ODS

Individuals and families

HEALTH BENEFIT PLAN OPTIONS

www.odscompanies.com

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WELCOME TO ODS.

We are honored to have the opportunity to provide you with everything you need to feel your best. When you choose ODS, you not only choose a partner dedicated to serving you; you choose our local team backed by an entire company with more than 55 years of experience.

ODS is proud to stand on the front line of innovation, advancing a wide range of initiatives to enhance evidence-based preventive healthcare. Our in-house health experts, diverse networks and superb customer service also guarantee you have the resources that will help you get well sooner and live well longer.

Think of us as your partner in health

When you choose ODS, you choose much more than just an insurance plan. You choose a healthier you. That's because our integrated clinical teams and programs are designed to support you and help you achieve your health goals.

myODS

As a member of ODS, you have access to myODS, your personalized member website. myODS helps you manage your benefits so you get the most from your plan. With myODS, you can:

- View your benefits, eligibility and history
- Review prescription history and pharmacy benefits, including medication pricing information
- View account details, such as contact information and enrolled dependents
- Order additional or replacement ID cards
- Check the status of pending claims, view personal claim history and access claim forms
- Receive and view electronic Explanation of Benefits (EOBs)

ODS WELL

ODS Well™ includes tools and individualized support to help you get well sooner and live well longer. Included as part of all ODS medical plans, ODS Well is available through myODS and includes:

ODS eDoc

This service helps you understand your symptoms and make informed health decisions. Email a specialized health professional at any time of the day to get the answers you need. ODS eDoc gives you access to:

- Board-certified physicians
- Licensed psychologists
- Pharmacists
- Dentists
- Dietitians
- Fitness experts
- ODS eDocVoice – leave a message for a provider and you'll get a phone response within 24 hours

Nurse Line

The ODS Registered Nurse Advice Line allows you to get answers and information about your health over the phone, day or night. Nurses can help you with basic health situations, such as:

- Understanding symptoms
- Treatment for minor injuries and burns
- Home cold and flu remedies
- When it's time to make a doctor's appointment
- Whether you should go to urgent care or the emergency room

Condition management and health coaching

ODS offers in-depth support programs for those dealing with chronic health conditions. You have access to tools and resources that help you maintain a healthy lifestyle. Individual health coaches provide you with one-on-one support. These specialized programs include:

- Cardiac Care
- Depression Care
- Diabetes Care
- Lifestyle Coaching
- Maternity Care
- Respiratory Care
- Spine & Joint Care

Care coordination

If you are dealing with a serious illness or recovering from an accident, you have access to case managers who can help you navigate the complexities of the healthcare system. An ODS case manager can help:

- Communicate with providers
- Explain treatment options
- Arrange for in-home caregivers
- Order medical equipment

Tobacco cessation

If you or one of your covered dependents age 10 or older participates in a tobacco cessation program, related expenses for the following are covered:

- Counseling
- Office visits
- Medical supplies
- Drugs provided or recommended by a tobacco cessation program

A tobacco cessation program means a professional provider offering an overall treatment program that follows the U.S. Public Health Services guidelines for tobacco cessation.

Online tracking tools*

ODS provides secure, online health education tools and information to help you better manage your health. Keep track of your progress by using the following tools:

- Health and symptom evaluation
- Medical library
- Health helpers (tools such as healthtrackers, calculators and more)
- Pharmacy costs and research
- My health files
- News, forums and communication

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.

** These services are available to members with a pharmacy benefit.*

Finding the right coverage is easier than ever

ODS is pleased to offer you extensive access to in-network health plan benefits whether you're at home or on the road. This makes finding coverage easy and convenient, regardless of your location.

ODS PLUS NETWORK

The ODS Plus Network is the largest directly contracted PPO network in Oregon, giving members broad physician choice and geographic coverage. With more than 11,000 providers in our network participating across all specialties — including primary care, surgery, radiology, anesthesiology, chiropractic, naturopathic and acupuncture — your service needs have been anticipated.

