ODS

Washington individuals and families

HEALTH BENEFIT PLAN OPTIONS

www.odscompanies.com

Available effective
October 2012

WELCOME TO ODS HEALTH

At ODS Health Plan, Inc. (ODS Health), we are honored to have the opportunity to help you on your journey to better health. When you choose ODS Health, you choose much more than just a health plan. You choose a healthier you. With access to our local team of experts and online tools, we are focused on helping you achieve your best health.

ODS Health is proud to stand on the front line of health innovation, advancing a wide range of initiatives to enhance evidence-based preventive healthcare. For you, that means we make sure you get the right care, in the right place, at the right time. It also means we are dedicated to being your partner in health.

We look forward to a long and healthy partnership.

Think of us as your partner in health

Helping you get well sooner and live well longer is our goal. Our integrated clinical teams and programs are designed to support you and help you achieve your health goals.

myODS

As a member of ODS Health, 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)
- Pay your premium online with eBill. Using eBill, you can view invoices online, set up payment methods (credit card, debit, checking or savings) and set a recurring payment using our AutoPay feature.

ODS WELL

ODS Well™ includes tools and individualized support to help you manage your health. Included as part of all health plans, ODS Well is available through myODS and includes the following features.

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 Health 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
- Suggest if you should go to urgent care or the emergency room

Condition management and health coaching

ODS Health 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
- Dental 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 Health case manager can help:

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

Online tracking tools*

ODS Health 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 health trackers, 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 Washington Prescription Drug Program (WPDP). 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 Health 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 HEALTH NETWORKS HAVE YOU COVERED

As a member of ODS Health, you'll have access to the First Choice Health PPO Washington network as well as the ODS Plus Network, giving you a broad choice of physicians and geographic coverage. With more than 60,000 providers participating across all specialties — including primary care, surgery, radiology, anesthesiology, chiropractic, naturopathic and acupuncture — your needs have been anticipated.

TRAVEL WITH PEACE OF MIND

When you are traveling, care is never far. As an ODS Health member you have access to the ODS Plus Network throughout Oregon and Idaho, and the PHCS Healthy Directions Network in all other states.

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

Choosing the right plan for you

As you compare our plan designs, look for the features that best fit your healthcare needs. To help you navigate our plans, we have provided a glossary of terms on page 15.

PREMIUM PLAN: PREFERRED PROVIDER ORGANIZATION (PPO)

The ODS Health Premium plan is a comprehensive plan with a high level of benefits, including maternity and prescription coverage for both generic and brand name drugs. The ODS Health Premium plan includes services that can be accessed before the deductible, including preventive care, doctor's office or urgent care center visits and generic drug coverage.

- $0 copay and deductible waived for most in-network preventive care visits
- $30 copay for first three in-network office, urgent care, naturopathic or mental health visits; after the first three visits, deductible and coinsurance apply
- 30 percent coinsurance and deductible waived for a combined limit of 10 in-network visits per calendar year for spinal manipulation and acupuncture
- 30 percent coinsurance after deductible for in-network maternity services
- Deductible waived for treatment completed within 90 days of an accident
- Prescriptions covered at $2 value tier, $10 for select generics (deductible waived), and brand drugs subject to a $500 deductible, then 50 percent coinsurance

HYBRID PLAN: PREFERRED PROVIDER ORGANIZATION (PPO)

The ODS Health Hybrid plan includes catastrophic coverage, which is ideal for individuals who want a mid-level deductible paired with affordable coverage. Services that can be accessed before the deductible applies include preventive care, doctor's office or urgent care center visits and the first $200 in lab and X-ray services.

- $0 copay and deductible waived for most in-network preventive care visits
- $25 copay for the first three in-network office, urgent care center, or naturopathic visits; after the first three visits, deductible and coinsurance apply
- $25 copay for the first three in-network outpatient mental health visits, after which deductible and coinsurance apply
- $25 copay for the first six in-network visits for spinal manipulation or acupuncture; after the first six visits, the deductible and coinsurance apply (up to 10 combined visits per calendar year)
- 100 percent coverage for in-network routine lab and X-ray services for the first $200, then deductible and coinsurance apply
- Annual in-network per person deductible choices of $2,500 or $3,500
- Deductible waived for treatment completed within 90 days of an accident with a $10,000 per person, per calendar year limit
- Pharmacy discount program available for both generic and brand drugs

BASIC PLAN: PREFERRED PROVIDER ORGANIZATION (PPO)

The ODS Health Basic plan is a great choice for those shopping for catastrophic coverage at a lower premium cost. The ODS Health Basic plan waives the deductible for preventive care and limited doctor's office or urgent care center visits.

