



Basic Oregon Plan

Maximum Lifetime Benefit	\$1,000,000
	(You Pay)
Annual Deductible	None
Annual Out-of-Pocket Limit	\$3,750 Individual / \$7,500 Family ¹
PREVENTIVE CARE	
Well Baby Care	\$15 co-pay
Routine Physicals	\$15 co-pay
Routine Women's Exams	\$15 co-pay
Prostate Rectal Exam (PRE)	\$15 co-pay
Immunizations	\$15 co-pay
PROFESSIONAL SERVICES	
Office and Home Visits	50%
Urgent Care Visits	50%
Surgery	50%
Acupuncture	Not Covered
Chiropractic	
Naturopathic	
MATERNITY CARE	
Practitioner Services	50%
Hospital Stay	50%
HOSPITAL SERVICES	
Inpatient Care	50%
Skilled Nursing Facility Care	50%
OUTPATIENT SERVICES	
Outpatient Hospital/Facility	50%
Diagnostic X-Ray and Lab	50%
Specified Imaging (MRI, CT, CAT, PET scans)	50%
Emergency Room Visits	50%
OTHER COVERED SERVICES	
Physical Therapy	50%
Allergy Injections	50%
Ambulance Service (\$5,000 annual max)	50%
Durable Medical Equipment/Prosthetics	50%
Home Health, Hospice, and Respite Care	50%
PRESCRIPTION DRUG (Show your ODS ID card to access discounts at participating pharmacies.)	\$15 or 50%, whichever is greater for retail or mail order

¹ Prescription drug co-pays and disallowed charges do not apply to the annual out of pocket maximum.

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DEPENDENT ELIGIBILITY

Dependents are lawful spouse and unmarried children to age 23, including children an employee is required to enroll due to a court or administrative order.

LIMITATIONS

* Pre-existing conditions even if they worsen or reoccur.

Note: *Your plan's six month pre-existing exclusion period will be shortened one day for each day you had "creditable coverage" under another health plan, provided you do not have a 63 day lapse (or longer) in coverage immediately prior to your enrollment date in our plan, or, if earlier, the first day of the waiting period for such enrollment.*

* All medical and surgical admissions must be authorized by ODS.

* Mental illness/chemical dependency (including alcoholism) will be treated the same as other medical conditions except for mental health residential treatment that has a 45-day limit per calendar year.

* When a member has more than one group plan, combined benefits for both group plans will be provided up to, but not exceeding, the maximum plan allowance for all covered services.

* Inpatient rehabilitation benefits are limited to 30 days per calendar year (prior authorization for up to 60 days for head and spinal cord injuries); outpatient rehabilitation benefits are limited to 30 sessions per calendar year (prior authorization for up to 60 sessions for head and spinal cord injuries).

* Hospice benefits are limited to \$20,000 for home care; 12 days of inpatient care; Respite care is limited to 170 hours.

EXCLUSIONS

* Services provided by the patient or a member of the patient's immediate family.

* Services or supplies which 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.

* Acupuncture.

* Massage or massage therapy.

* Services or supplies related to Gender Identity Disorders or to sex change procedures, for members age nineteen and older.

* Services or supplies related to Gender Identity Disorders or related to sex change procedures, for members eighteen and younger, except when delivered by a mental health provider as defined in this plan.

* Medical services or supplies for the treatment of sexual dysfunctions or inadequacies, except when delivered by a mental health provider as defined in this plan.

* Experimental or investigational treatment.

* Chiropractic Services.

* Naturopathic Services.

* Services or supplies available in whole, or in part under any city, county, state, or federal law, except Medicaid.

* Charges above 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.

* Instruction 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.

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This is a benefit summary only. For a complete description of benefits, limitations and exclusions refer to your member handbook.