OUT-OF-NETWORK PROVIDERS

All of our health 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 or travel networks.

Out-of-network coverage coinsurance is based on the maximum plan allowance for these services. If you seek treatment from a non-contracted provider, they may bill you for the difference between the maximum plan allowance and their billed charge; an ODS-contracted — or in-network — provider is prohibited from this practice. To review out-of-network benefits, please see pages 10-11.

ODS TRAVEL NETWORK

If you need medical care while you are traveling, the ODS Travel Network will make sure you enjoy in-network benefits coast to coast.

The ODS Travel Network is served by the PHCS Healthy Directions Network, which gives you access to thousands of primary care physicians, specialists, hospitals and other medical facilities.

How does it work?

When you or a dependent need medical care while traveling outside of your primary service area, ODS will review your claim to see if the provider is part of the PHCS Healthy Directions Network. If so, ODS will pay the claim at the in-network benefit level. Best of all, you can seek care whether or not it's an emergency.

Choosing the right plan for you

As you compare our health plan designs, you'll notice that 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 16.

MAXIMIZER PLAN: PREFERRED PROVIDER ORGANIZATION (PPO)

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

- $0 copay and deductible waived for most in-network preventive care visits
- $20 copay for the first six office or urgent care center visits received in-network; after the first six visits, the deductible and coinsurance apply
- $20 copay for chiropractic, acupuncture and naturopathic care when in-network, up 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 $2 value tier, $15 generic or 50% brand; deductible waived

BENEFICIAL RX PLAN: 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.

- $0 copay and deductible waived for most 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 $2 value tier, $15 generic or 50% brand; deductible waived

**Family Health Insurance Assistance Program (FHIAP) eligible plan is the Beneficial Rx, with a $1,000 deductible. Downgrades are not permitted for FHIAP participants.*

BENEFICIAL VALUE PLAN: PREFERRED PROVIDER ORGANIZATION (PPO)

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

- $0 copay and deductible waived for most 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 per plan year maximum
- Annual deductible choices of $1,000, $2,500, $5,000 or $7,500
- Prescriptions covered with optional rider; benefit is $2 value tier, $15 generic or 50% brand; deductible waived

HEALTH SAVINGS ACCOUNT PLANS

Health savings account (HSA) plans offer lower insurance premiums through a tax-advantaged and high-deductible health plan.

HSA 3000 PLAN

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

HSA VALUE PLAN

- $2,800 individual/$5,600 family deductible
- In-network preventive care at 100%, 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 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
Plan year essential benefit maximum	$2,000,000		$2,000,000	
PREVENTIVE CARE	**Member responsibility**		**Member responsibility**	
The deductible is waived for in-network preventive care.	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
Annual women's exam — Pap, pelvic, breast	$0*	50%	$0*	40%
Women's routine mammogram	$0*	50%	$0*	40%
Well-baby care	$0*	Not covered	$0*	Not covered
Routine physical exams	$0*	Not covered	$0*	Not covered
Immunizations	$0*	Not covered	$0*	Not covered
PROFESSIONAL SERVICES				
Office visits	First six at $20 copay*	50%	First three at $15*	40%
Alternative care ($1,000 per plan year limit) — Chiropractic, naturopathic and acupuncture	$20 copay*	50%	First three 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 — Inpatient, outpatient, residential (see limitations on page 18)	30%	50%	20%	40%
Lab and X-ray services; medical supplies and devices; in-hospital care; home healthcare	30%	50%	20%	40%
Vision (see limitations on page 18)	Not covered		20%*	Not covered
EMERGENCY SERVICES				
Urgent care	First six at $20 copay*	50%	First three at $15*	40%
Emergency room (deductible applies)	30% after $100 copay		20% after $100 copay	
Ambulance ($5,000 per plan year)	30%		20%	
OTHER BENEFITS				
Prescription services	$2 value tier, $15 generic or 50% brand*		$2 value tier, $15 generic or 50% brand*	
Accident benefit	Deductible waived for treatment completed within 90 days of accident		Deductible waived for treatment completed within 90 days of accident	

