

INDIVIDUAL BENEFITS | August 2008-July 2009

OREGON



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**CLEAR
CHOICE**
HEALTH PLANS
your life. your choice.

Clear Access PPO Plan

Clear Access is a comprehensive Preferred Provider Organization (PPO) plan that offers the following:

- Preferred and national network of doctors and hospitals
- Referrals not required
- Deductible waived for preventive services, alternative care, vision exams, accidental injury coverage, and pharmacy services
- Comprehensive prescription drug coverage
- Annual deductible options: \$500, \$1,000, \$2,500, \$5,000, \$7,500 or \$10,000
- Out-of-pocket maximum is \$5,000 plus chosen deductible

The deductible, coinsurance (%), and copay represent what YOU pay. The maximum family deductible is 3x's the individual deductible. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care (Subject to scheduled plan limits)	\$25 copay	50% after deductible	
Women's Annual Exam (Subject to scheduled plan limits)	\$25 copay	50% after deductible	
Mammograms (Subject to scheduled plan limits)	\$25 copay	50% after deductible	
Professional Services			
Office Visit	1st 4 visits \$25 copay, thereafter subject to deductible and 30% coinsurance		50% after deductible
Office Procedures, Lab & X-Rays	30% after deductible		50% after deductible
Alternative Care	\$25 copay up to \$500 per calendar year		
Hospital & Emergency Services			
Urgent Care	30% after deductible		
Emergency Room	\$100 copay (waived if admitted within 24 hours), then subject to deductible and 30% coinsurance		
Air & Ground Ambulance (Subject to plan limits)	30% after deductible		
Inpatient & Outpatient Hospital	30% after deductible	50% after deductible	
Maternity Services			
Prenatal, Delivery & Postpartum Physician Services	30% after deductible	50% after deductible	
Other Services			
Mental Health (Subject to plan limits)	30% after deductible	50% after deductible	
Vision Eye Exam	\$25 copay up to \$75 per calendar year		
Accidental Injury	1st \$1,000 covered in full for treatment sought within 90 days of injury, thereafter subject to deductible and coinsurance		
Pharmacy Services			
Prescriptions (Subject to plan limits)	Retail 1-Month Supply	\$15 copay generics, 50% all other drugs	
	Mail Order 3-Month Supply	2x copay or coinsurance	
		Not covered	

Clear Premier POS Plan

Clear Premier is our most comprehensive Point of Service (POS) plan that offers the following benefits:

- Local and national network of doctors and hospitals
- Referrals not required
- Lower copay for Primary Care Provider (PCP) office visits
- Deductible waived for preventive services, office visits, alternative care, vision exams, accidental injury coverage, and pharmacy services
- Comprehensive prescription drug coverage
- Annual deductible options: \$500, \$1,000, \$1,500 or \$2,500
- Out-of-pocket maximum per person is \$4,000 plus chosen deductible

The deductible, coinsurance (%) and copay represent what YOU pay. The maximum family deductible is 3x's the individual deductible. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care <i>(Subject to scheduled plan limits)</i>		\$25 copay - PCP \$35 copay - Non-PCP	40% after deductible
Women's Annual Exam <i>(Subject to scheduled plan limits)</i>		\$25 copay	40% after deductible
Mammograms <i>(Subject to scheduled plan limits)</i>		\$25 copay	40% after deductible
Professional Services			
Office Visit		\$25 copay - PCP \$35 copay - Non-PCP	40% after deductible
Office Procedures, Lab & X-Rays		20% after deductible	40% after deductible
Alternative Care		\$25 copay up to \$500 per calendar year	
Hospital & Emergency Services			
Urgent Care		\$50 copay	
Emergency Room		\$100 copay (waived if admitted within 24 hours), then subject to deductible and 20% coinsurance	
Air & Ground Ambulance <i>(Subject to plan limits)</i>		20% after deductible	
Inpatient & Outpatient Hospital		20% after deductible	40% after deductible
Maternity Services			
Prenatal, Delivery & Postpartum Physician Services		20% after deductible	40% after deductible
Other Services			
Mental Health <i>(Subject to plan limits)</i>		20% after deductible	40% after deductible
Vision Eye Exam		\$25 copay up to \$75 per calendar year	
Accidental Injury		1st \$1,000 covered in full for treatment sought within 90 days of injury, thereafter subject to deductible and coinsurance	
Pharmacy Services			
Prescriptions <i>(Subject to plan limits)</i>	Retail 1-Month Supply	\$10 copay generics, 50% all other drugs	
	Mail Order 3-Month Supply	2x copay or coinsurance	
		Not covered	

