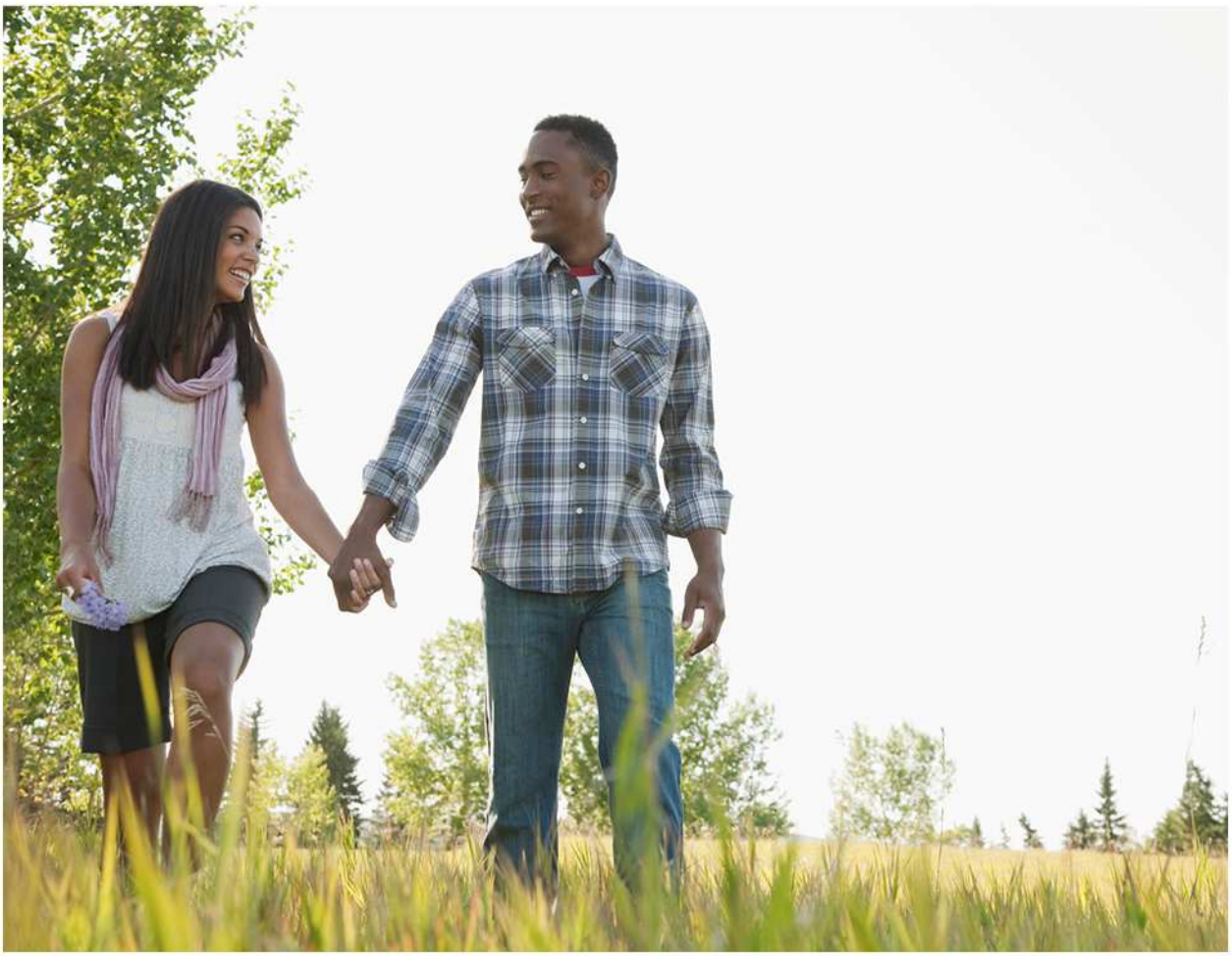
Oregon Underwriting Field Guide

2012



www.odscompanies.com

ODS Health Plan, Inc. Underwriting Field Guide for Producers

For state of Oregon individual health benefit plans

The ODS Underwriting Field Guide is designed to assist the producer in submission of individual and family health benefit plan applications to ODS underwriters. Adherence to these guidelines will help you and your clients complete applications correctly and thoroughly, thereby reducing processing time in the Underwriting department.

