



Type of Plan

Medical- Managed Care

Dental -Premier

Service Area

Medical– All areas statewide outside the Kaiser Permanente Service Area.

Dental– All areas statewide.

Providers

Medical- You must use in-network providers in order to be covered, except in the case of a medical emergency or authorized referral to an out-of-network provider. You must select a Primary Care Physician (PCP) from the ODS Plus Network which is available at www.odscompanies.com or if currently enrolled, by logging into myODS at www.odscompanies.com/members. The PCP coordinates all healthcare needs including referrals and specialty care authorization, hospitalization authorization and severe healthcare problems. Each family member may choose a different PCP. Benefits under this plan will not be available to you if you receive care from a participating provider or from any other physician without a referral from your PCP.

Dental- You may choose services from any licensed dental provider. Reimbursement to ODS Premier dental providers and Non-contracted dental providers may differ. To maximize your benefits, you can find ODS Premier dental providers by visiting www.odscompanies.com.

Pre-existing Condition Limitation –Medical only

This plan has a six-month pre-existing condition limitation for members age 19 and older. A pre-existing condition is a physical or mental condition that was diagnosed and for which you received medical advice or treatment during the six-month period immediately before your enrollment date.

Your six-month exclusion period will be reduced if you had prior coverage and your prior coverage ended within 63 days of the enrollment date of coverage under this Plan. Please submit a certificate of creditable coverage form from your prior plan to receive credit.

For more information about this pre-existing condition limitation, contact ODS.

Dependent Age Limits

Your group plan covers enrolled dependents to age 26 (see Eligibility Rules, Section 1 for definition of eligible family members).

Member Services

Medical Customer Service
(503) 265-2964
(888) 217-2363

Dental Customer Service
(503) 265-2965
(888) 217-2365

Pharmacy Customer Service
800-913-4284

Summary of Medical Plan Benefits

April 1, 2011 – December 31, 2011

OREGON HOME CARE COMMISSION

10001759

Service

ODS Network you pay

Calendar Year Deductible Member / Family

\$100¹

Calendar Year Maximum Out-of-Pocket Per Member

\$2,500 (2x for family)

Essential Benefit Annual Maximum (Medical and Rx)

\$750,000

PREVENTIVE CARE (refer to schedule in member handbook)

NO DEDUCTIBLE

Routine Physical Exams

\$0

Routine Immunizations (all ages)

\$0

Well Baby Exams

\$20

Women's Routine Mammograms

\$0

Women's Annual Exams

\$0

Routine X-ray & Lab Services (related to routine physical exams)

20%

VISION

This Plan pays for vision examinations for you and your insured dependents, corrective lenses and frames when prescribed by a licensed Ophthalmologist or licensed Optometrist.

Eye exam, lenses, frames and contact lenses paid at 100% up to a maximum total of \$200 every calendar year for those under age 18 and every 2 calendar years for those 18 and older.

PHYSICIAN / PROVIDER SERVICES

NO DEDUCTIBLE

Office Visits

\$20

Outpatient Rehabilitation

\$20

Urgent Care Office Visit

\$20 visit

OUTPATIENT PRESCRIPTION DRUGS

Generic

40% Copay

Brand Name

40% Copay

Up to a maximum of \$150 copayment per prescription. See your ODS Plan Handbook for information on limitations and exclusions.

HOSPITAL SERVICES

DEDUCTIBLE APPLIES

Inpatient Care (including X-ray & Lab Services)

20%

Outpatient Surgery (including surgery performed in physician/provider's office)

20%

Surgery Center / Surgery Facility Charge

20%

Physician Visits While Hospitalized

20%

Surgeon Fees

20%

EMERGENCY SERVICES

DEDUCTIBLE APPLIES

Emergency Room Facility (\$100 per visit waived if admitted)

\$100 copay, then 20%

Ambulance

20%

Summary of Medical Plan Benefits

April 1, 2011 – December 31, 2011

Service

OTHER SERVICES

- Diagnostic X-ray & Lab Services (office and outpatient)
- Specified Imaging (MRI, CT, CAT, PET scans)
- Allergy Shots & Other Therapeutic Injections
- Medical Equipment & Supplies
- Hospice Care (subject to limitations)
- Mental health/chemical dependency (outpatient)
- Mental health/chemical dependency (residential)
- Mental health/chemical dependency (inpatient)
- Home Health Care
- Skilled Nursing Facility

ODS Network you pay

DEDUCTIBLE APPLIES

- 20%
- 20%
- 20%
- 20%
- 20%
- \$20 (no deductible)
- 20%
- 20%
- 20%
- 20%

¹ Fixed dollar copays, prescription drug copays, and disallowed charges do not apply to the annual deductible or to the out of pocket maximum.

This benefit summary does not fully describe your benefit coverage with ODS Medical Plan. For more details on your coverage, see your ODS Member Handbook or call ODS Customer Service. In the case of a conflict between this Summary and the ODS Member Handbook, the Handbook will prevail.