- $0 copay and deductible waived for most in-network preventive care visits
- $35 copay for the first three in-network office, urgent care center, or naturopathic visits; after the first three visits, deductible and coinsurance apply
- $35 copay for the first three in-network outpatient mental health visits; after the first three visits, deductible and coinsurance apply
- 35 percent coinsurance after deductible for a combined limit of 10 in-network visits per calendar year for spinal manipulation and acupuncture
- Deductible waived for treatment completed within 90 days of an accident, with a $10,000 per person, per calendar year limit
- Annual in-network per person deductible choices of $5,000 or $7,500
- Pharmacy discount program available for both generic and brand drugs

HSA PLAN

The ODS Health HSA plan provides catastrophic coverage and offers lower premiums through a tax-advantaged and high-deductible health plan.

- $2,500 individual/$5,000 family deductible
- $0 copay and deductible waived for most in-network preventive care visits
- 20 percent coinsurance for most in-network services and 50 percent coinsurance for out-of-network services, after the deductible
- Pharmacy discount program available for both generic and brand drugs

Individual deductible must be met for subscriber only plan, and family deductible must be met on HSA plans if enrolled with dependents, before plan pays benefits other than most 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

Use any banking partner you choose to set up your HSA.

INDIVIDUAL PLANS	PREMIUM ODSPPO-IH-PREMIUM-WA (5/2012)	
	In-network	Out-of-network
Calendar year deductible options, individual (family deductible is 3x the individual, HSA is 2x)	$1,500	
Calendar year out-of-pocket maximum, per person (after deductible)	$5,000	No maximum
Calendar year essential benefit maximum	$2,000,000	
PREVENTIVE CARE	**Member responsibility**	
Annual women's exam – Pap, pelvic, breast	$0*	50%
Women's routine mammogram	$0*	50%
Well-baby care	$0*	50%
Routine physical exams	$0*	50%
Immunizations	$0*	50%
PROFESSIONAL SERVICES		
Office and urgent care visits (including naturopathic visits, with some exceptions)	First three at $30 copay*[2]	50%
Spinal manipulation and acupuncture care (10 combined visits per calendar year)	30%*	50%
FACILITY AND ANCILLARY SERVICES		
Hospital – inpatient and outpatient surgery; room, ancillary and physician charges; skilled nursing facility care	30%	50%
Maternity – all prenatal/postnatal office visits and doctor delivery; hospital charges	30%	50%
Mental health – inpatient, outpatient, residential (see limitations on page 18)	Inpatient: 30% Outpatient: first three at $30 copay*[2]	50%
Routine diagnostic lab and X-ray services	30%	50%
Specified imaging (MRI, CT, CAT, PET scans)	30%	50%
Medical supplies and devices; in-hospital care; home healthcare	30%	50%
EMERGENCY SERVICES		
Emergency room (deductible applies)	30% after $150 copay	
Ambulance ($5,000 per calendar year)	30%	
OTHER BENEFITS		
Prescription services	$2 value tier, $10 select generic or 50% brand ($500 deductible for brand only)	
Accident benefit	Deductible waived for treatment completed within 90 days of accident	

** Deductible waived.*
[1] HSA plans require the family deductible to be met when an individual and a spouse, or one or more dependents, are enrolled prior to benefits being paid.
[2] Premium plan includes a copay for the first three office, urgent care, naturopathic or mental health visits; after the first three visits, deductible and coinsurance apply

HYBRID ODSPPO-IH-HYBRID-WA (5/2012)		**BASIC** ODSPPO-IH-BASIC-WA (5/2012)		**HSA** ODSPPO-IH-HSA-WA (5/2012)	
In-network	**Out-of-network**	**In-network**	**Out-of-network**	**In-network**	**Out-of-network**
$2,500 / $3,500	$5,000 / $7,000	$5,000 / $7,500	$10,000 / $15,000	$2,500 (individual) / $5,000[1] (family)	
$5,000	No maximum	$10,000	No maximum	$3,000 (individual) / $6,000 (family)	No maximum
$2,000,000		$2,000,000		$2,000,000	
Member responsibility		**Member responsibility**		**Member responsibility**	
$0*	50%	$0*	50%	$0*	50%
$0*	50%	$0*	50%	$0*	50%
$0*	50%	$0*	50%	$0*	50%
$0*	50%	$0*	50%	$0*	50%
$0*	50%	$0*	50%	$0*	50%
First three at $25 copay*[3]	50%	First three at $35 copay*[4]	50%	20%	50%
First six at $25 copay*[3]	50%	35%	50%	20%	50%
25%	50%	35%	50%	20%	50%
Not covered		Not covered		Not covered	
Inpatient: 25% Outpatient: first three at $25 copay*[3]	50%	Inpatient: 35% Outpatient: first three at $35 copay*[4]	50%	20%	50%
$0* for the first $200, then 25% deductible applies	50%	35%	50%	20%	50%
25%	50%	35%	50%	20%	50%
25%	50%	35%	50%	20%	50%
25% after $150 copay		35% after $150 copay		20%	
25%		35%		30%	
Not covered; pharmacy discount card available		Not covered; pharmacy discount card available		Not covered; pharmacy discount card available	
Deductible waived for treatment completed within 90 days of accident; $10,000 per person, per year maximum		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	

[3] Hybrid plans include a copay for the first three office, urgent care center, or naturopathic visits. In addition, the plan includes a copay for the first six spinal manipulation or acupuncture visits and a separate first three outpatient mental health visits. After the initial copay visits, deductible and coinsurance apply.