Clear Savings PPO 1500 & 2500 Plan (HSA-Qualified)

Clear Savings is a qualified Health Savings Account (HSA) PPO plan that offers the following benefits:

- Preferred and national network of doctors and hospitals
- Referrals not required
- Deductible waived for first \$500 of preventive services
- Annual individual deductible options: \$1,500 or \$2,500
 - Annual individual out-of-pocket maximum: \$5,500 (includes deductible)
- Annual family deductible options: \$3,000 or \$5,000
 - Annual family out-of-pocket maximum: \$11,000 (includes deductible)

The deductible and coinsurance (%) represent what YOU pay. The maximum family deductible is 2x's the individual deductible. A family is an individual plus one or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care (Subject to scheduled plan limits)	1st \$500 of all preventive services covered in full, thereafter subject to deductible and 20% coinsurance	50% after deductible	
Women's Annual Exam (Subject to scheduled plan limits)			
Mammograms (Subject to scheduled plan limits)			
Professional Services			
Office Visit	20% after deductible	50% after deductible	
Office Procedures, Lab & X-Rays	20% after deductible	50% after deductible	
Alternative Care	Not covered		
Hospital & Emergency Services			
Urgent Care	20% after deductible		
Emergency Room	20% after deductible		
Air & Ground Ambulance (Subject to plan limits)	20% after deductible		
Inpatient & Outpatient Hospital	20% after deductible	50% after deductible	
Maternity Services			
Prenatal, Delivery & Postpartum Physician Services	20% after deductible	50% after deductible	
Other Services			
Mental Health (Subject to plan limits)	20% after deductible	50% after deductible	
Vision Eye Exam	Not covered		
Accidental Injury	Not covered		
Pharmacy Services			
Prescriptions (Subject to plan limits)	Retail 1-Month Supply	50% after deductible	Not covered
	Mail Order 3-Month Supply	2x coinsurance	

Clear Savings PPO 3500 & 5500 Plan (HSA-Qualified)

Clear Savings is a qualified Health Savings Account (HSA) PPO plan that offers the following benefits:

- Preferred and national network of doctors and hospitals
- Referrals not required
- Deductible waived for first \$500 of preventive services
- Annual individual out-of-pocket maximum (includes deductible): \$3,500 or \$5,500
- Annual family out-of-pocket maximum (includes deductible): \$7,000 or \$11,000

The deductible and coinsurance (%) represent what YOU pay. The maximum family deductible is 2x's the individual deductible. A family is an individual plus one or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care (Subject to scheduled plan limits)	1st \$500 of all preventive services covered in full, thereafter subject to deductible		50% after deductible
Women's Annual Exam (Subject to scheduled plan limits)			50% after deductible
Mammograms (Subject to scheduled plan limits)			50% after deductible
Professional Services			
Office Visit		Covered in full after deductible	50% after deductible
Office Procedures, Lab & X-Rays		Covered in full after deductible	50% after deductible
Alternative Care		Not covered	
Hospital & Emergency Services			
Urgent Care		Covered in full after deductible	
Emergency Room		Covered in full after deductible	
Air & Ground Ambulance (Subject to plan limits)		Covered in full after deductible	
Inpatient & Outpatient Hospital		Covered in full after deductible	50% after deductible
Maternity Services			
Prenatal, Delivery & Postpartum Physician Services		Covered in full after deductible	50% after deductible
Other Services			
Mental Health (Subject to plan limits)		Covered in full after deductible	50% after deductible
Vision Eye Exam		Not covered	
Accidental Injury		Not covered	
Pharmacy Services			
Prescriptions (Subject to plan limits)	Retail 1-Month Supply	Covered in full after deductible	Not covered
	Mail Order 3-Month Supply	2x prescription price	

