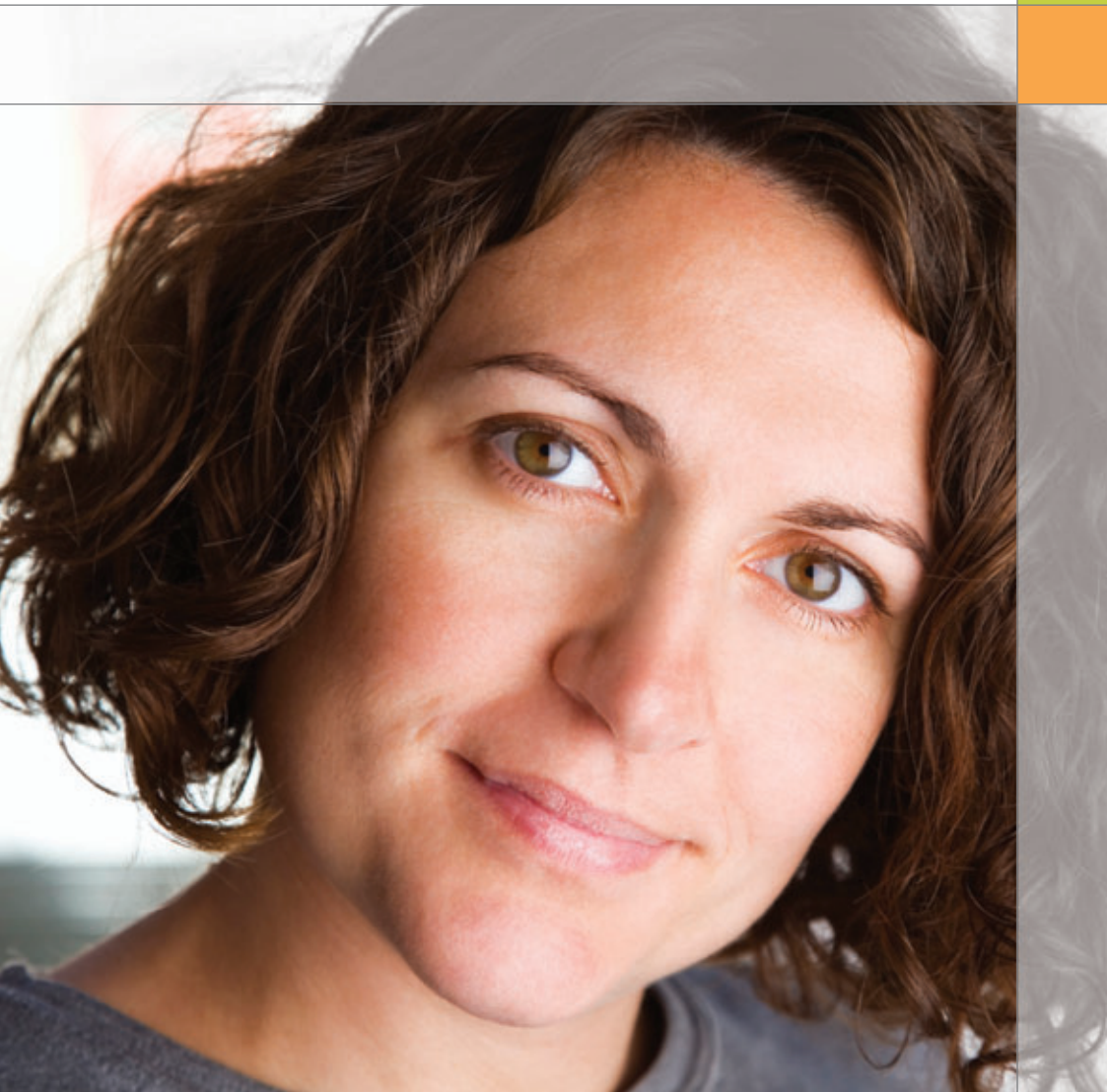




Individual and family plans

MEDICAL AND DENTAL

www.odscompanies.com



ODS **WELL**—PLANS AND TOOLS TO HELP YOU FEEL YOUR BEST

For more than 50 years, we have been working to make sure you have everything you need to feel your best. From our broad network of physicians, hospitals and clinics to our in-house health experts, state-of-the-art claims payment system and standard ODS health tools, we are committed to helping you live well at every stage of your life.

