



Individual and family plans

MEDICAL AND DENTAL

www.odscompanies.com



DOCTORS ARE IN THE BUSINESS OF HELPING PEOPLE FEEL GOOD. **SO ARE WE.**

For half a century, we have made our mark by treating every customer like our friend. Little things go a long way to show how much we care, but so do the big things – like our large network of physicians, hospitals, dentists and pharmacists, and our state-of-the-art claims payment system.

We also offer members innovative tools and services to help them better manage their own health. With ODS, you get more than just insurance.

PERSONALIZED MEMBER WEBSITE

Members can access all insurance-related information at one convenient online location with myODS, which provides access to member handbooks, claims status and history, detailed benefit information and more.

MEDICAL ADVICE ONLINE

ODS medical members can correspond via e-mail with a board-certified physician or psychologist 24 hours a day, seven days a week. Also available in Spanish.

24-HOUR ACCESS TO A REGISTERED NURSE

With our 24-hour Nurse Advice Line, medical members can call anytime to get help with medical issues – along with peace of mind. Also available in Spanish.

EVIDENCE-BASED DENTAL PLAN DESIGNS

We know that good overall health depends on good oral health. Dental benefits give additional protection to your total health, which is why ODS offers evidence-based dental programs to augment your medical coverage.

PHARMACY DISCOUNT CARD

Save money on prescription drugs through our partnership with the Oregon Prescription Drug Program (OPDP). This program gives you the opportunity to receive discounts on prescriptions not covered under your plan. Enrollment is free, and you can sign up online, over the phone or by mailing an enrollment form. All prescription drugs are eligible for a discount; you are responsible to pay the cost in full after the discount is applied.





Choosing the right plan for you

ODS offers a variety of health plans to meet your needs. All of our health plans include access to the largest directly contracted PPO medical provider network in Oregon. With more than 11,000 providers in our network participating across all specialties — including primary care, surgery, radiology, anesthesiology, vision, chiropractic, naturopathic and acupuncture — your service needs have been anticipated. All of our plan designs give you the freedom to see any licensed provider you choose, but with a better benefit if you access a preferred provider from our statewide network. Coverage varies from plan to plan, so look for the features that best fit your healthcare preferences. To help you more easily navigate our plans, we have provided a glossary of terms on page 6.

MAXIMIZER: PREFERRED PROVIDER ORGANIZATION (PPO)

The Maximizer plan is ideal for individuals who want broad coverage for a range of services, including pharmacy benefits and unlimited office visits with just a copay.

- \$20 copay for office visits received in-network, including preventive and urgent care center visits
- \$20 copay for chiropractic, acupuncture and naturopathic care when in-network
- Deductible waived for treatment received within 90 days of an accident
- Annual deductible choices of \$1,000, \$2,500, \$5,000
- Prescriptions covered at \$15 generic or 50% brand, up to \$5,000 maximum benefit

BENEFICIAL Rx: PREFERRED PROVIDER ORGANIZATION (PPO)

The Beneficial Rx plan is best for those looking for a higher level of benefits and a lower total out-of-pocket cost. The Beneficial Rx plan includes services that can be accessed before the deductible, including preventive care, pharmacy services, limited doctor's office or urgent care center visits, and alternative care.

- \$15 copay for in-network preventive care visits
- \$15 copay for first three in-network office visits or urgent-care-center visits. After the first three visits for illness or injury, the deductible and coinsurance apply
- \$15 copay for the first three alternative care visits. After the first three alternative care visits, the deductible and coinsurance apply to the benefit maximum of \$1,000
- Deductible waived for treatment received within 90 days of an accident
- Annual deductible choices of \$1,000,* \$2,500 or \$5,000
- Prescriptions covered at \$15 generic or 50% brand, up to \$5,000 maximum benefit

**Family Health Insurance Assistance Program (FHIAP) eligible plan is the Beneficial Rx, with a \$1,000 deductible. Waivers and downgrades are not permitted to apply to FHIAP participants.*



BENEFICIAL VALUE: PREFERRED PROVIDER ORGANIZATION (PPO)

The Beneficial Value plan is suited to individuals shopping for a lower premium cost. The Beneficial Value plan offers catastrophic coverage and also waives the deductible for preventive care and the first three office and alternative care visits per plan year.

