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 1-888-217-2363. You can find a copy of the Uniform Glossary at www.cciio.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$1,500** per person / **$4,500** per family. Doesn't apply to most in-network preventive care, breastfeeding support, or 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?	Yes $1,000 for prescription medications	You must pay all of the costs for these services up to the specific deductible amount before this plan begins to pay for these services.
Is there an out-of-pocket limit on my expenses?	Yes. in-network **$6,000,** out-of-network **$10,000** out-of-pocket (stop loss) 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, prescription drugs, 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, visit www.odscompanies.com and click on the Find Care link for a list of in-network **providers** or call 1-888-217-2363.	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**.

Questions: Call 1-888-217-2363 or visit www.odscompanies.com.

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.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-888-217-2363 to request a copy.

Copayments are fixed dollar amounts (for example, $15) you pay for covered healthcare, usually when you receive the service.
Coinsurance 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 **coinsurance** 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 **coinsurance** 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	30% coinsurance	50% coinsurance	----------None----------
	Specialist visit	30% coinsurance	50% coinsurance	----------None----------
	Other practitioner office visit	30% coinsurance	50% coinsurance	----------None----------
	Preventive care/screening/immunization	No charge for most service. 30% coinsurance for remaining services.	Not covered	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 drug coverage** is available at www.odscompanies.com	Generic drugs	$20 copay retail, mail-order and specialty	$20 copay retail	Covers up to a 30-day supply. Prior authorization may be required. Failure to obtain prior authorization results in a penalty. Exclusive mail order pharmacy only.
	Preferred drugs	$40 copay retail, mail-order and specialty	$40 copay retail	
	Brand drugs	$60 copay retail, mail-order and specialty	$60 copay retail	
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	

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 need immediate medical attention	Emergency room services	$100 copay/visit, then 30%	$100 copay/visit, then 30%	Copay waived if hospital admission immediately follows
	Emergency medical transportation	30% coinsurance	30% coinsurance	Calendar year maximum of $5,000.
	Urgent care	30% coinsurance	50% coinsurance	----------None----------
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	----------None----------
	Mental/Behavioral health inpatient services	30% coinsurance	50% coinsurance	Prior authorization is required for inpatient and residential services. Failure to obtain prior authorization results in a penalty.
	Substance use disorder outpatient services	30% coinsurance	50% coinsurance	----------None----------
	Substance use disorder inpatient services	30% coinsurance	50% coinsurance	Prior authorization is required for inpatient and residential services. Failure to obtain prior authorization results in a penalty.
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	Calendar year maximum of 140 visits. Prior authorization is required. Failure to obtain prior authorization results in a penalty.
	Rehabilitation services	30% coinsurance	50% coinsurance	Calendar year maximum of 30 days for inpatient and 30 sessions for outpatient rehabilitation.
	Habilitation services	30% coinsurance	50% coinsurance	
	Skilled nursing care	30% coinsurance	50% coinsurance	Calendar year maximum of 60 days.
	Durable medical equipment	30% coinsurance	50% coinsurance	Include items such as supplies and prosthetics. Wheelchairs subject to frequency limits. Prior authorization may be required. Failure to obtain prior authorization results in a penalty.
	Hospice service	30% coinsurance	50% coinsurance	Six month hospice coverage including a calendar year maximum of 12 days for inpatient care and 170 hours for respite care.

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.)

- Acupuncture
- Bariatric surgery
- Chiropractic care
- Cosmetic surgery
- Dental care (adult) except for accident-related injuries
- Infertility treatment
- Long-term care
- 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.)

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

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium** which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-888-217-2363. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

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 1-888-217-2363. 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/external/ins/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	$4,140
Patient pays	$3,400
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	$1,500
Copays	$20
Coinsurance	$1,730
Limits or exclusions	$150
Total	$3,400

Managing type 2 diabetes

(routine maintenance of a well-controlled condition)

Amount owed to providers:	$5,400
Plan pays	$1,990
Patient pays	$3,410
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	$2,500
Copays	$600
Coinsurance	$230
Limits or exclusions	$80
Total	$3,410

Questions: Call 1-888-217-2363 or visit www.odscompanies.com.

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.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-888-217-2363 to request a copy.

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.

Questions: Call 1-888-217-2363 or visit www.odscompanies.com.

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.cms.gov/resources/files/Files2/02102012/uniform-glossary-final.pdf or call 1-888-217-2363 to request a copy.