Producers must be appointed with ODS before submitting an application. It is the producer's responsibility to be thoroughly familiar with Oregon regulations governing these products.

The guidelines stated herein illustrate ODS' probable actions for many conditions. The guidelines are not binding and are subject to change without notice at ODS' sole discretion; however, every attempt will be made to keep producers informed of any changes in a timely manner.

ODS individual health benefit plans are not guaranteed issue for applicants age 19 and older. Only ODS underwriters make a final decision to accept or reject an individual; producers have no authority to bind or guarantee coverage.

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Eligibility requirements/enrollment guidelines

Residence requirements

All applicants must be residents of the state of Oregon and maintain residency for at least six months of the year. Out-of-area enrolled children may receive the in-network benefit level by using the ODS 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.

Dependent's coverage

An existing insured member's newborn child, newly adopted child or child placed for adoption can be added to the policy within 31 days of the date of birth, adoption or placement, without undergoing medical underwriting (when underwriting is permissible by law). If the addition causes a change in premium, the insured must submit a change form to add the child within 31 days of birth, adoption or placement of adoption. If there is no change in premium, ODS will automatically add the child to the existing policy once notified.

Adult dependents of an applicant are eligible to be covered under their parent's policy until their 26th birthday.

The parent or guardian must sign the application for minors. Grandparents and other representatives of minors may apply on behalf of the minor with documentation of legal guardianship or power of attorney. Stepchildren and adopted children are eligible and are considered children, but foster children are not. Children may be written on a policy without adults, one child per application and policy.

Prior coverage

If prior coverage is in existence, it is imperative to caution applicants to keep their coverage active until notified by ODS of their acceptance. Failure to do so may result in loss of coverage if ODS declines the application. Applicants will be required to provide a valid certificate of creditable coverage to receive prior coverage credit against any applicable waiting periods.

Patient Protection and Affordable Care Act — Pre-existing conditions, children

The Patient Protection and Affordable Care Act was passed on March 23, 2010, and took effect Sept. 23, 2010. As a result, ODS may not limit, exclude or deny health insurance coverage under a non-grandfathered individual health insurance policy based on health status or pre-existing condition of a person under age 19.

Completing an application

Application submission

Online applications are available at the ODS website at www.odscompanies.com/agents under "Individual applications." Detailed instructions are provided for the producer link and online application submission. Online submissions without a producer can be accessed through our website at www.odscompanies.com by selecting one of the options under "Shopping for health insurance?"

Paper applications are available in PDF on our website or from ODS by contacting the Individual Sales department at 503-243-3973. Paper applications must be completed in either blue or black ink and should be faxed to 503-243-3949 or mailed to:

ODS
Individual Underwriting
601 S.W. Second Ave.
Portland, OR 97204

The applicant's home address must be the applicant's physical address. A PO Box is not acceptable as a primary address, but may be used for billing purposes.

All answers to the application questions must be accurate and complete. If more space is needed, a separate sheet of paper providing more detail may be submitted with the application, providing it is signed and dated by the applicant. Any changes must be crossed out and initialed by the applicant.

If any questions are not answered, the application will be delayed until the missing information is received. Please ensure that each application is correct and complete before submitting. If the application is incomplete and we do not receive the missing information in a timely manner, the application will be closed and a new application, including the missing information and a new, dated signature, will be required.

Trial and prescreen applications cannot be accepted. Approved applicants do have a 10-day free look period for review of the policy. The approved applicant may request to cancel his or her policy during this period as though it had never been effective and receive a full refund of the initial premium, assuming no claims have been paid.

Effective dates

Upon underwriting approval, the underwriter will assign an effective date. To be considered for an effective date of the first of a month, an application must be received prior to the first of the month. For example, an application received by ODS on Oct. 31 could be considered for a Nov. 1 effective date, or the first of the month within 60 days of the signature date. An application

received by ODS on Nov. 1 would be considered for a Dec. 1 effective date, or the first of the month within 60 days of the signature date.

An applicant should request a specific effective date on the application, and ODS will work to accommodate the request during the approval process.

First month's premium

In the case of direct bill, the producer is responsible for collecting the full first premium. All checks should be drawn on a personal bank account, dated with the same date the application is signed and made payable to ODS. Checks made payable to an agency will be returned.

