



ODS PPO Prescription Drug Options

	Rx Option A	Rx Option B	Rx Option C
Deductible	None	None	None
Plan Year Copay/Coinsurance Maximum	\$1,000	\$1,000	\$1,000
Retail (31 Day Supply)			
Generic	\$5	\$5	50%
Preferred	20%	\$25	50%
Non-Preferred	50%	50%, \$50 max	50%
Mail (90 Day Supply)			
Generic	\$10	\$10	50%
Preferred	20%	\$50	50%
Non-Preferred	50%	50%, \$100 max	50%
Specialty (31 Day Supply)			
Generic	\$10	\$10	50%
Preferred	20%	\$50	50%
Non-Preferred	50%	50%, \$100 max	50%

ODS Vision Plan Options

Plan Option	Vision Plan 1	Vision Plan 2	Vision Plan 3	Vision Plan 4	Vision Plan 5
Plan Year Maximum	\$250	\$350	\$450	\$600	See allowances
Routine Eye Exam	\$10 copay	100%	100%	100%	100% up to \$64.50
Exam Frequency	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year
Lenses - One pair of lenses or contacts per plan year					
Single Vision	100%*	100%*	100%*	100%*	100% up to \$58.50 per year
Bifocal	100%*	100%*	100%*	100%*	100% up to \$86.00 per year
Lenticular	100%*	100%*	100%*	100%*	100% up to \$86.00 per year
Trifocal	100%*	100%*	100%*	100%*	100% up to \$109.00 per year
Contact Lenses (Conventional or Disposable)	100%*	100%*	100%*	100%*	100% up to \$192.50 per year
Non-Covered Materials/Lense Extras	0%	0%	0%	100%*	100% up to \$192.50 per year
Frame Frequency - See below					
Child (less than 17)	Once per plan year	Once per plan year	Once per plan year	Once per plan year	Once per plan year
Adult (17+)	Once every two plan years	Once every two plan years	Once every two plan years	Once every two plan years	Once every two plan years
Frames	100%*	100%*	100%*	100%*	100% up to \$75.00 per year

* Please see exclusion list. Benefits payable to plan year maximum. 10/1/09 ms