- \$25 copay for in-network preventive care visits
- \$25 copay for first three in-network office visits or urgent-care-center visits. After the first three visits for illness or injury, the deductible and coinsurance apply
- \$25 copay for the first three alternative care visits. After the first three alternative care visits, the deductible and coinsurance apply to the benefit maximum of \$1,000
- Deductible waived for treatment received within 90 days of an accident, with \$10,000 PPY maximum
- Annual deductible choices of \$1,000, \$2,500, \$5,000 or \$7,500
- Prescriptions not covered unless optional rider is purchased; benefit is \$15 generic, 50% brand, \$2,000 maximum benefit

HEALTH SAVINGS ACCOUNT (HSA)

HSA plans offer lower insurance premiums through a tax-advantage and high-deductible health plan.

HSA CHOICE

- \$1,500 individual/\$3,000 family deductible
- Preventive care deductible waived
- 80% in-network/60% out-of-network
- 70% prescription benefit after deductible

HSA VALUE

- \$2,800 individual/\$5,600 family deductible
- Preventive care deductible waived
- 50% in- and out-of-network benefit
- 50% prescription benefit after deductible

Individual deductible must be met for insured-only plan, and family deductible must be met on HSA plans if enrolled with dependents before plan pays benefits other than preventive care.

How does an HSA work?

Use HSA tax-free dollars to pay for:

- Covered medical expenses to help satisfy your deductible
- Your coinsurance for medical expenses (after deductible is met)
- Qualified medical expenses that may not be covered by your plan

Tax advantages

- Contributions are made on a tax-advantaged basis
- Any unused funds carry over from year to year and grow tax-deferred
- When used to pay for qualified medical expenses, funds can be withdrawn tax-free

Setting up your HSA

Use any banking partner you choose to set up an HSA. Contact us if you need information on banking partners that work with ODS.



We understand healthcare can be complex and sometimes confusing.

This brief list of commonly used terms in insurance and commonly asked questions and answers will help make choosing an individual medical and dental plan for you and your family as easy as possible. For more detailed information, visit www.odskompanies.com.

COINSURANCE

The percentage of allowable charges for which the patient is responsible.

COPAY

The insured patient's share of the total medical bill, usually expressed as a specific dollar amount paid for a given service, product or treatment. For example, the patient might

pay \$20 for each doctor's office visit. The patient is usually responsible for payment at the time of the treatment or service.

DEDUCTIBLE

The portion of an individual's applicable healthcare expenses that must be paid by the member in a given year before the insurance plan will start paying for treatment.

OUT-OF-POCKET MAXIMUM

A specified amount of applicable claims expenses in a plan year that must be met before benefits are paid in full. Once the member has met his or her out-of-pocket maximum, the plan begins covering eligible expenses at 100 percent. The out-of-pocket maximum starts over every plan year.

PPO

A Preferred Provider Organization is a panel of providers contracted with ODS to provide in-network benefits at agreed-upon rates.

PPY

Per person, per plan year.

PLAN YEAR

The 12-month period commencing on the effective date and each 12-month period thereafter.

PREFERRED PROVIDER

A provider contracted within a network. By choosing a preferred provider, the member's out-of-pocket expenses will be less than if he or she chooses a physician outside the network.



How am I eligible to apply for ODS individual medical and dental plans?

In order to be eligible for any ODS individual medical and dental plan, you and any dependents applying for coverage must be an Oregon resident and live in Oregon at least six months out of the year. Eligible members include you, your legal spouse or registered partner pursuant to the Oregon Family Fairness Act and any unmarried children younger than age 23. Individuals must be younger than age 65 and not eligible for Medicare.

Do you offer a dental plan?