Clear Quality POS Plan

Clear Quality is a Point of Service (POS) plan that offers the following benefits:

- Local and national network of doctors and hospitals
- Referrals not required
- Lower copay for Primary Care Provider (PCP) office visits
- Deductible waived for preventive services, accidental injury coverage, and pharmacy services
- Annual deductible \$2,500
- Out-of-pocket maximum per person is \$5,000 over deductible

The deductible, copay, and coinsurance (%) represent what YOU pay. The maximum family deductible is 3x's the individual deductible. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care <i>(Subject to scheduled plan limits)</i>	\$30 copay - PCP \$40 copay - Non-PCP		50% after deductible
Women's Annual Exam <i>(Subject to scheduled plan limits)</i>	\$30 copay		50% after deductible
Mammograms <i>(Subject to scheduled plan limits)</i>	\$30 copay		50% after deductible
Professional Services			
Office Visit	1st 4 visits \$30 copay, thereafter subject to deductible - PCP 1st 4 visits \$40 copay, thereafter subject to deductible - Non-PCP		50% after deductible
Office Procedures, Lab & X-Rays	30% after deductible		50% after deductible
Alternative Care	Not Covered		Not Covered
Hospital & Emergency Services			
Urgent Care			30% after deductible
Emergency Room	\$100 copay (waived if admitted within 24 hours), then subject to deductible and 30% coinsurance		
Air & Ground Ambulance <i>(Subject to plan limits)</i>			30% after deductible
Inpatient & Outpatient Hospital	30% after deductible		50% after deductible
Maternity Services			
Prenatal, Delivery & Postpartum Physician Services	30% after deductible		50% after deductible
Other Services			
Mental Health <i>(Subject to plan limits)</i>	30% after deductible		50% after deductible
Vision Eye Exam			Not covered
Accidental Injury	1st \$1,000 covered in full for treatment sought within 90 days of injury, thereafter subject to deductible and coinsurance		
Pharmacy Services			
Prescriptions <i>(Subject to plan limits)</i>	Retail 1-Month Supply	\$15 copay generics only	Not covered
	Mail Order 3-Month Supply	2x copay	

Clear Value POS Plan

Clear Value is a Point of Service (POS) plan that offers the following benefits:

- Local and national network of doctors and hospitals
- Referrals not required
- Lower copay for Primary Care Provider (PCP) office visits
- Deductible waived for preventive services, accidental injury coverage, and pharmacy services
- Annual deductible and out-of-pocket maximum per person is \$5,000
(once you reach \$5,000, BOTH your deductible and your out-of-pocket maximum are satisfied)

The deductible, copay, and coinsurance (%) represent what YOU pay. The maximum family deductible is 3x's the individual deductible. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care (Subject to scheduled plan limits)	\$30 copay - PCP \$40 copay - Non-PCP		50% after deductible
Women's Annual Exam (Subject to scheduled plan limits)	\$30 copay		50% after deductible
Mammograms (Subject to scheduled plan limits)	\$30 copay		50% after deductible
Professional Services			
Office Visit	1st 4 visits \$30 copay, thereafter subject to deductible - PCP 1st 4 visits \$40 copay, thereafter subject to deductible - Non-PCP		50% after deductible
Office Procedures, Lab & X-Rays	Covered in full after deductible		50% after deductible
Alternative Care	Not covered		
Hospital & Emergency Services			
Urgent Care	Covered in full after deductible		
Emergency Room	\$100 copay (waived if admitted within 24 hours), then covered in full after deductible		
Air & Ground Ambulance (Subject to plan limits)	Covered in full after deductible		
Inpatient & Outpatient Hospital	Covered in full after deductible		50% after deductible
Maternity Services			
Prenatal, Delivery & Postpartum Physician Services	Covered in full after deductible		50% after deductible
Other Services			
Mental Health (Subject to plan limits)	Covered in full after deductible		50% after deductible
Vision Eye Exam	Not covered		
Accidental Injury	1st \$1,000 covered in full for treatment sought within 90 days of injury, thereafter subject to deductible and coinsurance		
Pharmacy Services			
Prescriptions (Subject to plan limits)	Retail 1-Month Supply	\$15 copay generics only	Not covered
	Mail Order 3-Month Supply	2x copay	