For automatic bank withdrawal from a personal bank account only, a copy of a voided personal check must be submitted with the application. First premium withdrawal will occur immediately on approval. After the first premium withdrawal, billing occurs on the fifth of each month. Multiple policies can be drawn from a single bank account.

Employer sponsorship

ODS individual products are not sold to employers. No employer-sponsored coverage is allowed. Consequently, only personal checks will be accepted with the application. Business or employer checks will be returned and the application will be pended for 15 days awaiting a personal check.

ODS individual application checklist for paper applications

Please use the following checklist to make sure the application is complete. The application may be delayed if sections are not complete.

Section 1: Type of application

- ☐ Select type of application
- ☐ Request an effective date

Section 2: Select a plan

- ☐ Select only one medical plan choice
- ☐ Select a dental plan choice (optional)

Section 3: Applicant information

- ☐ Height and weight
- ☐ First and last name
- ☐ Gender
- ☐ Date of birth
- ☐ Phone number
- ☐ Residence address

Section 4: Insurance history

- ☐ The first question must be answered

Section 5: Health history statement (pages 3 and 4)

- ☐ ALL questions must be clearly and individually marked "yes" or "no"

Section 6: Health statement

- ☐ ALL "yes" answers on the health history statement (pages 3 and 4) are clearly explained and the question number, dates, condition, treatment, final result and attending physician are included
- ☐ ALL medications listed under question 54 match up with health conditions on the health statement
- ☐ Include medical providers with current medical records

Section 7: Issuance alternatives

- ☐ Questions are optional

Section 8: Prior coverage credit

- ☐ If prior coverage is applicable, attach a copy of the certificate of creditable coverage

Section 9: Agent of record section

- ☐ Agent of record section must be completed, signed and dated

Section 10: Authorization section

- ☐ Applicants' names are clearly printed in the box for conditional authorization to use/disclose protected health information; all applicants age 18 and older have to sign and date the application in the correct signature boxes

Section 11: Payment options

- ☐ Initial payment option selected
- ☐ Subsequent payment option selected
- ☐ If auto pay is selected for either the initial or subsequent payments, the auto pay authorization agreement must be completed
- ☐ No business checks are being submitted

Incomplete application and follow-up process
Applications cannot go to Underwriting until complete with the following information.

Information must be updated by the *applicant* for:

- Height and weight
- Missed question on the health statement (1-53e) (any missed questions will need to be answered on the application)
- "Yes" answer to a question (1-53e) but no details or incomplete information provided in Section 6 or on any additional sheet of paper
- Missing signature for any applicant age 18 and over
- Signatures not dated, signature date is more than 60 days old, or a future date
- Business checks will be returned for replacement from a personal checking account

Application must be updated by the *producer* for:

- Missing producer signature or date on applications with producer involved
- Support personnel signed for appointed producer
- Non-appointed producer submission

Individual Sales can collect the following via email or phone from the producer or applicant and initial by representative. We will contact the producer, if there is one, for this information:

- Last menstrual period (LMP)
- Reason last names are different
- Plan selected
- Type of application: A = new enrollment, B = upgrade, C = reinstatement, D = add dependent
- Insurance history section: first question regarding declines
- Billing method not selected
- Conditional authorization does not list applicants' names, but is signed correctly

The following can be omitted altogether:

- Dental election — presumed no, if no election
- SSN of any applicant
- Marital status
- Business phone
- Mailing address and email address
- Age
- Primary language
- Whether applicant has had ODS coverage in the last five years
- Whether applicant or any family members work for an employer that offers coverage
- Date of last Depo-Provera shot, if not applicable
- Waiver or downgrade — presumed no, if no election
- Prior coverage credit section

Medical underwriting policies and procedures

Underwriting process

Applications are reviewed in the order they are received. ODS underwriters review the application, obtain medical records when necessary, and may contact the producer or applicant if additional information is required. ODS' target turnaround time for underwriting decisions is within 10 business days of receipt, if additional information is not required. Most decisions are to accept or to decline to offer coverage to an applicant. Offers may be made to other family members when one family member may be uninsurable. In some cases, the underwriter may be able to offer coverage if the applicant agrees to accept a higher deductible. Please see examples of disorders and the probable action under "Common conditions and potential underwriting actions."

