



Practical PPO Plan

Practical is a comprehensive Preferred Provider Organization (PPO) plan that offers the following:

- Preferred and national network of doctors and hospitals
- Referrals not required
- Deductible waived for preventive services, outpatient mental health, urgent care, alternative care, accidental injury coverage, and vision exams
- Comprehensive prescription drug coverage
- In-Network Calendar Year Deductible Options: \$1,000, \$1,500, \$2,500, \$5,000 / Out-of-Network Deductible is 2x's In-Network
- In-Network Out-of-Pocket Maximum is \$5,000 plus chosen Deductible / No Limit Out-of-Network

The Deductible, Copay, and Coinsurance (%) represent what YOU pay. The maximum family Deductible and Out-of-Pocket Maximum are 3x's the individual. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care (Subject to plan limits)	Covered in Full*		50% after Deductible
Women's Annual Exam/Mammograms (Subject to plan limits)			
Colon Cancer Screening (Subject to plan limits)			
Professional Services			
Office Visit	1st 4 visits (office visits or urgent care) \$30*, then 30% after Deductible	50% after Deductible	
Office Procedures, Lab & X-Rays	30% after Deductible		
Alternative Care (Subject to plan limits)	\$30* up to \$500 per calendar year		
Hospital & Emergency Services			
Urgent Care	1st 4 visits (office visits or urgent care) \$30*, then 30% after Deductible		
Emergency Room	\$150 (waived if admitted within 24 hours), then 30% after Deductible		
Air & Ground Ambulance (Subject to plan limits)	30% after Deductible		
Inpatient & Outpatient Hospital	30% after Deductible		50% after Deductible
Maternity Services			
Prenatal, Delivery & Postnatal Physician Services, Hospital Services	30% after Deductible		50% after Deductible
Other Services			
Mental Health	Outpatient: \$30*, Inpatient: 30% after Deductible		50% after Deductible
Vision Eye Exam (Subject to plan limits)	1st \$50 Covered in Full per calendar year		
Accidental Injury (Subject to plan limits)	1st \$1,000 per calendar year Covered in Full for treatment sought within 90 days, then subject to Deductible and Coinsurance		
Pharmacy Services			
Prescriptions (Subject to plan limits)	Retail 1-Month Supply	\$15* generics, 20%* specialty, 50%* all other	Not Covered
	Mail Order 3-Month Supply	2.5x Copay or Coinsurance (Does not apply to speciality)	

Premier POS Plan

Premier is our most comprehensive Point of Service (POS) plan that offers the following benefits:

- Local and national network of doctors and hospitals
- Referrals not required
- Deductible waived for preventive services, office visits, outpatient mental health, urgent care, alternative care, accidental injury coverage, and vision exam
- Comprehensive prescription drug coverage
- In-Network Calendar Year Deductible Options: \$1,000, \$1,500, \$2,500, \$5,000 / Out-of-Network Deductible is 2x's In-Network
- In-Network Out-of-Pocket Maximum is \$4,000 plus chosen Deductible / No Limit Out-of-Network

