



Basic Oregon Plan

	(You Pay)
Annual Deductible	None
Annual Out-of-Pocket Limit	\$3,750 Individual / \$7,500 Family ¹
PREVENTIVE CARE	
Well Baby Care	No co-pay
Routine Physicals	No co-pay
Routine Women's Exams	No co-pay
Prostate Rectal Exam (PRE)	No co-pay
Immunizations	No 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%
Outpatient 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, mail order & specialty pharmacy

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, Oregon registered domestic partners and eligible children to age 26, including children an employee is required to enroll due to a court or administrative order.

LIMITATIONS

* Pre-existing conditions for members age 19 and older 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 condition (prior authorization for up to 60 days for head and spinal cord injuries); outpatient rehabilitation benefits are limited to 30 sessions per condition (prior authorization for up to 60 sessions for head and spinal cord injuries).
- * Transplant benefits are limited to an aggregate annual maximum benefit of \$750,000.
- * Hospice benefits are limited to 12 days of inpatient care; Respite care is limited to 170 hours.

EXCLUSIONS

- * Services provided by members or their relatives. Relatives, for the purpose of this exclusion, include a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.
- * 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, for members age nineteen and older.
- * Services or supplies related to sex change procedures or sexual dysfunction unless delivered by a mental health provider.
- * 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.