We offer two individual dental options. In order to be eligible to enroll in an individual dental plan, you need to enroll when you first apply for an ODS individual medical plan.

What payment methods do you offer?

We offer monthly electronic deduction from your checking account, monthly billing statements with a \$2 administrative fee and quarterly payments.

Can my employer sponsor my individual coverage?

ODS Individual plans cannot be employer-sponsored plans. You will be responsible for directly paying ODS your monthly premium using a personal check. ODS does not accept employer checks for individual plans.

When do your rates change?

ODS renews all individual plans on November 1 each year, including benefit and rate adjustments. Rates also change when the primary applicant moves into the next age band; new rates are effective the following month.

Is there a waiting period for pre-existing conditions?

ODS does not pay toward a pre-existing condition, even if the pre-existing condition worsens or recurs during the first six months you or your dependent(s) are insured under the policy. However, creditable coverage can reduce the six-month period if an individual's most recent period of creditable coverage is still in effect on the date of enrollment or ended within 63 days of the effective date of coverage. Creditable coverage followed by a significant break in coverage cannot be used to reduce the waiting period. Each day of creditable coverage will reduce the six-month period by one day.

How soon can a new mother apply for herself and her newborn?

For a new applicant, the mother and/or newborn must be released from a doctor's care. This usually occurs at the six-week post-birth checkup. To acquire coverage for a newborn, the signing parent or legal guardian must be at least 18 years of age.

Can I switch to a different plan at any time?

Yes, if you would like to switch to a plan with lower benefits, a written letter must be sent to ODS prior to the requested effective date for the change. The letter will need to include the plan you would like to switch to with a dated signature from the primary applicant. If you would like to switch to a plan with higher benefits, you will need to submit a new application. The application will be health underwritten and you could be approved or declined for the new plan.

INDIVIDUAL MEDICAL PLAN OFFERINGS

INDIVIDUAL PLANS	MAXIMIZER		BENEFICIAL Rx (PPO)	
Plan year deductible options, individual (family deductible is 3x the individual; HSA is 2x)	\$1,000 / \$2,500 / \$5,000		\$1,000 / \$2,500 / \$5,000	
Out-of-pocket maximum, per person (after deductible)	\$5,000	\$10,000	\$3,000	\$6,000
PREVENTIVE CARE	Member Responsibility		Member Responsibility	
	In-Network	Out-of-Network	In-Network	Out-of-Network
Annual women's exam — pap, pelvic, breast	\$20 copay*	50%	\$15 copay*	40%
Women's routine mammogram	\$20 copay*	50%	\$15 copay*	40%
Well-baby care	\$20 copay*	Not covered	\$15 copay*	Not covered
Routine physical exams	\$20 copay*	Not covered	\$15 copay*	Not covered
Immunizations	\$0*	Not covered	\$0*	Not covered
PROFESSIONAL SERVICES				
Office visits	\$20 copay*	50%	First 3 at \$15**	40%
Alternative care (\$1,000 per plan year limit) Chiropractic, naturopathic and acupuncture	\$20 copay*	50%	First 3 at \$15**	40%
FACILITY AND ANCILLARY SERVICES				
Hospital — Inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	30%	50%	20%	40%
Maternity — All pre/post office visits and doctor delivery; hospital charges	30%	50%	20%	40%
Mental Health (\$2,500 maximum in a 12-month period) Inpatient, outpatient, residential combined	30%	50%	20%	40%
Lab and X-ray services; rehabilitation services; medical supplies and devices; in-hospital care; home healthcare	30%	50%	20%	40%
EMERGENCY SERVICES				
Urgent care	\$20 copay*	50%	First 3 at \$15**	40%
Emergency room (deductible applies)	30% after \$100 copay		20% after \$100 copay	
Ambulance	30%		20%	
OTHER BENEFITS				
Prescription services	\$15 generics or 50% brand*; \$5,000 annual maximum benefit		\$15 generics or 50% brand*; \$5,000 annual maximum benefit	
Lifetime maximum	\$2,000,000 (\$250,000 out-of-network)		\$2,000,000 (\$250,000 out-of-network)	
Accident benefit	Deductible waived for treatment completed within 90 days of accident.		Deductible waived for treatment completed within 90 days of accident.	