Intentional fraud or misrepresentation

All applicants are required to provide all medical history within the last five years. This would include any medical advice; diagnosis; care or treatment; conditions covered by workers' compensation or liability insurance; all prescribed medications; and any illness, ailment, injury, health problem, symptom, physical impairment, surgery or hospital confinement related to medical conditions.

If fraud or intentional misstatements or omissions of material health history are discovered, the policy may be subject to rescission. Fraud or intentional material misrepresentation exists when an applicant or his or her legal representative misrepresents medical history, residence or other significant factors that, had they been made known at the time of application, would have resulted in the underwriter modifying or declining coverage. If this occurs, coverage will be deemed to never have been in force and all premiums, minus the costs of any claims paid, will be refunded. ODS will require the producer to return any commissions that had been paid.

Pre-existing conditions

ODS does not pay toward a pre-existing condition for members over age 18, even if the pre-existing condition worsens or recurs, during the first six months of the term of the policy. Existing creditable coverage can reduce the six-month period if a member'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 break in coverage exceeding 63 days will not reduce the pre-existing conditions waiting period. Each day of creditable coverage will reduce the six-month period by one day. To apply the credit, ODS requires the submission of a certificate of creditable coverage provided by the previous insurer to the insured.

HIPAA and OMIP/FMIP

ODS adheres to all of HIPAA's (Health Insurance Portability and Accountability Act) confidentiality guidelines. You can view these at www.odscompanies.com/hipaa/index.shtml.

OMIP (Oregon Medical Insurance Pool) and FMIP (Federal Medical Insurance Pool) are default providers for individuals who are declined by an individual insurer. OMIP/FMIP may give pre-existing credit for HIPAA individuals who apply within 63 days of the cessation of COBRA

coverage or other coverage where COBRA benefits are not available. Individuals who have certain conditions as defined by OMIP may automatically qualify without being declined by an insurer. The conditions listed by OMIP for automatic coverage are the same conditions that are declined by ODS. Producers should follow the OMIP automatic conditions listed in the OMIP application. Applications should not be submitted if the applicant has a condition on the OMIP list. To view a list of OMIP conditions, go to http://www.omip.state.or.us/OPHP/OMIP/docs/member_handbook.pdf.

Applicant appeal options

If an applicant does not agree with a decline, he or she may file an appeal with ODS. Send a written request within 180 calendar days of receiving the decline letter. The applicant has the right to be represented in the appeal process by any person he or she chooses, including an attorney, but representation is not required. The applicant may submit additional evidence and testimony to help establish eligibility for coverage. The appeal will be reviewed by individuals who were not involved in the previous decision to deny coverage. ODS will review the information and respond within 30 calendar days.

In addition, the applicant has the right to file a complaint or seek assistance from the Oregon Insurance Division by calling 503-947-7984 or toll-free at 888-877-4894; by writing to Oregon Insurance Division, PO Box 14480, Salem, OR 97309-0405; online at www.cbs.state.or.us/external/ins/; or by emailing cp.ins@state.or.us.

The applicant may request a copy of all documents ODS used in making this denial decision, free of charge. For this information, the applicant may contact us at the address or telephone number below.

The applicant must send the appeal, in writing, within 180 calendar days of receipt of the denial letter. A Complaint and Appeal Form is available at www.odscompanies.com or by calling the phone number at the bottom of the letter. The applicant does not need to use the form, as long as the written request includes the applicant's name, address and application date. Mail or fax the appeal to:

ODS
Attention: Appeal Unit
601 S.W. Second Ave.
Portland, OR 97204
Fax: 866-796-3222

When filing an appeal, please submit all necessary documents at the time of appeal (e.g., medical records, doctors' notes or any additional information). All applicants have the right to one appeal level per decline. For further questions, you may contact ODS' Individual Sales Department at 877-277-7073 or e-mail individualplans@odscompanies.com.

Incomplete applications

ODS has access to prior ODS claims. If a prior ODS member, whether on a group or individual plan, submits an application and claims history that was not originally indicated on the application is found, the application will be considered incomplete. Underwriting may return the application for further details regarding the applicant's medical history.

