Individuals and families

MEDICAL AND DENTAL PLAN OPTIONS

www.odscompanies.com

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WELCOME TO ODS.

More than 55 years ago, ODS sunk its roots deep into the Pacific Northwest, its culture and communities. Our healthcare plans now cover you from your head to your toes, including dental, medical, pharmacy and Medicare products.

PERSONALIZED MEMBER WEBSITE

As an ODS member, you'll enjoy around-the-clock access to your health plan information with myODS, your personal member website, where handbooks, claims status and history, detailed benefit information and more are just a mouse-click away.

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. 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, chronic obstructive pulmonary disease (COPD), depression and cardiac care. We also have a lifestyle coach who will help you with things such as sleep, nutrition and stress. In addition, a coach will guide you through your pregnancy with our maternity care program. These programs will help you navigate the complexities of the healthcare system, optimize clinical outcomes and save you money on out-of-pocket claims costs.

ODS WELL

ODS Well™, a standard part of every ODS medical plan, provides tools and personalized health support. ODS Well also gives you access to a variety of health tools, available online and via phone, including:

- Email answers from doctors, psychologists, dentists, pharmacists, dietitians and fitness experts
- 24/7 phone access to a registered nurse
- Online tools to track healthy living habits
- Tobacco cessation counseling

Individual plan members with a pharmacy benefit can access additional health tools, including:

- 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, 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 12.

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 office visits with just a copay.

- $0 copay 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 $15 generic or 50% brand

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.

- $0 copay 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 $15 generic or 50% brand

**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: 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.

- $0 copay 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 not covered unless optional rider is purchased; benefit is $15 generic, 50% brand

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
- 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

- $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✦	$750,000		$750,000	
PREVENTIVE CARE	**Member responsibility**		**Member responsibility**	
	In-network	**Out-of-network[1]**	**In-network**	**Out-of-network[1]**
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, pg. 14)	30%	50%	20%	40%
Lab and X-ray services; medical supplies and devices; in-hospital care; home healthcare	30%	50%	20%	40%
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	$15 generic or 50% brand◆		$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	

[1] Out-of-network coverage coinsurance is based on the maximum plan allowance for these services.

✦ Includes combined medical and prescription drug costs

◆ Deductible waived

** Maximizer plans pay the first six office visits with a copay, which may be used for either office visits or urgent care for illness and injury, some exceptions apply. Thereafter, the deductible and coinsurance apply for additional office visits.*

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
$750,000		$750,000		$750,000	
Member responsibility		**Member responsibility**		**Member responsibility**	
In-network	**Out-of-network[1]**	**In-network**	**Out-of-network[1]**	**In-network**	**Out-of-network[1]**
$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%
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	

*** 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 copay, which may be used for either office visits or urgent care for illness and injury, some exceptions apply. Alternative care includes an additional three visits with a copay. 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; 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 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 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 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** to access our up-to-date Find Care directory (formerly called Provider Search) and 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 bitewing X-rays once every six months); prophylaxis (cleanings once every six months); fissure sealants; fluoride 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***: 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 to age 19	**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