* Deductible waived

** HSA plans require the family deductible to be met when an individual and a spouse or one (1) or more dependents are enrolled prior to benefits being paid.

(The deductibles, copayments and coinsurance percentages below represent what you pay.)

	BENEFICIAL VALUE (PPO)		HSA CHOICE		HSA VALUE	
	\$1,000 / \$2,500 / \$5,000 / \$7,500		\$1,500 (individual) \$3,000 (family)*		\$2,800 (individual) \$5,600 (family)*	
	\$5,000	\$10,000	\$3,500 (individual) \$7,000 (family)	no maximum	\$2,200 (individual) \$4,400 (family)	no maximum
	Member Responsibility		Member Responsibility		Member Responsibility	
	In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
	\$25 copay*	50%	20%*	40%	50%*	50%
	\$25 copay*	50%	20%*	40%	50%*	50%
	\$25 copay*	Not covered	20%*	40%	50%*	50%
	\$25 copay*	Not covered	20%*	40%	50%*	50%
	\$0*	Not covered	20%*	40%	50%*	50%
	First 3 at \$25**	50%	20%	40%	50%	50%
	First 3 at \$25**	50%	20%	40%	50%	50%
	30%	50%	20%	40%	50%	50%
	30%	50%	20%	40%	50%	50%
	30%	50%	20%	40%	50%	50%
	30%	50%	20%	40%	50%	50%
	First 3 at \$25**	50%	20%	40%	50%	50%
	30% after \$100 copay		20%		50%	
	30%		20%		50%	
	optional***		30%		50%	
	\$2,000,000 (\$250,000 out-of-network)		\$2,000,000 (\$250,000 out-of-network)		\$2,000,000 (\$250,000 out-of-network)	
	Deductible waived for treatment completed within 90 days of accident; \$10,000 per person, per year maximum		Paid as any other illness subject to deductible/coinsurance.		Paid as any other illness subject to deductible/coinsurance.	

** Beneficial plans pay first three office visits with a copayment, which may be used for either office visits or urgent care for illness and injury. Alternative care includes an additional three visits with a copayment. Thereafter, the deductible and coinsurance apply for additional office visits and alternative care.

*** Can purchase a prescription rider separately; benefit is \$15 generic or 50% brand, \$2,000 maximum benefit; deductible waived.

Individual dental plans protect your total health

Wherever you go, ODS goes with you — along with the nation's largest dental network, Delta Dental. With ODS individual plans, you can choose from two Delta Dental plan options: Delta Dental Premier and Delta Dental PPO. You are eligible to enroll in one of our dental plans at the time of your medical plan enrollment.

DELTA DENTAL PREMIER

This popular, traditional fee-for-service product offers members access to the largest dental network available in Oregon and across the nation. Members can save money by seeking care from participating Delta Dental Premier providers.

- Indemnity plan — any licensed dentist is eligible
- Deductible applies to all services
- Delta Dental Premier network includes more than nine out of 10 practicing dentists in Oregon
- More than 2,000 participating providers

DELTA DENTAL PPO

Like the Delta Dental Premier plan, this preferred provider option offers access to the largest PPO network in Oregon and across the country.

- PPO plan — better benefits using PPO network dentists
- Deductible waived for Class I services rendered by a participating PPO dentist
- Largest PPO dental network in the state
- More than 600 participating providers

Does my dentist participate in the Premier or PPO networks?

Log on to www.odskompanies.com to access our up-to-date provider directory and search for participating dentists in your area.