PERSONALIZED MEMBER WEBSITE

ODS 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.

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 enhance 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 for paying the cost, in full, after the discount is applied.

YOUR PARTNER IN HEALTH

Our wide array of personalized health programs, services and support help you improve your health and live a more productive

life. Through our care coordination and health coaching programs, clinical professionals — physicians, nurses, social workers, dietitians and pharmacists — help you identify, plan and achieve your health goals.

Our integrated clinical teams use evidence-based practices to work one-on-one with you to manage both acute and chronic medical conditions including diabetes, asthma, depression and cardiac care. In addition, a coach will guide you through your pregnancy with our maternity care program. Helping you navigate the complexities of the healthcare system optimizes clinical outcomes and saves you money on out-of-pocket claims costs.

A variety of helpful tools, both online and via telephone are available around the clock to help you improve your health, including:

- E-mail answers from physicians, psychologists, dentists, pharmacists, dietitians and fitness experts
- Phone advice from a registered nurse, 24/7
- Online tools to track healthy living habits
- Web-based health and symptom evaluator
- Health assessments
- Online medical library
- Health news articles, forums and more





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 network in Oregon, the ODS Plus Network. 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 13.

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 or \$5,000
- Prescriptions covered at \$15 generic or 50% brand, up to a \$5,000 PPY maximum

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 a \$5,000 PPY maximum

**Family Health Insurance Assistance Program (FHIAP) eligible plan is the Beneficial Rx, with a \$1,000 deductible. Waivers and downgrades are not permitted for 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 a \$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, up to a \$2,000 PPY maximum

HEALTH SAVINGS ACCOUNT (HSA)

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

HSA 3000

- \$3,000 individual/\$6,000 family deductible
- Preventive care at 50%, deductible waived
- 100% in-network/50% out-of-network benefit after deductible
- 100% prescription benefit after deductible

HSA VALUE

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

INDIVIDUAL MEDICAL PLAN OFFERINGS

INDIVIDUAL PLANS	MAXIMIZER (PPO)		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 prenatal/postnatal 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 generic or 50% brand*; \$5,000 annual maximum benefit		\$15 generic 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.

** 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.

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

BENEFICIAL VALUE (PPO)		HSA 3000		HSA VALUE	
\$1,000 / \$2,500 / \$5,000 / \$7,500		\$3,000 (individual) \$6,000 (family)*		\$2,800 (individual) \$5,600 (family)*	
\$5,000	\$10,000	\$0	no maximum	\$2,200 (individual) \$4,400 (family)	no maximum
		\$2,000 (individual) \$4,000 (family)****			
Member Responsibility		Member Responsibility		Member Responsibility	
In-Network	Out-of-Network	In-Network	Out-of-Network	In-Network	Out-of-Network
\$25 copay*	50%	50%*	50%	50%*	50%
\$25 copay*	50%	50%*	50%	50%*	50%
\$25 copay*	Not covered	50%*	50%	50%*	50%
\$25 copay*	Not covered	50%*	50%	50%*	50%
\$0*	Not covered	50%*	50%	50%*	50%
First 3 at \$25**	50%	0%	50%	50%	50%
First 3 at \$25**	50%	0%	50%	50%	50%
30%	50%	0%	50%	50%	50%
30%	50%	0%	50%	50%	50%
30%	50%	0%	50%	50%	50%
30%	50%	0%	50%	50%	50%
First 3 at \$25**	50%	0%	50%	50%	50%
30% after \$100 copay		0%		50%	
30%		0%		50%	
optional***		0%		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	

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

**** Out-of-pocket maximum for preventive care services only.

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 90 percent of all 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 1 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.odscompanies.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 Plus with TBlue 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.