All questions in the Health History Statement Section must have a "yes" or "no" answer. If any questions are left unmarked, the application will be considered incomplete. If there are any "yes" answers, they must be addressed in the Health History Details Section with complete medical history, including: question number, beginning and end dates, condition, treatment, resolution and physician/hospital.

All applicants must indicate all past (last five years) and current prescription and over-the-counter medications. Each medication must be explained in the Health History Details Section with the medical condition(s) treated. If there is no condition indicated, ODS will return the application as incomplete requiring updates.

Underwriting requires a new signature in the authorization section when an application is returned as incomplete; this ensures we can continue to process the application.

Reinstatement

An application is considered a reinstatement if the prior individual plan was terminated within the last 60 days. ODS must collect previously unpaid premiums at the time of reinstatement. The applicant must also choose EFT (electronic funds transfer) as the future billing method. If an applicant would like to reinstate his or her policy, please contact our Individual Billing and Eligibility department at 503-265-5696 or indunit@odscompanies.com.

Medical underwriting guidelines

Declinable conditions

For applicants age 19 and over, ODS declines those conditions listed on the OMIP application. ODS may also decline some additional conditions that are not on the OMIP list, as indicated below. An applicant must submit an application in order to receive a formal declination and be eligible to apply for OMIP if the condition is not listed as an OMIP condition.

ODS' list of declinable conditions includes, but is not limited to, the following:

Acromegaly
Adams-Stokes syndrome
Addison's disease
Adrenal insufficiency
AIDS/HIV+
Alcohol/chemical dependency
Alzheimer's disease
Amaurosis fugax
Amyloidosis
Amyotrophic lateral sclerosis
Analgesic abuse nephropathy
Aneurysm
Angina pectoris
Ankylosing spondylitis
Anorexia/bulimia
Aortic valve insufficiency
Aortic valve stenosis
Aplastic/sickle cell/splenic anemia
Arnold-Chiari malformation
Arteriosclerosis obliterans
Artificial heart valve
Ascites
Ataxia
Autism
Barrett's esophagus
Becker muscular dystrophy
Behcet's syndrome
Berger's disease
Bipolar disorder
Blood coagulation disorder
Brain tumors
Burkitt's lymphoma
Cancer/metastatic cancer
Celiac disease
Cerebral palsy
Charcot-Marie-Tooth disease
Chronic obstructive pulmonary disease
Cirrhosis of the liver
Congestive heart failure/ cardiomyopathy
Coronary insufficiency/occlusion/ artery disease
Cretinism
Crohn's disease
Cushing's disease
Cystic fibrosis
Dementia
Dermatomyositis
Diabetes
Ehlers-Danlos syndrome
Emphysema
Fibromyalgia
Fragile X syndrome
Friedreich's disease
Gastric bypass surgery
Gaucher's disease
Glaucoma
Heart enlargement
Hemochromatosis
Hemophilia
Hepatitis C, D
Hodgkin's disease
Huntington's chorea
Hydrocephalus
Hypertensive renal disease
Intermittent claudication
Ischemic heart disease
Kidney failure
Lead poisoning (cerebral)
Liver failure
Lupus
Malignant tumor
Marfan's syndrome
Melanoma
Mixed connective tissue disease
Multiple or disseminated sclerosis
Muscular atrophy/dystrophy
Myasthenia gravis
Myotonia
Obesity
Open heart surgery
Paraplegia/quadriplegia
Parkinson's disease
Pending surgery
Peripheral arteriosclerosis
Pituitary gland disorders
Polyarteritis
Polycystic kidney
Polycystic ovarian syndrome
Posterolateral sclerosis
Pregnancy (current)
Progressive systemic sclerosis
Pulmonary fibrosis
Rheumatoid arthritis
Schizophrenia
Silicosis
Sjogren's syndrome
Still's disease
Stroke
Suicide attempt
Syringomyelia
Topectomy and lobotomy
Transient ischemic attack
Transplants
Ulcerative colitis
Von Recklinghausen's disease
Von Willebrand disease
Wilson's disease

The final decision regarding coverage rests with the underwriter and the ODS medical director.

Build charts

ODS underwriters use height and weight to determine if a person is insurable. The minimums and maximums are noted below; any build outside these limits is not insurable. Please provide the most recent height and weight of all applicants. Estimates and guesses are not sufficient.