Oral Health, Total Health

Oral health research has shown a strong link between oral health and overall health. ODS believes when you see your dentist regularly and maintain a healthy mouth, you can help keep the rest of your body healthy, too. Through our Oral Health, Total Health program, ODS offers additional preventive benefits to diabetics and pregnant women in their third trimester. ODS also provides other evidence-based dental benefits, including routine oral cancer exams and coverage for ViziLite and brush biopsy, two non-surgical screenings designed to aid in the early detection of abnormal cells in the mouth.

DENTAL LIMITATIONS AND EXCLUSIONS

- Examination and bitewing X-rays are limited to once every six months.
- Full mouth X-rays are limited to once every three years.
- Prophylaxis (cleaning) is limited to once every six months.
- Fluoride application is limited to once every six months.
- Surgical placement or removal of implants is not covered.
- Orthodontic services are not covered.
- Services for cosmetic reasons are not covered.

Refer to your policy for a complete listing of limitations and exclusions. This is a benefit summary only. For a complete description of benefits, refer to your policy.



DELTA DENTAL PREMIER PLAN

SERVICE	BENEFIT
Plan year maximum, per member	\$750: 1st year benefit maximum \$1,000: 2nd year benefit maximum \$1,250: 3rd year benefit maximum
Plan year deductible, per member	\$50
CLASS 1: Examinations/X-rays (routine exam and bitewing X-rays once every six months); prophylaxis (cleanings once every six months); fissure sealants; fluoride	Premier network 80%
CLASS 2: Restorative dentistry (treatment of tooth decay with amalgam, synthetic porcelain and plastic materials); space maintainers	80%
CLASS 3: Oral surgery (surgical extractions and certain minor surgical procedures); endodontics and periodontics 12-month waiting period on major services*: crowns; cast restorations; dentures and bridge work (construction or repair of fixed bridges, partials and complete dentures)	50%

DELTA DENTAL PREFERRED PROVIDER OPTION (PPO) PLAN

SERVICE	BENEFIT	
Plan year maximum, per member	\$750: 1st year benefit maximum \$1,000: 2nd year benefit maximum \$1,250: 3rd year benefit maximum	
Plan year deductible, per member	\$50	
CLASS 1: (**deductible waived): Examinations/X-rays (routine exam and bitewing X-rays once every six months); prophylaxis (cleanings once every six months); fissure sealants; fluoride	PPO network	Non-PPO network
	100%**	80%
CLASS 2: Restorative dentistry (treatment of tooth decay with amalgam, synthetic porcelain and plastic materials); space maintainers	80%	50%
CLASS 3: Oral surgery (surgical extractions and certain minor surgical procedures); endodontics and periodontics 12-month waiting period on major services*: crowns; cast restorations; dentures and bridge work (construction or repair of fixed bridges, partials and complete dentures)	50%	50%

* *Waiting period may be waived by creditable prior coverage from a comparable plan*

** *Deductible waived only in PPO network*

Individual dental plan highlights

- Freedom to choose any licensed dentist
- No waiting periods for Class 1 and Class 2 services
- 12-month waiting period for some Class 3 services
- Filed-fee savings from participating dentists
- Increasing maximums
- Pre-determination of benefits if requested in a pre-treatment plan
- No claim forms
- Prompt and accurate claims payment
- Superior customer service



MONTHLY RATES (Effective 11/1/08 – 10/31/09)