* *Deductible waived.*

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
$2,000,000		$2,000,000		$2,000,000	
Member responsibility		**Member responsibility**		**Member responsibility**	
In-network	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
$0*	50%	$0*	50%	$0*	50%
$0*	50%	$0*	50%	$0*	50%
$0*	Not covered	$0*	50%	$0*	50%
$0*	Not covered	$0*	50%	$0*	50%
$0*	Not covered	$0*	50%	$0*	50%
First three at $25*	50%	0%	50%	50%	50%
First three 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%
Not covered		Not covered		Not covered	
First three at $25*	50%	0%	50%	50%	50%
30% after $100 copay		0%		50%	
30%		0%		50%	
Optional*		0%		50%	
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	

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

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

- Examinations are limited to once every six months.
- Bitewing X-rays are limited to once every 12 months.
- Full mouth X-rays are limited to once every five years.
- Prophylaxis (cleaning) is limited to once every six months.
- Fluoride application is limited to once every 12 months to age 19.
- 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.

Does my dentist participate in the Delta Dental Premier or Delta Dental PPO networks?

Visit **www.odscompanies.com** and use our Find Care tool to search for participating dentists in your area.

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 prophylaxis/cleanings once every six months; bitewing X-rays once every 12 months); fissure sealants; fluoride is limited to once every 12 months to age 19	**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**[1]: cast restorations (including crowns); dentures and bridge work (construction or repair of fixed bridges, partials and complete dentures)	50%

DELTA DENTAL PREFERRED PROVIDER ORGANIZATION (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[2]): Examinations/X-rays (routine exam and prophylaxis/cleanings once every six months; bitewing X-rays once every 12 months); fissure sealants; fluoride is limited to once every 12 months to age 19	**PPO network** 100%[2]	**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**[1]: cast restorations (including crowns); dentures and bridge work (construction or repair of fixed bridges, partials and complete dentures)	50%	50%

1 Waiting period may be waived by creditable prior coverage from a comparable plan. 2 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

		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
INSURED	Maximizer $1,000	$131	$186	$202	$234	$255	$316	$374	$444	$526	$613	$705
	Maximizer $2,500	106	149	162	189	205	254	301	357	422	493	566
	Maximizer $5,000	82	117	126	146	160	199	235	279	330	385	442
	Beneficial Rx $1,000	151	215	234	272	296	367	436	515	609	711	818
	Beneficial Rx $2,500	114	160	174	202	221	274	325	384	454	530	609
	Beneficial Rx $5,000	94	132	145	168	184	227	269	318	377	441	506
	Beneficial Value $1,000	99	142	153	179	195	243	287	340	404	469	539
	Beneficial Value $2,500	77	110	120	140	153	188	224	266	315	367	422
	Beneficial Value $5,000	61	86	93	108	118	147	174	208	245	285	328
	Beneficial Value $7,500	47	66	71	83	90	113	134	160	190	219	252
	HSA 3000 $3,000	112	157	173	200	218	269	320	377	447	523	601
	HSA Value $2,800	67	95	104	120	131	162	192	227	270	314	361