		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	$125	$169	$184	$214	$233	$288	$342	$405	$480	$560	$643
	Maximizer $2,500	100	136	147	172	187	232	275	326	385	450	517
	Maximizer $5,000	78	107	115	134	146	182	215	254	301	351	404
	Beneficial Rx $1,000	143	195	212	247	269	333	395	467	553	645	742
	Beneficial Rx $2,500	108	145	158	183	200	248	295	348	412	481	553
	Beneficial Rx $5,000	89	120	132	153	167	206	244	289	342	400	459
	Beneficial Value $1,000	94	129	140	164	178	222	262	311	369	428	492
	Beneficial Value $2,500	73	101	110	127	139	172	204	243	287	335	385
	Beneficial Value $5,000	58	79	85	99	108	134	159	190	224	261	299
	Beneficial Value $7,500	44	60	65	76	83	103	122	146	173	200	230
	HSA 3000 $3,000	106	144	158	182	199	246	292	344	408	477	548
	HSA Value $2,800	63	86	95	109	119	148	176	207	246	286	330
		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	$247	$336	$389	$454	$493	$573	$679	$803	$952	$1,117	$1,288
	Maximizer $2,500	198	270	312	365	397	461	546	647	765	898	1,035
	Maximizer $5,000	154	210	244	286	310	360	426	505	598	701	809
	Beneficial Rx $1,000	285	387	448	525	568	662	784	928	1,098	1,288	1,485
	Beneficial Rx $2,500	212	288	334	391	424	494	584	691	819	960	1,107
	Beneficial Rx $5,000	177	240	278	324	352	410	486	575	681	798	921
	Beneficial Value $1,000	189	256	296	348	376	439	520	617	731	855	987
	Beneficial Value $2,500	147	200	231	271	293	342	406	483	572	668	772
	Beneficial Value $5,000	114	156	179	211	228	267	316	375	444	519	600
	Beneficial Value $7,500	87	119	138	162	176	205	243	289	343	400	462
	HSA 3000 $6,000	211	286	332	388	420	490	579	686	811	951	1,097
	HSA Value $5,600	127	171	200	233	253	294	348	412	488	573	660
		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	$214	$299	$352	$404	$434	$491	$503	$565	$634	$680	$784
	Maximizer $2,500	171	241	282	325	348	394	403	454	509	547	630
	Maximizer $5,000	134	188	221	254	272	307	315	355	398	426	492
	Beneficial Rx $1,000	247	345	406	467	500	566	578	653	731	784	905
	Beneficial Rx $2,500	183	257	303	349	373	422	431	486	545	584	674
	Beneficial Rx $5,000	153	214	251	289	311	351	359	405	453	486	561
	Beneficial Value $1,000	163	228	268	311	330	375	385	434	487	519	602
	Beneficial Value $2,500	126	179	208	242	259	293	300	340	380	407	470
	Beneficial Value $5,000	98	138	163	188	201	227	233	264	295	315	365
	Beneficial Value $7,500	75	106	125	144	154	175	180	204	228	243	281
	HSA 3000 $6,000	183	255	300	345	370	418	428	482	540	579	668
	HSA Value $5,600	110	153	180	207	223	252	258	291	325	348	402
		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	$345	$478	$560	$640	$665	$779	$846	$976	$1,124	$1,203	$1,386
	Maximizer $2,500	276	383	451	514	535	626	680	784	903	967	1,114
	Maximizer $5,000	215	299	352	402	417	489	530	612	705	756	870
	Beneficial Rx $1,000	396	550	646	738	767	899	975	1,124	1,296	1,388	1,598
	Beneficial Rx $2,500	296	411	481	550	572	671	728	839	966	1,035	1,192
	Beneficial Rx $5,000	247	342	401	458	475	558	605	697	804	860	991
	Beneficial Value $1,000	262	366	427	489	507	597	648	750	863	922	1,062
	Beneficial Value $2,500	204	286	333	383	395	465	506	585	675	719	829
	Beneficial Value $5,000	159	222	258	297	308	361	394	456	525	559	644
	Beneficial Value $7,500	121	172	198	228	236	278	304	352	406	431	498
	HSA 3000 $6,000	294	407	477	545	566	664	720	830	959	1,025	1,181
	HSA Value $5,600	176	244	287	327	341	400	433	500	576	616	710

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	$10	$12	$13	$15	$18	$21	$24	$28	$34	$39
Individual + Spouse	16	21	25	28	31	36	42	48	57	69	78
Individual + Child(ren)	14	18	23	25	28	31	31	34	38	42	47
Individual + Spouse + Child(ren)	22	29	37	40	43	49	51	57	66	74	84

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 shopping for health insurance (formerly called "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. 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 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. 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

We understand healthcare can be complex and sometimes confusing. This brief list of commonly used terms in insurance 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, 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.

PLAN YEAR ESSENTIAL BENEFIT MAXIMUM

The term essential benefit refers to benefits subject to a plan year maximum of $750,000. 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 service
- Prescription drugs, including those administered in a professional provider's office, urgent care center, 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.

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.

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.

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 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 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 $4,000 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

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 $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 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
- 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

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DELTA DENTAL®

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

901328 (7/11) MKT-1034

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