	MONTHLY RATES (Effective 11/1/08 – 10/31/09)										
	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	
INSURED	Maximizer \$1,000	\$85	\$124	\$135	\$157	\$171	\$211	\$250	\$297	\$352	\$411
	Maximizer \$2,500	70	101	110	129	139	173	205	243	287	335
	Maximizer \$5,000	56	82	88	102	112	139	164	195	231	269
	Beneficial Rx \$1,000	93	136	148	172	187	232	276	326	386	450
	Beneficial Rx \$2,500	77	112	122	142	155	192	228	269	318	371
	Beneficial Rx \$5,000	61	88	97	112	123	151	180	212	252	294
	Beneficial Value \$1,000	64	95	102	120	131	162	192	228	270	314
	Beneficial Value \$2,500	50	74	81	94	102	126	150	179	211	246
	Beneficial Value \$5,000	38	56	60	70	76	95	112	134	158	184
	Beneficial Value \$7,500	28	41	45	52	57	71	84	100	119	137
	HSA Choice \$1,500	69	101	111	128	140	172	205	242	286	335
	HSA Value \$2,800	45	65	72	83	90	112	133	157	186	217
INSURED + SPOUSE	Maximizer \$1,000	\$169	\$246	\$285	\$333	\$362	\$420	\$498	\$589	\$698	\$819
	Maximizer \$2,500	137	201	233	272	296	344	407	482	571	670
	Maximizer \$5,000	110	161	187	219	237	276	327	387	458	537
	Beneficial Rx \$1,000	185	270	313	366	396	462	547	647	766	898
	Beneficial Rx \$2,500	152	222	258	302	328	381	451	534	633	742
	Beneficial Rx \$5,000	121	176	205	238	259	302	357	423	501	587
	Beneficial Value \$1,000	129	187	217	255	276	321	381	452	536	626
	Beneficial Value \$2,500	100	147	170	199	216	252	298	355	420	491
	Beneficial Value \$5,000	75	110	126	149	161	188	223	265	314	367
	Beneficial Value \$7,500	56	82	95	111	121	140	167	198	235	274
	HSA Choice \$3,000	138	201	233	272	295	344	406	481	569	668
	HSA Value \$5,600	89	130	151	176	192	222	264	311	369	433
INSURED + CHILD(REN)	Maximizer \$1,000	\$146	\$212	\$249	\$286	\$308	\$350	\$360	\$406	\$457	\$492
	Maximizer \$2,500	119	174	204	234	252	285	294	332	374	403
	Maximizer \$5,000	96	139	163	188	201	229	236	267	299	322
	Beneficial Rx \$1,000	160	233	273	315	338	383	394	446	501	540
	Beneficial Rx \$2,500	132	193	227	260	279	317	326	368	414	445
	Beneficial Rx \$5,000	105	152	179	206	221	250	258	292	328	353
	Beneficial Value \$1,000	111	162	189	220	234	267	276	311	351	376
	Beneficial Value \$2,500	86	127	148	172	184	209	216	245	274	295
	Beneficial Value \$5,000	64	95	111	129	137	156	161	183	205	220
	Beneficial Value \$7,500	48	71	83	96	102	117	121	137	154	164
	HSA Choice \$3,000	119	173	204	234	251	285	294	332	373	401
	HSA Value \$5,600	77	112	132	151	163	185	191	216	242	260
INSURED + SPOUSE + CHILD(REN)	Maximizer \$1,000	\$235	\$343	\$402	\$460	\$479	\$561	\$612	\$707	\$816	\$878
	Maximizer \$2,500	192	280	329	376	392	458	500	577	666	718
	Maximizer \$5,000	154	224	264	302	314	368	401	463	535	576
	Beneficial Rx \$1,000	257	376	441	504	525	615	671	774	894	963
	Beneficial Rx \$2,500	212	310	364	416	433	509	554	640	738	795
	Beneficial Rx \$5,000	169	246	289	330	343	403	439	506	585	629
	Beneficial Value \$1,000	179	262	306	351	365	429	468	542	625	672
	Beneficial Value \$2,500	139	206	240	276	285	335	367	425	491	526
	Beneficial Value \$5,000	105	154	179	206	213	250	274	318	367	393
	Beneficial Value \$7,500	77	115	133	154	159	187	206	238	276	294
	HSA Choice \$3,000	192	280	327	375	390	457	499	576	665	715
	HSA Value \$5,600	124	181	212	243	254	297	323	374	431	464

OPTIONAL PRESCRIPTION DRUG RIDER FOR BENEFICIAL VALUE PLAN

	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Individual	\$5	\$8	\$9	\$10	\$11	\$13	\$15	\$17	\$21	\$25
Individual + Spouse	11	15	19	21	23	26	30	35	41	50
Individual + Child(ren)	10	13	16	17	20	22	22	24	27	30
Individual + Spouse + Child(ren)	15	21	26	28	30	35	37	41	48	53