[4] Basic plans include a copay for the first three office, urgent care center, or naturopathic visits and a separate first three outpatient mental health visits; after the first three visits, deductible and coinsurance apply.

WESTERN WASHINGTON

NON-TOBACCO USER

Age	Dep. child	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Premium PPO - $1,500	215	256	292	333	400	468	590	722	840	956
Hybrid PPO - $2,500	109	131	148	170	204	239	301	369	429	489
Hybrid PPO - $3,500	98	117	133	153	183	215	271	331	387	438
Basic PPO - $5,000	75	91	103	118	143	167	210	256	299	340
Basic PPO - $7,500	62	75	86	97	116	137	172	211	244	279
HSA - $2,500 - Single	—	143	160	188	226	267	332	405	476	534
HSA - $5,000 - Family	91	111	123	143	169	200	252	309	361	407

TOBACCO USER

Age	Dep. child	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Premium PPO - $1,500	215	300	337	388	466	550	682	840	975	1,118
Hybrid PPO - $2,500	109	153	172	196	238	280	347	429	497	569
Hybrid PPO - $3,500	98	139	156	178	214	253	313	387	448	513
Basic PPO - $5,000	75	106	119	138	166	195	242	299	347	397
Basic PPO - $7,500	62	89	98	114	136	161	198	244	285	326
HSA - $2,500 - Single	—	168	188	219	260	309	386	472	550	628
HSA - $5,000 - Family	91	128	143	167	199	236	292	361	419	477

EASTERN WASHINGTON

NON-TOBACCO USER

Age	Dep. child	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Premium PPO - $1,500	224	266	303	347	416	487	614	750	873	994
Hybrid PPO - $2,500	114	136	153	177	212	248	312	383	446	508
Hybrid PPO - $3,500	102	122	138	160	191	224	281	345	402	455
Basic PPO - $5,000	78	95	107	123	148	173	218	266	311	353
Basic PPO - $7,500	65	78	89	101	120	142	179	219	254	290
HSA - $2,500 - Single	—	149	167	195	235	277	345	421	494	555
HSA - $5,000 - Family	94	115	128	148	176	208	262	321	375	423

TOBACCO USER

Age	Dep. child	0-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64
Premium PPO - $1,500	224	312	350	404	484	571	709	873	1,014	1,163
Hybrid PPO - $2,500	114	159	179	204	247	291	361	446	517	592
Hybrid PPO - $3,500	102	144	162	185	223	263	326	402	465	533
Basic PPO - $5,000	78	111	124	143	172	203	251	311	361	413
Basic PPO - $7,500	65	92	102	118	141	168	205	254	296	339
HSA - $2,500 - Single	—	175	195	228	270	321	401	491	571	653
HSA - $5,000 - Family	94	133	148	174	207	245	304	375	436	495

Western Washington counties: *Clallam, Clark, Cowlitz, Grays Harbor, Island, Jefferson, King, Kitsap, Lewis, Mason, Pacific, Pierce, San Juan, Skagit, Snohomish, Thurston, Wahkiakum, Whatcom*

Eastern Washington counties: *Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Skamania, Spokane, Stevens, Walla Walla, Whitman, Yakima*

HOW TO ENROLL

1. Compare plans and benefits on pages 10 and 11 and choose the health plan that best meets your coverage needs.
2. Complete an ODS Health application for yourself and any dependents who will be covered under the policy. A Washington State Standard Health Questionnaire will need to be completed for each applicant (if not exempt by Washington law) to determine your acceptance for coverage. We require complete submission prior to the requested effective date. Applicants under age 19 cannot be declined due to their reported health conditions.
3. You will be notified in writing of the outcome. If you are accepted, the application will be processed and we will draft the initial premium or send the billing statement for the first month's premium. We will also send a member ID card and policy. If you are not accepted, your notice will include the reason for the decline and appeal options.