ADULT BUILD CHARTS

MALES		
HEIGHT	**MINIMUM LBS**	**MAXIMUM LBS**
4'11"	97	163
5'0"	99	168
5'1"	101	171
5'2"	103	176
5'3"	105	183
5'4"	107	190
5'5"	109	197
5'6"	113	204
5'7"	115	211
5'8"	119	218
5'9"	123	224
5'10"	125	230
5'11"	129	236
6'0"	133	243
6'1"	137	250
6'2"	141	257
6'3"	145	264
6'4"	149	271
6'5"	153	278
6'6"	157	286
6'7"	161	292
6'8"	165	299

FEMALES		
HEIGHT	**MINIMUM LBS**	**MAXIMUM LBS**
4'8"	81	149
4'9"	85	151
4'10"	88	154
4'11"	90	156
5'0"	93	159
5'1"	95	164
5'2"	98	169
5'3"	102	176
5'4"	104	182
5'5"	108	189
5'6"	111	196
5'7"	114	203
5'8"	117	209
5'9"	123	215
5'10"	126	221
5'11"	130	227
6'0"	134	233
6'1"	137	240
6'2"	141	247
6'3"	145	253
6'4"	149	260

Common conditions and potential underwriting actions

In some situations, ODS may decide to offer coverage with a higher annual deductible, rather than declining the applicant. A limited number of examples of common conditions are noted below. An application must be submitted in order for the applicant to be formally declined.

"Subject to deductible" indicates some conditions may limit plan choices to higher deductibles. Approval is not guaranteed, but upon underwriting review a downgrade may be offered instead of a decline.

CONDITION	POTENTIAL ACTION
ACNE	
A skin disorder. Severe form may require prescription medication.	
Mild, treated with topical ointments only	Standard
Moderate, treated with oral meds, not Accutane	Subject to deductible
Severe or currently on Accutane	Decline
ALLERGIES OR ALLERGIC RHINITIS	
A seasonal or perennial allergy to dust and pollens.	
Seasonal, no asthma or inhaler use	Standard
Perennial or with asthma	Subject to deductible
Undergoing desensitization treatments	Subject to deductible
ASTHMA	
Difficult breathing due to allergens.	
Mild, seasonal, no hospitalizations	Subject to deductible
Perennial, no hospitalizations	Subject to deductible
Severe or with hospitalizations	Decline
BACK AND NECK STRAIN OR SPRAIN	
Back and neck muscle pain due to overexertion.	
One episode, fully recovered under one year	Decline
One episode, fully recovered over one year	Standard
Multiple episodes within three years, no disc disorder	Subject to deductible
Multiple episodes over three years, no disc disorder	Standard
With spinal manipulation, no more than six per year	Standard
With spinal manipulation, more than six per year	Subject to deductible
Over one year since last manipulation	Standard
CATARACT	
An opacity of the lens of the eye.	
Un-operated: congenital, traumatic and senile	Decline
Operated: congenital and traumatic	Standard
Operated: senile, recovered under one year	Decline
Operated: senile, recovered over one year	Standard

DIVERTICULITIS/ DIVERTICULOSIS	
Diverticulosis is a pouch in the intestine. Diverticulitis is inflammation of the pouch.	
Diverticulosis, found incidentally, asymptomatic	Standard
Diverticulitis un-operated, one attack, recovered; over two years since recovery	Standard
Multiple attacks	Decline
Diverticulitis, operated, recovered over two years	Standard
GENITAL HERPES	
A viral infection of the genitals.	
Less than six months since infection	Decline
Over six months since infection, controlled	Subject to deductible
GERD	
Gastroesophageal reflux disorder. Acid reflux.	
Mild, treated with non-prescription medication	Standard
Treated with prescription medication	Subject to deductible
HEADACHES OR MIGRAINES	
Mild, occasional episodes	Standard
Frequent, definite diagnosis, not disabling	Subject to deductible
Disabling or chronic	Decline
HEPATITIS	
An acute or chronic inflammation of the liver.	
Hepatitis A, E: over six months since recovery	Standard
Hepatitis B: over one year since full recovery	Standard
Hepatitis C, D, G	Decline
HERNIA	
A hernia is a protrusion of a loop or knuckle of an organ or tissue through an abnormal cavity.	
Present: incisional, inguinal, umbilical, scrotal, ventral	Decline
Surgical resolved: incisional, inguinal, umbilical, scrotal, ventral	Standard
Hiatal hernia	Subject to deductible
HYPOTHYROIDISM	
Inadequate production of thyroid hormone.	
Adequately treated with thyroid supplements	Standard
Not adequately treated	Decline