The Deductible, Copay, and Coinsurance (%) represent what YOU pay. The maximum family Deductible and Out-of-Pocket Maximum are 3x's the individual. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care (Subject to plan limits)	Covered in Full*		40% after Deductible
Women's Annual Exam/Mammograms (Subject to plan limits)			
Colon Cancer Screening (Subject to plan limits)			
Professional Services			
Office Visit	\$30*	40% after Deductible	
Office Procedures, Lab & X-Rays	20% after Deductible		
Alternative Care (Subject to plan limits)	\$30* up to \$500 per calendar year		
Hospital & Emergency Services			
Urgent Care	\$30*		
Emergency Room	\$150 (waived if admitted within 24 hours), then 20% after Deductible		
Air & Ground Ambulance (Subject to plan limits)	20% after Deductible		
Inpatient & Outpatient Hospital	20% after Deductible	40% after Deductible	
Maternity Services			
Prenatal, Delivery & Postnatal Physician Services, Hospital Services	20% after Deductible	40% after Deductible	
Other Services			
Mental Health	Outpatient: \$30*, Inpatient: 20% after Deductible	40% after Deductible	
Vision Eye Exam (Subject to plan limits)	1st \$50 Covered in Full per calendar year		
Accidental Injury (Subject to plan limits)	1st \$1,000 per calendar year Covered in Full for treatment sought within 90 days, then subject to Deductible and Coinsurance		
Pharmacy Services			
Prescriptions (Subject to plan limits)	Retail 1-Month Supply	\$10* generics, 20%* specialty, 50%* all other	
	Mail Order 3-Month Supply	2.5x Copay or Coinsurance (Does not apply to speciality)	
		Not Covered	

Savings PPO 2,500 (HSA-Qualified)

Savings 2,500 is a qualified Health Savings Account (HSA) PPO plan that offers the following benefits:

- Preferred and national network of doctors and hospitals
- Referrals not required
- Deductible waived for preventive services
- In-Network Calendar Year Individual Deductible: \$2,500 / Out-of-Network Deductible is 2x's In-Network
- In-Network Calendar Year Individual Out-of-Pocket Maximum: \$5,950 (includes Deductible) / No Limit Out-of-Network
- In-Network Calendar Year Family Deductible: \$5,000 / Out-of-Network Deductible is 2x's In-Network
- In-Network Calendar Year Family Out-of-Pocket Maximum: \$11,900 (includes Deductible) / No Limit Out-of-Network

The Deductible and Coinsurance (%) represent what YOU pay. A family is an individual plus one or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care <i>(Subject to scheduled plan limits)</i>		Covered in Full*	50% after Deductible
Women's Annual Exam/Mammograms <i>(Subject to scheduled plan limits)</i>			
Colon Cancer Screening <i>(Subject to scheduled plan limits)</i>			
Professional Services			
Office Visit		20% after Deductible	50% after Deductible
Office Procedures, Lab & X-Rays			
Alternative Care		Not Covered	
Hospital & Emergency Services			
Urgent Care		20% after Deductible	
Emergency Room			
Air & Ground Ambulance <i>(Subject to plan limits)</i>			
Inpatient & Outpatient Hospital		20% after Deductible	50% after Deductible
Maternity Services			
Prenatal, Delivery & Postnatal Physician Services, Hospital Services		20% after Deductible	50% after Deductible
Other Services			
Mental Health		20% after Deductible	50% after Deductible
Vision Eye Exam		Not Covered	
Accidental Injury		Covered same as all other medical services	
Pharmacy Services (subject to Medical Deductible)			
Prescriptions	Retail 1-Month Supply	Specialty 20%, all other 50%	
	Mail Order 3-Month Supply	2.5x Coinsurance <i>(Does not apply to speciality)</i>	
		Not Covered	

Savings PPO 5,950 Plan (HSA-Qualified)

Savings 5,950 is a qualified Health Savings Account (HSA) PPO plan that offers the following benefits:

- Preferred and national network of doctors and hospitals
- Referrals not required
- Deductible waived for preventive services
- In-Network Calendar Year Individual Deductible: \$5,950 / Out-of-Network Deductible is 2x's In-Network
- In-Network Calendar Year Individual Out-of-Pocket Maximum: \$5,950 (includes Deductible) / Out-of-Network Deductible is 2x's In-Network
- In-Network Calendar Year Family Deductible: \$11,900 / No Limit Out-of-Network
- In-Network Calendar Year Family Out-of-Pocket Maximum: \$11,900 (includes Deductible) / No Limit Out-of-Network

