**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs **Coverage for: Individual and family | Plan Type: PPO**

**This is only a summary.** If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at www.odscompanies.com or by calling 1-877-605-3229. You can find a copy of the Uniform Glossary at www.cciio.cms.gov.

| Important Questions | Answers | Why this Matters: |
|---|---|---|
| **What is the overall deductible?** | **$7,500** per person / **$22,500** per family. Doesn't apply to most in-network preventive care, breastfeeding support, first 3 office visits and alternative care; additional accident benefit; routine nursery care; and prescription drugs. Copayments don't count toward the **deductible**. | You must pay all the costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over (usually, but not always, January 1st). See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible.** |
| **Are there other deductibles for specific services?** | No. | You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers. |
| **Is there an out-of-pocket limit on my expenses?** | Yes. For in-network **providers, $5,000** per person. For out-of network **providers $10,000** per person. | The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses. |
| **What is not included in the out-of-pocket limit?** | Premiums, **deductibles,** copayments, balance-billed charges, transplants not performed at exclusive facilities, penalties for failure to obtain prior authorization and health care this plan doesn't cover. | Even though you pay these expenses, they don't count toward the **out-of-pocket limit.** |
| **Is there an overall annual limit on what the plan pays?** | Yes. $2 million on essential benefits only. | This plan will pay for covered services only up to this limit during each coverage period, even if your own need is greater. You're responsible for all expenses above this limit. The chart starting on page 2 describes specific coverage limits, such as limits on the number of office visits. |
| **Does this plan use a network of providers?** | Yes. For a list of in-network **providers**, visit www.odscompanies.com and click on the Find Care link or call 1-877-605-3229. | If you use an in-network doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred,** or participating for **providers** in their network. See the chart starting on page 2 for how this plan pays different kinds of **providers.** |
| **Do I need a referral to see a specialist?** | No. | You can see the **specialist** you choose without permission from this plan. |
| **Are there services this plan doesn't cover?** | Yes. | Some of the services this plan doesn't cover are listed on page 4. See your policy or plan document for additional information about **excluded services**. |

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If you aren't clear about any of the bolded terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cma.gov or call 1-877-605-3229 to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you visit a health care provider's office or clinic** | Primary care visit to treat an injury or illness | $25 copay/visit for first 3, 30% coinsurance for subsequent visits | 50% coinsurance | First 3 primary care and specialist visits do not include mental health, alcohol treatment, physical therapy, occupational therapy, speech therapy, family planning or biofeedback. |
| | Specialist visit | $25 copay/visit for first 3, 30% coinsurance for subsequent visits | 50% coinsurance | |
| | Other practitioner office visit | $25 copay/visit for first 3 chiropractic, acupuncture and naturopathic care. 30% coinsurance for subsequent visits. | 50% coinsurance | $1,000 plan year maximum for these alternative care services. |
| | Preventive care/screening/immunization | No charge for most services. $25 copay/visit or 30% coinsurance for remaining services. | 50% coinsurance | Only select services are covered out-of-network. Each type of service may be subject to limitations. |
| **If you have a test** | Diagnostic test (x-ray, blood work) | 30% coinsurance | 50% coinsurance | Include other tests such as EKG, allergy testing and sleep study. |
| | Imaging (CT/PET scans, MRIs) | 30% coinsurance | 50% coinsurance | Prior authorization is required for many services. Failure to obtain prior authorization results in denial. |
| **If you need drugs to treat your illness or condition** More information about **prescription** available at www.odscompanies.com | Prescription drugs | Not covered | Not Covered | ----------None---------- |

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**Summary of Benefits and Coverage:** What this Plan Covers & What it Costs