INFERTILITY	
Treatment with infertility drugs, artificial insemination or IVF within the last five years	Decline
With no treatment or sterile	Standard
IRRITABLE BOWEL SYNDROME	
A non-ulcerating irritation of the intestines.	
Definite diagnosis, not on prescription medication: one episode, less than one year since last attack	Subject to deductible
One episode, over one year since last attack	Standard
KIDNEY STONE(S)	
Abnormal mineral collections (mainly calcium) that form in the kidney, ureter or bladder.	
History of one attack, within last three years	Decline
History of one attack, over three years	Standard
History of multiple attacks	Decline
Present	Decline
KNEE DISORDERS	
Arthritis of knee or knee replacement	Decline
ACL or meniscus tears, fractures, un-operated	Decline
Operated, over one year since surgery, recovered	Standard
OSTEOARTHRITIS	
A degenerative arthritis commonly associated with aging.	
Minimal, no interference with function, non-weight-bearing joint	Standard
Moderate, some interference with function or on prescription medication, non-weight-bearing joint	Subject to deductible
Severe or affecting hips, knees or ankles	Decline
SLEEP APNEA	
Cessation of breathing during sleep. Two types — obstructive: due to blockage of the airway; central (mixed): due to a brain stem disorder.	
Obstructive apnea using CPAP, not overweight	Subject to deductible
Operated, recovered, no treatment required	Standard
Central or mixed apnea	Decline

Co-morbidity factors

Multiple risk factors can affect risk in an adverse way. For example, an applicant with high blood pressure that is controlled may be an acceptable risk. An applicant who is a smoker may be an acceptable risk. However, an applicant who is a smoker and has controlled high blood pressure may be declined. The final decision may deviate from guidelines when multiple conditions exist.

Partial list of conditions requiring additional information

Some conditions will require additional information and may be submitted with the original application, as indicated below. Submitting this information with the application will assist the underwriting process.

Condition	Additional information
ARTHRITIS	Provide affected areas and treatment.
BREAST (LUMPS OR MASSES)	Provide diagnosis and biopsy or ultrasound results if applicable.
CHOLESTEROL, ELEVATED	Please give total cholesterol, HDL, LDL and triglyceride readings.
COLON POLYPS	Provide colonoscopy and biopsy results, number and size of polyps.
COSMETIC SURGERY/IMPLANTS	Please indicate the type of implant.
EPILEPSY	Provide date of last seizure and name of current medication.
HYPERTENSION	Please provide the most recent reading from a doctor's office.
MENTAL/ EMOTIONAL CONDITION/ DEPRESSION AND THERAPY	Subject to underwriting review. Please indicate any mental health drugs. If therapy or counseling is indicated, include the most recent date of service.
MISCARRIAGE	Provide number and dates of occurrences within the last five years. Please inform when released from care and resumed normal menstrual cycles.
OSTEOPOROSIS OR OSTEOPENIA	Please submit latest DEXA scan results.
OTITIS MEDIA (EAR INFECTION)	Provide number of episodes and any recommended treatment.
PAP SMEARS (ABNORMAL)	If past history of abnormal results, two normal Pap smears required.
PREGNANCY	Please complete post partum follow-up, typically around six weeks. Provide type of birth (vaginal or cesarean section).
SKIN TUMORS OR ABNORMAL MOLES	Please submit pathology report.
SPINAL MANIPULATION	Provide number of chiropractor visits within the last year.
SURGICALLY REPAIRED BONE FRACTURES/JOINT REPLACEMENTS	Please indicate if hardware is present, surgery date and any follow-up care.
TESTOSTERONE, LOW	Provide the diagnosis/cause of abnormal levels and any treatment or medications.
WORKERS' COMP INJURY	Explain injury/condition and any treatment.


ODS