This is a benefit summary only. For a complete description of benefits, limitations and exclusions, 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*: cast restorations (including crowns); 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 100%**	Non-PPO network 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*: cast restorations (including crowns); 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 (For subscribers effective December 2009 – October 2010)

INSURED		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	Maximizer \$1,000	\$100	\$146	\$159	\$185	\$201	\$249	\$295	\$350	\$414	\$483
	Maximizer \$2,500	82	119	129	151	164	204	241	286	338	395
	Maximizer \$5,000	65	96	104	120	132	164	194	229	272	317
	Beneficial Rx \$1,000	109	160	174	202	220	273	324	383	454	529
	Beneficial Rx \$2,500	91	132	144	167	182	226	268	317	374	437
	Beneficial Rx \$5,000	72	104	114	132	145	178	211	250	296	346
	Beneficial Value \$1,000	76	111	120	141	154	191	226	268	318	369
	Beneficial Value \$2,500	59	87	95	110	120	149	177	210	249	290
	Beneficial Value \$5,000	45	65	70	82	90	111	132	158	186	217
	Beneficial Value \$7,500	33	49	53	62	67	83	99	118	140	161
	HSA 3000 \$3,000	81	118	129	150	164	202	240	283	335	392
	HSA Value \$2,800	53	77	85	97	106	132	156	185	219	255
INSURED + SPOUSE		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	Maximizer \$1,000	\$199	\$290	\$336	\$392	\$425	\$495	\$586	\$693	\$821	\$964
	Maximizer \$2,500	161	237	274	320	349	405	479	568	671	788
	Maximizer \$5,000	129	190	220	258	279	324	384	455	539	632
	Beneficial Rx \$1,000	218	318	368	431	466	543	643	761	901	1,057
	Beneficial Rx \$2,500	179	261	304	355	386	449	531	628	745	873
	Beneficial Rx \$5,000	142	208	241	281	305	355	420	497	589	691
	Beneficial Value \$1,000	151	220	255	300	324	378	449	532	630	737
	Beneficial Value \$2,500	118	173	200	235	254	296	351	418	495	578
	Beneficial Value \$5,000	88	129	149	176	190	222	263	311	369	432
	Beneficial Value \$7,500	65	96	111	131	142	165	196	233	277	323
	HSA 3000 \$6,000	161	235	273	319	345	402	476	564	666	782
	HSA Value \$5,600	105	152	178	208	226	261	310	366	434	510
INSURED + CHILD(REN)		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	Maximizer \$1,000	\$172	\$250	\$293	\$337	\$363	\$411	\$424	\$478	\$538	\$579
	Maximizer \$2,500	140	205	240	276	296	336	346	391	440	474
	Maximizer \$5,000	113	164	192	222	237	269	278	314	352	379
	Beneficial Rx \$1,000	188	274	322	370	397	451	464	525	589	636
	Beneficial Rx \$2,500	155	227	267	306	328	373	383	433	487	524
	Beneficial Rx \$5,000	123	179	210	242	260	295	304	343	386	415
	Beneficial Value \$1,000	131	191	223	259	276	314	324	366	413	442
	Beneficial Value \$2,500	101	150	174	202	217	246	254	288	323	347
	Beneficial Value \$5,000	76	111	131	151	161	183	190	215	241	259
	Beneficial Value \$7,500	56	83	97	113	120	137	142	161	181	194
	HSA 3000 \$6,000	140	203	239	274	294	334	344	388	437	470
	HSA Value \$5,600	91	132	155	178	192	218	224	254	284	306
INSURED + SPOUSE + CHILD(REN)		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
	Maximizer \$1,000	\$277	\$404	\$473	\$541	\$564	\$660	\$720	\$832	\$960	\$1,033
	Maximizer \$2,500	226	329	387	442	461	539	588	679	784	844
	Maximizer \$5,000	181	264	310	355	369	433	472	545	629	678
	Beneficial Rx \$1,000	302	442	519	593	618	724	789	911	1,052	1,133
	Beneficial Rx \$2,500	250	365	428	490	510	598	652	753	869	935
	Beneficial Rx \$5,000	199	290	340	388	404	474	516	596	688	741
	Beneficial Value \$1,000	210	309	360	413	429	505	551	638	736	791
	Beneficial Value \$2,500	164	242	282	324	336	395	432	500	578	619
	Beneficial Value \$5,000	123	181	210	242	251	295	323	374	432	463
	Beneficial Value \$7,500	91	136	156	181	187	220	242	281	324	346
	HSA 3000 \$6,000	225	327	383	439	457	536	584	674	779	838
	HSA Value \$5,600	146	213	250	286	299	350	381	440	507	546