Clear & Simple POS Plan

Clear & Simple is a Point of Service (POS) plan that offers the following benefits:

- Local and national network of doctors and hospitals
- Referrals not required
- Copay for Primary Care Provider (PCP) office visits
- Excellent catastrophic coverage
- Deductible waived for a limited number of PCP office visits, accidental injury coverage, and pharmacy services
- Annual deductible \$10,000
- Out-of-pocket maximum per person is \$5,000 over deductible

The deductible, copay, and coinsurance (%) represent what YOU pay. The maximum family deductible is 3x's the individual deductible. A family is an individual plus two or more.

		\$2,000,000 Lifetime Maximum	
		In-Network	Out-of-Network
Preventive Services			
Routine Physical Exams/Well Child Care <i>(Subject to scheduled plan limits)</i>		30% after deductible	50% after deductible
Women's Annual Exam <i>(Subject to scheduled plan limits)</i>		30% after deductible	50% after deductible
Mammograms <i>(Subject to scheduled plan limits)</i>		30% after deductible	50% after deductible
Professional Services			
Office Visit		1st 4 visits \$40 copay, thereafter subject to deductible - PCP 30% after deductible - Non-PCP	Not covered
Office Procedures, Lab & X-Rays		30% after deductible	50% after deductible
Alternative Care		Not covered	
Hospital & Emergency Services			
Urgent Care		30% after deductible	
Emergency Room		\$100 copay (waived if admitted within 24 hours), then subject to deductible and 30% coinsurance.	
Air & Ground Ambulance <i>(Subject to plan limits)</i>		30% after deductible	
Inpatient & Outpatient Hospital		30% after deductible	50% after deductible
Maternity Services			
Prenatal, Delivery & Postpartum Physician Services		30% after deductible	50% after deductible
Other Services			
Mental Health <i>(Subject to plan limits)</i>		30% after deductible	50% after deductible
Vision Eye Exam		Not covered	
Accidental Injury		1st \$1,000 covered in full for treatment sought within 90 days of injury, thereafter subject to deductible and coinsurance	
Pharmacy Services			
Prescriptions <i>(Subject to plan limits)</i>	Retail 1-Month Supply	\$20 copay generics only	Not covered
	Mail Order 3-Month Supply	2x copay	

Limitations, Exclusions and Disclosure Statement

Limitations

Benefit plans typically have exclusions and limitations (what the plans do not cover). The following include some general exclusions and limitations for the plans described in this brochure. Once enrolled, you will be given a policy with a detailed description of your coverage.