**Coverage for: Individual and family | Plan Type: PPO**

| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If you have outpatient surgery** | Facility fee (e.g., ambulatory surgery center) | 30% coinsurance | 50% coinsurance | Prior authorization may be required. Failure to obtain prior authorization results in a penalty. |
| | Physician/surgeon fees | 30% coinsurance | 50% coinsurance | |
| **If you need immediate medical attention** | Emergency room services | $100 copay/visit, then 30% coinsurance | $100 copay/visit, then 30% coinsurance | Copay waived if hospital admission immediately follows |
| | Emergency medical transportation | 30% coinsurance | 30% coinsurance | Plan year maximum of $5,000 |
| | Urgent care | $25 copay/visit for first 3, 30% coinsurance for subsequent visits | 50% coinsurance | First 3 visits include other office visits except mental health, alcohol treatment, physical therapy, occupational therapy, speech therapy, family planning or biofeedback. |
| **If you have a hospital stay** | Facility fee (e.g., hospital room) | 30% coinsurance | 50% coinsurance | Prior authorization is required. Failure to obtain prior authorization results in a penalty. |
| | Physician/surgeon fee | 30% coinsurance | 50% coinsurance | |
| **If you have mental health, behavioral health, or substance abuse needs** | Mental/Behavioral health outpatient services | 30% coinsurance | 50% coinsurance | Plan year maximum of 20 visits |
| | Mental/Behavioral health inpatient services | 30% coinsurance | 50% coinsurance | Plan year maximum of 10 inpatient days and 10 residential days |
| | Substance use disorder outpatient services | 30% coinsurance | 50% coinsurance | Limit to alchohol treatment. Plan year maximum of 20 visits. |
| | Substance use disorder inpatient services | 30% coinsurance | 50% coinsurance | Limit to alcohol treatment. Plan year maximum of 10 inpatient days and 10 residential days. |
| **If you are pregnant** | Prenatal and postnatal care | 30% coinsurance | 50% coinsurance | ----------None---------- |
| | Delivery and all inpatient services | 30% coinsurance | 50% coinsurance | |
| **If you need help recovering or have other special health needs** | Home health care | 30% coinsurance | 50% coinsurance | Plan year maximum of 140 visits |
| | Rehabilitation services | 30% coinsurance | 50% coinsurance | Plan year maximum of 15 days for inpatient and 15 sessions for outpatient services |
| | Habilitation services | 30% coinsurance | 50% coinsurance | |
| | Skilled nursing care | 30% coinsurance | 50% coinsurance | Plan year maximum of 100 days |
| | Durable medical equipment | 30% coinsurance | 50% coinsurance | Prior authorization may be required. Wheelchairs subject to frequency limits. Failure to obtain prior authorization results in a penalty. |
| | Hospice service | No charge | No charge | Six month hospice coverage including a plan year maximum of 12 days for inpatient care and 170 hours for respite care |

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| Common Medical Event | Services You May Need | Your Cost If You Use an In-network Provider | Your Cost If You Use an Out-of-network Provider | Limitations & Exceptions |
|---|---|---|---|---|
| **If your child needs dental or eye care** | Eye exam | Covered under preventive | Not covered | ----------None---------- |
| | Glasses | Not covered | Not covered | |
| | Dental check-up | Not covered | Not covered | |

## Excluded Services & Other Covered Services:

**Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Bariatric surgery
- Cosmetic surgery
- Chemical dependency except for alcohol treatment
- Dental care (adult) except for accident-related injuries
- Drugs treating mental health illness
- Infertility treatment
- Long-term care
- Out-of-network preventive care, with exceptions for some services
- Pharmacy drug coverage
- Private-duty nursing
- Routine eye care (adult)
- Routine foot care
- Vision care
- Weight loss programs

**Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture
- Chiropractic care
- Hearing aids
- Non-emergency care when traveling outside the U.S.

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## Your Rights to Continue Coverage:

Federal and State laws may provide protections that allow you to keep this health insurance coverage as long as you pay your **premium**. There are exceptions, however, such as if:

- You commit fraud
- The insurer stops offering services in the State
- You move outside the coverage area

For more information on your rights to continue coverage, contact the insurer at 1-877-605-3229. You may also contact your state insurance department at 1-877-877-4894 or www.cbs.state.or.us/ins/consumer/consumer/html.

## Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the insurer at 1-877-605-3229. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/healthreform.

Additionally, a consumer assistance program can help you file your appeal. Contact the Oregon Insurance Division at 1-888-877-4894 or www.cbs.state.or.us/ins/consumer/consumer/html.

## Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 888-786-7461

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 888-873-1395

CHINESE (**中文**): **如果需要中文的帮助**， 请拨打这个号码 888-873-1395

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 888-873-1395

'----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.*----------

## About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

**This is not a cost estimator.**

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

| Having a baby (normal delivery) | |
|---|---|
| **Amount owed to providers:** | $7,540 |
| **Plan pays** | $2,370 |
| **Patient pays** | $5,170 |
| **Sample care costs:** | |
| Hospital charges (mother) | $2,700 |
| Routine obstetric care | $2,100 |
| Hospital charges (baby) | $900 |
| Anesthesia | $900 |
| Laboratory tests | $500 |
| Prescriptions | $200 |
| Radiology | $200 |
| Vaccines, other preventive | $40 |
| **Total** | **$7,540** |
| **Patient pays:** | |
| Deductibles | $4,160.00 |
| Copays | $0.00 |
| Coinsurance | $840.00 |
| Limits or exclusions | $170.00 |
| **Total** | $5,170.00 |

| Managing type 2 diabetes (routine maintenance of a well-controlled condition) | |
|---|---|
| **Amount owed to providers:** | $5,400 |
| **Plan pays** | $910 |
| **Patient pays** | $4,490 |
| **Sample care costs:** | |
| Prescriptions | $2,900 |
| Medical Equipment and Supplies | $1,300 |
| Office Visits and Procedures | $700 |
| Education | $300 |
| Laboratory tests | $100 |
| Vaccines, other preventive | $100 |
| **Total** | $5,400 |
| **Patient pays:** | |
| Deductibles | $1,270 |
| Copays | $250 |
| Coinsurance | $40 |
| Limits or exclusions | $2,930 |
| **Total** | $4,490 |

**Questions:** Call 1-877-605-3229 or visit www.odscompanies.com.

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## Questions and answers about the Coverage Examples:

### What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

### What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

### Does the Coverage Example predict my own care needs?

✘ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

### Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

### Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

### Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.