The Deductible and Coinsurance (%) represent what YOU pay. A family is an individual plus one or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care <i>(Subject to plan limits)</i>	Covered in Full*		50% after Deductible
Women's Annual Exam/Mammograms <i>(Subject to plan limits)</i>			
Colon Cancer Screening <i>(Subject to plan limits)</i>			
Professional Services			
Office Visit	Covered in Full after Deductible		50% after Deductible
Office Procedures, Lab & X-Rays			
Alternative Care	Not Covered		
Hospital & Emergency Services			
Urgent Care	Covered in Full after Deductible		50% after Deductible
Emergency Room			
Air & Ground Ambulance <i>(Subject to plan limits)</i>			
Inpatient & Outpatient Hospital			
Maternity Services			
Prenatal, Delivery & Postnatal Physician Services, Hospital Services	Covered in Full after Deductible		50% after deductible
Other Services			
Mental Health	Covered in Full after Deductible		50% after deductible
Vision Eye Exam	Not Covered		
Accidental Injury	Covered same as all other medical services		
Pharmacy Services (subject to Medical Deductible)			
Prescriptions	Retail 1-Month Supply	Covered in Full after Deductible	Not Covered
	Mail Order 3-Month Supply	2.5x Coinsurance <i>(Does not apply to speciality)</i>	

Premium Saver PPO Plan

Premium Saver is a Preferred Provider Organization (PPO) plan that offers the following benefits:

- Local and national network of doctors and hospitals
- Referrals not required
- Excellent catastrophic coverage
- Deductible waived for preventive services, accidental injury coverage
- In-Network Calendar Year Deductible options: \$7,500 or \$10,000 / Out-of-Network Deductible is 2x's In-Network
- In-Network Calendar Year Out-of-Pocket Maximum is: \$5,000 plus chosen Deductible / No Limit Out-of-Network

The Deductible, Copay, and Coinsurance (%) represent what YOU pay. The maximum family Deductible and Out-of-Pocket Maximum are 3x's the individual. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care (Subject to plan limits)	Covered in Full*		50% after Deductible
Women's Annual Exam/Mammograms (Subject to plan limits)			
Colon Cancer Screening (Subject to plan limits)			
Professional Services			
Office Visit	30% after Deductible		50% after Deductible
Office Procedures, Lab & X-Rays			
Alternative Care	Not Covered		
Hospital & Emergency Services			
Urgent Care	30% after Deductible		
Emergency Room	\$150 (waived if admitted within 24 hours), then 30% after Deductible		
Air & Ground Ambulance (Subject to plan limits)	30% after Deductible		
Inpatient & Outpatient Hospital	30% after Deductible		50% after Deductible
Maternity Services			
Prenatal, Delivery & Postnatal Physician Services, Hospital Services	30% after Deductible		50% after Deductible
Other Services			
Mental Health	30% after Deductible		50% after Deductible
Vision Eye Exam	Not Covered		
Accidental Injury (Subject to plan limits)	1st \$1,000 per calendar year Covered in Full for treatment sought within 90 days, then subject to Deductible and Coinsurance		
Pharmacy Services			
Prescriptions	Retail 1-Month Supply	\$20 generics only, all other not covered	
	Mail Order 3-Month Supply	2.5x Copay	
		Not Covered	

Limitations, Exclusions and Disclosure Statement

Limitations

Benefit plans typically have exclusions and limitations (what the plans do not cover). The following include some general exclusions and limitations for the plans described in this brochure. Once enrolled, you will be given a policy with a detailed description of your coverage.