Covered Benefit	Plan Maximum														
Accidental Injury	\$1,000 per calendar year														
Alternative Care <i>Applies only to Clear Access plan and Clear Premier plan</i>	\$500 per calendar year														
Ambulance (Air and Ground)	\$5,000 per calendar year														
Durable Medical Equipment	\$5,000 per calendar year														
Home Health Care	130 visits or \$10,000 per calendar year, whichever comes first														
Hospice	\$10,000 Lifetime														
Physical, Occupational, Speech Therapy, Cardiac, Pulmonary	Outpatient: 20 visits or \$2,500 per calendar year, whichever comes first Inpatient: 30 days per calendar year														
Prescription and Self-Injectable Drugs	No limit for generics \$3,000 per calendar year brand, non-formulary, and self-injectable drugs														
Preventive Health Exams	<table border="0"> <tr> <td>Infants, 0-24 months:</td> <td>up to 8 well-baby visits</td> </tr> <tr> <td>Children, ages 2-6:</td> <td>1 exam every year</td> </tr> <tr> <td>Children, ages 7-18:</td> <td>1 exam every 2 years</td> </tr> <tr> <td>Adults, ages 19-29:</td> <td>1 exam every 5 years</td> </tr> <tr> <td>Adults, ages 30-39:</td> <td>1 exam every 3 years</td> </tr> <tr> <td>Adults, ages 40-49:</td> <td>1 exam every 2 years</td> </tr> <tr> <td>Adults, ages 50+:</td> <td>1 exam every year</td> </tr> </table>	Infants, 0-24 months:	up to 8 well-baby visits	Children, ages 2-6:	1 exam every year	Children, ages 7-18:	1 exam every 2 years	Adults, ages 19-29:	1 exam every 5 years	Adults, ages 30-39:	1 exam every 3 years	Adults, ages 40-49:	1 exam every 2 years	Adults, ages 50+:	1 exam every year
Infants, 0-24 months:	up to 8 well-baby visits														
Children, ages 2-6:	1 exam every year														
Children, ages 7-18:	1 exam every 2 years														
Adults, ages 19-29:	1 exam every 5 years														
Adults, ages 30-39:	1 exam every 3 years														
Adults, ages 40-49:	1 exam every 2 years														
Adults, ages 50+:	1 exam every year														
Refractive Eye Exam <i>Applies only to Clear Access plan and Clear Premier plan</i>	1 visit PCY, \$75 per calendar year														
Routine Mammography	< Age 40: high risk only > Age 40: Annually														
Skilled Nursing Facility	60 days per calendar year														
Transplant Services	\$250,000 lifetime, Subject 24-month waiting period														

Exclusions

- Acupuncture, naturopathic, chiropractic treatment
(Does not apply to the Clear Access and Clear Premier plans)
- Cosmetic/reconstructive surgery
- Certain mental health services for religious, marital, behavioral, family, occupational, developmental, learning disabilities, mental retardation, sexual, spiritual, or personality disorders
- Custodial care, intermediate care facility, private nursing services
- Dental services
- Electronic Beam Tomography (EBT)
- Experimental/investigational services
- Eye surgery to alter refractive character of the eye, including radial keratotomy and laser surgery
- Lay midwife or direct entry midwife services
- Light therapy or equipment for seasonal affective disorder
- Massage or massage therapy
- Mental examination and psychological testing and evaluation
- Physical examinations for third-party purposes
- Prevailing rates, missed appointments, records, or reports
- Routine foot care (except for diabetes)
- Routine vision exams, eyeglasses, and other vision services
- Services provided by volunteer worker or member of immediate family
- Services for sexual disorders/sex transformation
- Surrogate mother maternity care
- Treatment for obesity and weight control (including surgery)
- Treatment for which a third party is responsible
- Transportation except medically necessary ambulance transport
- Wigs, toupees, hair transplants
- Work-related conditions

Disclosure Statement

This brochure is a general outline of the important features of our plans for individuals and families in Oregon. The full terms and conditions of these plans will be provided in the policy at the time of purchase. This brochure is not intended to be a part of the policy. Only the policy is final and binding, which details your rights and obligations as well as those of Clear Choice Health Plans, Inc.

If you apply for coverage with Clear Choice Health Plans, please read your policy carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Be sure to fill out your application completely and truthfully. If misstatements are made or information about your health is omitted, Clear Choice may void the contract or deny your claims. If you are adding new coverage to a current policy, please review both policies to ensure you're not purchasing any unnecessary coverage or canceling any desired coverage. If you decline coverage under a group health plan in order to retain or obtain coverage under an individual health plan, you may be considered a late enrollee if you seek enrollment in the group health plan at a later date.

If you have any questions that are not answered by this disclosure statement, please ask your insurance agent or our Marketing & Sales Department at (866) 893-7883 or (541) 330-2545.