DENTAL

	2-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Individual										
Premier	\$36	\$38	\$38	\$38	\$46	\$46	\$48	\$48	\$48	\$48
Preferred PPO	33	36	36	36	41	41	45	45	45	45
Individual + Spouse										
Premier	72	77	77	77	95	95	97	97	97	97
Preferred PPO	67	72	72	72	81	81	88	88	88	88
Individual + Child(ren)										
Premier	70	77	77	77	91	91	97	97	97	97
Preferred PPO	64	70	70	70	80	80	87	87	87	87
Individual + Spouse + Child(ren)										
Premier	105	111	111	111	142	142	144	144	144	144
Preferred PPO	101	107	107	107	120	120	131	131	131	131

HOW TO ENROLL

- 1 Compare plans and benefits on pages 8 and 9 and choose the medical plan that best meets your coverage needs.
- 2 Carefully consider ODS’ one-time dental offer for inclusion with your medical plan. You will not be able to add it later if you do not select it at the time of your initial enrollment.
- 3 Review the monthly rates provided to find your total cost.
- 4 Complete an application and submit to ODS with the initial premium. The online application can be found at www.odskompanies.com by clicking on the “looking for insurance” link. A PDF of our paper application can be downloaded from our site as well. We require complete submission no less than 10 days before the desired effective date for underwriting and processing.

- 5 ODS will review the past five years of your health history to determine your acceptance for insurability. You will be notified in writing of the outcome. **If you are accepted**, the application will be processed and you will receive an ID card and member handbook. **If you are not accepted**, your notice will include the reason for the decline, and your initial premium check will be returned to you with the letter. For online applications, your premium will never debit your account if you are not accepted.

FOR HSA MEMBERS ONLY:

- 6 You are responsible for setting up a Health Savings Account with the bank of your choice for your contributions. ODS partners with some banking institutions to provide you with lower set-up fees; however, you may use any banking partner you choose. Contact our marketing department if you would like phone numbers for ODS banking partners.

For help, contact an ODS-appointed agent or call ODS at 503-243-3973 or toll-free at 877-277-7073.

SERVICE AREA

Illustrated in the ODS Provider Directory.

DEPENDENT ELIGIBILITY

Dependents are a lawful spouse or partner pursuant to the Oregon Family Fairness Act and unmarried children younger than age 23.

OUT-OF-AREA DEPENDENT CHILDREN COVERAGE

If your enrolled dependent 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 must access benefits within a 30-mile radius of their residence in order for the PPO benefit level to apply.

LIMITATIONS

Six-month exclusion period applies to the following:

- ▶ 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
- 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 admissions must be authorized by ODS.
 - ▶ Mental illness paid up to a \$2,500 maximum or 20 outpatient visits in a 12-month period for inpatient/outpatient/residential services, combined
 - ▶ Alcohol treatment up to a \$4,500 maximum in a 24-month period for inpatient/outpatient/residential services combined
 - ▶ A 24-month exclusion period for transplants
 - ▶ ODS will not pay benefits for covered expenses to the extent that you have any other coverage for those expenses.

- ▶ Inpatient rehabilitation benefits are limited to 30 days per plan year; outpatient rehabilitation benefits are limited to 30 sessions per plan year. Prior authorization is needed for up to 60 days inpatient, or 60 sessions outpatient, rehabilitation for head and spinal cord injuries.
- ▶ Transplant benefits are limited to an aggregate lifetime maximum benefit of \$250,000.
- ▶ Hospice benefits are limited to \$20,000 for home care; 12 days of inpatient care; 170 hours/three months respite care.

EXCLUSIONS

- ▶ Services provided by a member of the patient's immediate family
- ▶ Services or supplies that 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
- ▶ 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
- ▶ Instructional 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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*Insurance products provided by
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