FOR HSA MEMBERS ONLY:

4. You are responsible for setting up a Health Savings Account with the bank of your choice for your contributions.

HOW TO CALCULATE YOUR RATE

1. Choose your plan and the deductible amount. All family members must enroll in the same plan and deductible for coverage together on one policy.
2. Locate the correct rate table by county of residence of the primary applicant.
3. Find the rate by age of the primary applicant and tobacco usage (if used in the past 12 months).
4. Add rate for spouse, if applying, also based on their age and tobacco usage (if used in the past 12 months).
5. Add the rate for each dependent child enrolling with you by selecting the appropriate rate from the "Dep. child" column on page 12.
6. Add up the rates for all family members on the application. This will be your total monthly premium.

For help, contact an ODS Health-appointed producer, or call ODS Health toll-free at 866-939-0368.

Glossary of terms

CALENDAR YEAR ESSENTIAL BENEFIT MAXIMUM

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

Essential benefits according to the ACA include these categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and chemical dependency services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

The plan you choose may not cover every essential benefit.

CATASTROPHIC

Catastrophic coverage provides protection from an unforeseen, serious accident or medical emergency. Catastrophic coverage is an affordable way to protect yourself from large, unplanned medical expenses. It usually has a high deductible and doesn't cover maternity care or prescription coverage.

COINSURANCE

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

COMPREHENSIVE

These plans are designed to provide a high level of protection for most major and minor medical expenses, including maternity, a lower deductible and prescription coverage.

COPAY

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

DEDUCTIBLE

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

OUT-OF-POCKET MAXIMUM

A specified amount of applicable claims expenses in a calendar 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 calendar 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 under ODS Health to provide in-network benefits at agreed-upon rates.

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 provider 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 an ODS Health individual medical plan?

For any ODS Health individual medical plan, you and any dependents applying for coverage must be Washington residents for at least 30 days prior to submitting an application and reside in Washington at least six months out of the calendar year. Eligible members include you, your legal spouse or registered domestic partner, and any children up to age 26. Individuals must be younger than age 65 and not eligible for Medicare.

Applicants under the age of 19 can apply for coverage during the open enrollment periods from March 15 through April 30 and from Sept. 15 through Oct. 31 of each year or within 31 days of a special enrollment qualifying event.

Is there an exclusion period for pre-existing conditions?

ODS Health does not pay toward a pre-existing condition, even if the pre-existing condition worsens or recurs during the first nine months you or your dependent(s) are covered under the policy. However, creditable coverage can reduce the nine-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 nine-month period by one day. Pre-existing conditions do not apply to members under the age of 19.

When do my rates change?

Rates will change when the family composition changes. The new rate will be effective the first day of the following month. Rates will also change when a member moves into the next age bracket upon the following renewal. ODS Health will renew the rates for these individual plans on a yearly basis, beginning on Jan. 1, 2014. If the rates change with renewal, the new rates will be provided with 30 days prior notice.

When do my benefits change?

Benefits will renew each year in January with 30 days notice of changes.

What payment methods do you offer?

Payment can be made via monthly electronic deduction from your checking account, or you can elect to receive monthly or quarterly billing.

Can my employer sponsor my individual coverage?

ODS Health individual plans cannot be employer-sponsored plans. You will be responsible for directly paying ODS Health your monthly premium using a personal check. ODS Health 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 Health 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 and the Standard Health Questionnaire for Washington. The application will be health-underwritten, and you could be approved or declined for the new plan.

DEPENDENT ELIGIBILITY

Dependents are a lawful spouse or registered domestic partner 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 as if care were rendered by a participating provider. Out-of-area children 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 Health.
- Rehabilitation benefits are limited to eight inpatient days and 15 outpatient sessions per calendar year.
- Six-month hospice benefits are limited to 12 days of inpatient care; 170 hours of respite care in three months.
- Skilled nursing facility benefits are limited to 40 inpatient days per calendar year.
- Home health benefits are limited to 130 visits per calendar year.
- ODS Health will coordinate benefits for covered expenses to the extent that you have any other available coverage for those expenses.

EXCLUSION PERIODS

9-month exclusion period applies to:

- Pre-existing conditions, even if they worsen or recur, unless the covered person is under the age of 19

12-month exclusion period applies to:

- Transplants (benefits are limited to an aggregate lifetime maximum benefit of $350,000)

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
- Services and supplies for obesity, including complications arising out of such treatment, except for those required under the Affordable Care Act.
- Surgery to alter the refractive character of the eye
- Dental examinations and treatment, except as specifically listed
- 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 except for treating congenital anomalies
- Chemical dependency treatment
- Hearing aid coverage

For costs and further details of the coverage, including exclusions, any reductions or limitations and the terms under which the policy may be continued in force, see your producer or write to ODS Health.

www.odscompanies.com

For help, contact an ODS Health-appointed producer, or call ODS Health toll-free at 866-939-0368.

These benefits and ODS Health policies are subject to change in order to be compliant with state and federal guidelines. Health plans provided by ODS Health Plan, Inc.

902559 (10/12) SS IND-1234