Covered Benefit	Plan Maximum						
Accidental Injury	\$1,000 per calendar year						
Alternative Care Applies only to Practical Plan and Premier Plan	\$500 per calendar year						
Ambulance (Air and Ground)	\$5,000 per calendar year						
Colon Cancer Screening	< Age 50: high risk only > Age 50: 1 fecal occult blood test every year, 1 flexible sigmoidoscopy every 5 years; and 1 colonoscopy every 10 years OR 1 double contrast barium enema every 5 years						
Durable Medical Equipment	\$5,000 per calendar year Supplies: Unlimited						
Home Health Care	130 visits or \$10,000 per calendar year, whichever comes first						
Hospice	\$10,000 Lifetime						
Prescription and Specialty Drugs	No limit for generics \$3,000 per calendar year brand, non-formulary, and specialty drugs						
Preventive Health Exams	<table border="1"> <tr> <td>Infants, 0-24 months:</td> <td>Up to 8 well-baby visits</td> </tr> <tr> <td>Children, ages 2-18:</td> <td>1 exam every year</td> </tr> <tr> <td>Adults, ages 19+</td> <td>1 exam every year</td> </tr> </table>	Infants, 0-24 months:	Up to 8 well-baby visits	Children, ages 2-18:	1 exam every year	Adults, ages 19+	1 exam every year
Infants, 0-24 months:	Up to 8 well-baby visits						
Children, ages 2-18:	1 exam every year						
Adults, ages 19+	1 exam every year						
Refractive Eye Exam Applies only to Practical Plan and Premier Plan	\$50 per calendar year						
Rehabilitation (Physical, Occupational, Speech Therapy, Cardiac, Pulmonary)	Outpatient: 20 visits or \$2,500 per calendar year, whichever comes first Inpatient: 30 days per calendar year; 60 days for head or spinal injury						
Routine Mammography	< Age 40: high risk only > Age 40: Annually						
Skilled Nursing Facility	60 days per calendar year						
Transplant Services	\$250,000 Lifetime \$8,000 donor per transplant Subject to 24-month waiting period						

Exclusions

- Acupuncture, naturopathic, chiropractic treatment
(Does not apply to the Practical and Premier Plans)
- Cosmetic/reconstructive surgery
- Certain mental health services for religious, marital, behavioral, family, occupational, developmental, learning disabilities, mental retardation, sexual, spiritual, or personality disorders
- Custodial care, intermediate care facility, private nursing services
- Dental services
- Electronic Beam Tomography (EBT)
- Experimental/investigational services
- Eye surgery to alter refractive character of the eye, including radial keratotomy and laser surgery
- Lay midwife or direct entry midwife services
- Light therapy or equipment for seasonal affective disorder
- Massage or massage therapy
- Mental examination and psychological testing and evaluation
- Physical examinations for third-party purposes
- Prevailing rates, missed appointments, records, or reports
- Routine foot care (except for diabetes and circulatory related conditions)
- Routine vision exams **(Does not apply to Practical and Premier Plans)**,
- Eyeglasses and other vision services
- Services provided by volunteer worker or member of immediate family
- Services for sexual disorders/sex transformation
- Surrogate mother maternity care
- Treatment for obesity and weight control (including surgery)
- Treatment for which a third party is responsible
- Transportation except medically necessary ambulance transport
- Wigs, toupees, hair transplants
- Work-related conditions

Disclosure Statement

This brochure is a general outline of the important features of our plans for individuals and families in Oregon. Clear One Health Plans' contracts comply with all state mandated benefits. The full terms and conditions of these plans will be provided in the policy at the time of purchase. This brochure is not intended to be a part of the policy. Only the policy is final and binding, which details your rights and obligations as well as those of Clear One Health Plans, Inc.

If you apply for coverage with Clear One Health Plans, please read your policy carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Be sure to fill out your application completely and truthfully. If misstatements are made or information about your health is omitted, Clear One may void the contract or deny your claims. If you are adding new coverage to a current policy, please review both policies to ensure you're not purchasing any unnecessary coverage or canceling any desired coverage. If you decline coverage under a group health plan in order to retain or obtain coverage under an individual health plan, you may be considered a late enrollee if you seek enrollment in the group health plan at a later date.

If you have any questions that are not answered by this disclosure statement, please ask your insurance agent or our Marketing & Sales Department at (888) 863-3637 or (541) 385-5315.