependents enroll, only the family deductible applies. |                        |                            |
|   | \$1,000 - 2,000   |                        | \$3,000-6,000              |
|   | \$2,650 - 5,250   |                        | \$5,100-10,000             |
| Lifetime Maximum:   | \$2,000,000   |                        |                            |
| PREVENTATIVE/ROUTINE SERVICES   |   | PARTICIPATING PROVIDER | NON-PARTICIPATING PROVIDER |
| Routine Physical Exams  | 80%*  | 50%*                   |                            |
| Well-Baby Care  |   |                        |                            |
| Routine Immunizations/Vaccinations                                    |   |                        |                            |
| Women's Annual Exams  |   |                        |                            |
| Routine Mammograms  |   |                        |                            |
| PHYSICIAN/PROVIDER SERVICES   |   |                        |                            |
| Office Visits & Urgent Care Facilities                                | 80%   | 50%                    |                            |
| Surgery   |   |                        |                            |
| Alternative Care – Chiropractic, Acupuncture or Naturopathic Services | 80% to \$1,000 CYM  |                        |                            |
| HOSPITAL SERVICES   |   |                        |                            |
| Inpatient Room & Board  | 80%   | 50%                    |                            |
| Outpatient Surgery  |   |                        |                            |
| OUTPATIENT SERVICES   |   |                        |                            |
| Outpatient Hospital/Facility  | 80%   | 50%                    |                            |
| Lab, X-Ray, CT Scan, MRI  |   |                        |                            |
| Emergency Room, \$100 Copay per visit                                 |   |                        |                            |
| OTHER COVERED SERVICES  |   |                        |                            |
| Prescription Drugs  | 80%   |                        |                            |
| Accidental Injury – Medical (within 90 days of injury)                | 80%   | 50%                    |                            |
| Accidental Injury – Dental (within 365 days of injury)                | Not Covered   |                        |                            |
| Ambulance   | 80% to \$5,000 CYM  |                        |                            |
| Allergy Injections  | 80%   | 50%                    |                            |
| Durable Medical Equipment (\$5,000 CYM)                               |   |                        |                            |
| Home Health (130 visits or \$10,000 CYM)                              |   |                        |                            |
| Inpatient Mental Benefits (\$1,500 CYM)                               |   |                        |                            |
| Inpatient Rehabilitation (60 days CYM)                                |   |                        |                            |
| Maternity   |   |                        |                            |
| Outpatient Rehabilitation (\$2,500 CYM)                               |   |                        |                            |
| Skilled Nursing Facility (100 days CYM)                               |   |                        |                            |
| Transplant Services (Lifetime Maximum of \$250,000)                   |   |                        | 100%                       |

\* Combined Calendar Year Maximum of \$125

CYM = Calendar Year Maximum

OOP = Out-of-Pocket

# Limitations & Exclusions

This is a summarization of plan coverage only and is not considered a binding contract.

Please consult your policy for detailed information on plan use, benefit coverage and a complete listing of limitations and exclusions.

Not all services are applied to the out-of-pocket limits.

Please refer to your policy for further details or contact our Marketing Department in Klamath County at (541) 882-1466, Deschutes County at (541) 312-0018, and all other areas at (800) 303-8680.

## BENEFIT EXCLUSION PERIODS

### SIX MONTH WAITING PERIOD FOR THE FOLLOWING:

- All Pre-Existing Conditions
- Allergies
- Elective Procedures
- Otitis Media (ear infections)
- Sterilization
- Tonsils and Adenoids

### TWENTY-FOUR MONTH WAITING PERIOD FOR THE FOLLOWING:

- Human Organ Transplant

## LIMITATIONS

- Accidental Dental Injury (if applicable) - Treatment within 365 days, maximum of \$500
- Accidental Injury - Deductible waived for 1st \$500 within 90 days of accident, then deductible and coinsurance apply
- Alternative Care (if applicable) - \$1,000 CYM
- Ambulance - \$5,000 CYM (includes ground and air)
- Durable Medical Equipment (DME) - \$5,000 CYM
- Emergency Room - \$100 Copay per visit
- Foot Orthotics (custom molded) - \$200 CYM
- Home Health - 130 visits or \$10,000 CYM, whichever comes first
- Human Organ Transplant - Lifetime Maximum Benefit - \$250,000 per member
- Lifetime Maximum Benefit is \$2,000,000 per member
- Medical Supplies & Devices - see specific policy listing
- Mental Health (inpatient) \$1500 CYM
- Prescription Drugs (if applicable) - \$5,000 CYM
- Preventive Care - Combined benefit maximum of \$125 CYM
- Rehabilitation (inpatient) - 60 days CYM
- Rehabilitation (short-term outpatient) - \$2,500 CYM
- Skilled Nursing Facility - 100 days CYM

## GENERAL EXCLUSIONS

- Alcoholism Dependency
- Behavioral Disorders
- Biofeedback
- Chemical Dependency
- Children's Language, Cognitive, Motor or Social Skills
- Cosmetic Services
- Court-Ordered Treatment
- Custodial Care
- Dental
- Developmental Delay & Learning Disabilities
- Developmentally Disabled
- Dietary/Nutritional Services
- Dietary Supplements
- Experimental or Investigational
- Family Planning
- Foot Supplies/Care
- Growth Substances
- Health Clubs/Spas/Fitness Programs
- Hearing Care
- Illegal Activities
- Infertility
- Intoxicants and Controlled Substances
- Jaw Surgery
- Marriage, Family or Sex Counseling
- Mental Health Services in Excess of Inpatient Mental Benefits
- Obesity
- Oral Contraceptives and Other Contraceptives
- Liability of Other Carrier
- Personal Care Items
- Physical Therapy Equipment
- Sex Change
- Sexual Dysfunction
- Smoking Cessation
- State Taxes
- Sterilization Reversal
- Temporomandibular Joint Disorders (TMJ)
- Third Party/Legal Order
- Third Party Liability
- Transportation/Travel/Lodging
- Vehicle or Structure Modification
- Vision Care
- Vision Therapy
- War or Acts of War
- Work Related Injuries/Illnesses