		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
INSURED + SPOUSE	Maximizer $1,000	$260	$368	$426	$498	$540	$628	$744	$880	$1,043	$1,224	$1,411
	Maximizer $2,500	208	296	342	400	435	506	598	709	838	984	1,134
	Maximizer $5,000	162	231	268	313	340	394	467	553	656	768	886
	Beneficial Rx $1,000	302	427	494	578	627	730	864	1,023	1,210	1,420	1,637
	Beneficial Rx $2,500	225	317	368	431	468	544	643	762	903	1,058	1,220
	Beneficial Rx $5,000	187	264	307	357	389	452	535	633	751	880	1,015
	Beneficial Value $1,000	198	280	324	381	412	481	570	676	801	937	1,082
	Beneficial Value $2,500	154	219	253	297	321	375	445	529	627	732	846
	Beneficial Value $5,000	120	171	196	231	250	292	346	410	486	569	657
	Beneficial Value $7,500	92	130	151	177	193	224	266	317	376	438	506
	HSA 3000 $6,000	222	313	364	425	460	536	635	751	888	1,043	1,202
	HSA Value $5,600	133	188	219	255	278	322	382	451	534	628	724

		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
INSURED + CHILD(REN)	Maximizer $1,000	$225	$322	$378	$434	$467	$529	$544	$612	$689	$740	$853
	Maximizer $2,500	180	259	304	349	375	425	436	492	553	595	685
	Maximizer $5,000	141	202	237	273	292	331	341	385	432	464	536
	Beneficial Rx $1,000	261	373	439	505	541	614	629	712	798	858	990
	Beneficial Rx $2,500	194	279	328	377	404	458	469	530	595	639	738
	Beneficial Rx $5,000	162	232	272	313	336	380	391	441	495	532	614
	Beneficial Value $1,000	171	246	288	334	355	404	416	470	529	565	655
	Beneficial Value $2,500	132	193	224	260	278	316	325	369	412	442	511
	Beneficial Value $5,000	103	149	175	202	216	245	252	286	320	343	397
	Beneficial Value $7,500	79	115	134	155	166	189	195	221	247	264	306
	HSA 3000 $6,000	192	274	323	371	398	451	463	522	587	630	727
	HSA Value $5,600	116	165	194	222	240	271	279	315	353	379	438

		0-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65+
INSURED + SPOUSE + CHILD(REN)	Maximizer $1,000	$363	$517	$606	$693	$722	$845	$920	$1,062	$1,225	$1,314	$1,515
	Maximizer $2,500	291	415	488	557	581	679	739	853	984	1,057	1,217
	Maximizer $5,000	227	324	381	435	452	531	577	666	768	826	951
	Beneficial Rx $1,000	419	600	704	804	836	981	1,067	1,231	1,420	1,525	1,756
	Beneficial Rx $2,500	313	447	524	599	624	732	796	919	1,059	1,137	1,310
	Beneficial Rx $5,000	261	372	437	499	518	609	662	763	881	946	1,090
	Beneficial Value $1,000	276	396	462	529	550	647	705	816	939	1,007	1,161
	Beneficial Value $2,500	214	310	361	414	429	504	551	637	736	786	906
	Beneficial Value $5,000	167	240	280	322	334	392	428	496	572	611	704
	Beneficial Value $7,500	127	186	214	247	256	302	331	383	442	471	544
	HSA 3000 $6,000	309	441	516	591	614	720	783	904	1,044	1,120	1,291
	HSA Value $5,600	186	264	310	355	370	434	471	544	627	673	776

ODS invites you to use the younger spouse as the primary applicant if it will help you receive a lower premium.

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	65+
Individual	$8	$11	$13	$15	$16	$20	$23	$26	$31	$38	$43
Individual + spouse	17	23	28	31	34	39	46	52	62	75	85
Individual + child(ren)	15	20	25	27	30	33	33	36	41	46	51
Individual + spouse + child(ren)	24	31	40	43	46	53	56	62	72	80	92

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 10 and 11 and choose the medical plan that best meets your coverage needs.
2. Carefully consider ODS's one-time dental plan rider 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 "Shopping for health 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. Applicants under age 19 cannot be declined due to their reported health conditions. 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 be debited from 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. For a list of ODS banking partners and their contact information, please call our Sales and Account Services department.