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	\$6	\$9	\$10	\$12	\$13	\$15	\$18	\$21	\$24	\$29
Individual + Spouse	13	18	22	24	27	31	36	41	49	59
Individual + Child(ren)	12	15	19	21	23	26	26	28	32	36
Individual + Spouse + Child(ren)	18	24	31	33	36	41	44	49	56	63

DENTAL

	0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Individual										
Delta Dental Premier	\$38	\$40	\$40	\$40	\$49	\$49	\$51	\$51	\$51	\$51
Delta Dental PPO	34	38	38	38	43	43	48	48	48	48
Individual + Spouse										
Delta Dental Premier	77	81	81	81	100	100	102	102	102	102
Delta Dental PPO	71	77	77	77	86	86	93	93	93	93
Individual + Child(ren)										
Delta Dental Premier	75	81	81	81	97	97	102	102	102	102
Delta Dental PPO	68	75	75	75	85	85	92	92	92	92
Individual + Spouse + Child(ren)										
Delta Dental Premier	111	118	118	118	150	150	152	152	152	152
Delta Dental PPO	107	113	113	113	127	127	139	139	139	139

HOW TO ENROLL

- 1 Compare plans and benefits on pages 6 and 7 and choose the medical plan that best meets your coverage needs.
- 2 Carefully consider ODS's one-time dental offer for inclusion with your medical plan at this rate. You will not be able to add the rider 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.odscompanies.com by clicking on the "looking for a health plan" 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 policy. **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.

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

In order to be eligible for any ODS individual medical and/or dental plan, you and any dependents applying for coverage must be Oregon residents 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?

Yes. We offer two dental plan options for individuals and their families. To ensure eligibility for either plan, enrollment must occur at the same time you are enrolling in an ODS individual medical plan.

Please note: if you waive coverage for any dependent child younger than age three when you first enroll in either dental plan, you may add the child to your plan upon his or her third birthday, provided written request is received by ODS within 31 days of the birthday.

Is there an exclusion 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 exclusion period. Each day of creditable coverage will reduce the six-month period by one day.

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.

What payment methods do you offer?

Payment can be made via monthly electronic deduction from your checking account, free of charge, or you can elect to receive monthly or quarterly billing for an additional \$5 administrative fee per billed statement.

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.

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. A breastfeeding mother who has not resumed menstruation since childbirth will need to provide evidence that she is not pregnant prior to issue of this policy.

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.



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.odscompanies.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.



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 unmarried children under 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 in-network benefit level to apply.

LIMITATIONS

- ▶ 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
- ▶ ODS will not pay benefits for covered expenses to the extent that you have any other coverage for those expenses
- ▶ Smoking cessation coverage limited to \$500 per person lifetime benefit
- ▶ Hearing aid coverage limited to children under age 18 with a maximum benefit of up to \$4,000 every 48 months
- ▶ 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
- ▶ Hospice benefits are limited to \$20,000 for home care; 12 days of inpatient care; 170 hours/ three months respite care

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

24-month exclusion period applies to:

- ▶ Transplants (benefits are limited to an aggregate lifetime maximum benefit of \$250,000)

Note: Your plan's 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.

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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