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

Glossary of terms

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

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

PLAN YEAR ESSENTIAL BENEFIT MAXIMUM
The term essential benefit refers to benefits subject to a plan year maximum of $2,000,000. The coverage of these benefits — whether in- or out-of-network — accrue toward the plan year maximum for each member. Once the maximum is met, coverage for all essential benefits will cease until the following plan year.

Essential benefits include these categories:

- Ambulatory services
- Emergency services
- Hospitalization, including skilled nursing facility
- Maternity and newborn care
- Mental health and chemical dependency services
- Prescription drugs, including those administered in a professional provider's office, urgent care center, or facility, or in conjunction with home healthcare
- Covered rehabilitative and habilitative services and devices
- Hospice care
- Laboratory tests
- Covered preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care, if any

DEDUCTIBLE
The portion of an individual's applicable healthcare expenses that must be paid by the member in a given plan year before the insurance plan will start paying for treatment. Fixed dollar copayments, prescription drug out-of-pocket costs, and disallowed charges do not apply toward the deductible.

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. Fixed dollar copayments, prescription drug out-of-pocket costs, and disallowed charges do not apply toward the out-of-pocket maximum.

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

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.

VALUE TIER DRUG
Value drugs include select commonly prescribed products used to treat chronic medical conditions and preserve health.

Frequently asked questions

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

For any ODS individual medical and/or dental plan, you and any dependents applying for coverage must be Oregon residents living 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 children up to age 26. Individuals must be younger than age 65 and not eligible for Medicare.

Do you offer a dental plan?

Yes. We offer two dental riders 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.

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. Pre-existing conditions do not apply to members under the age of 19.

When do your rates change?

ODS renews all individual plans on Nov. 1 each year, including benefit and rate adjustments. Rates also change when the primary applicant moves into the next age bracket; 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 business checks for individual plans.

How soon can a new mother apply?

For a new applicant, age 19 and over, the mother must be released from a doctor's care. This usually occurs at the six-week, post-birth checkup.

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.

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 eligible children up to age 26.

COVERAGE FOR CHILDREN RESIDING OUTSIDE THE SERVICE AREA

If your enrolled 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 may receive the in-network benefit level by using the travel network. If a travel network provider is not available, the services will be paid at the in-network benefit level if provided within a 30-mile radius of the child's residence or at the closest appropriate facility. Fees charged by out-of-area providers will be reimbursed at the maximum plan allowance for those services.

LIMITATIONS

- All medical and surgical admissions must be authorized by ODS
- Mental illness treatment up to 20 outpatient visits, or 10 days each, for inpatient or residential services per plan year
- Alcohol treatment up to 20 outpatient visits, or 10 days each, for inpatient or residential services per plan year
- ODS will not pay benefits for covered expenses to the extent that you have any other coverage for those expenses
- Hearing aid coverage limited to members under age 26 with a maximum benefit of up to $4,100 every 48 months
- Rehabilitation benefits are limited to 15 inpatient days and 15 outpatient sessions per plan year
- Hospice benefits are limited to 12 days of inpatient care; 170 hours/three months respite care
- Vision benefits are limited to one visit per plan year for members under age 18, and one visit every two years up to $200 for members age 18 and over

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, unless the insured is under the age of 19

24-month exclusion period applies to:

- Transplants (benefits are limited to an aggregate lifetime maximum benefit of $750,000)

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 effective 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
- Surgery 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 (those exempt from state and federal workers' compensation law will have 24-hour coverage)
- 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 services and supplies
- Services and supplies associated with orthognathic surgery
- Drugs for treatment of mental illness
- Chemical dependency treatment, except for alcohol treatment

www.odscompanies.com

601 S.W. Second Ave.
Portland, OR 97204-3156
503-243-3973 or **877-277-7073**

DELTA DENTAL®

These benefits and ODS policies are subject to change in order to be compliant with state and federal guidelines.

901288 (10/11) MKT-1034

Insurance products provided by Oregon Dental Service and ODS Health Plan, Inc.