OEBB and ODS FAQs

BENEFITS – GENERAL 03/30/10

1. **Are the medical, vision, pharmacy and dental benefit plans administered on a calendar-year basis or a plan-year basis?**
   All benefits, including medical, vision, pharmacy and dental plans, are administered on a plan-year basis. The plan year begins Oct. 1 and goes through Sept. 30.

2. **What are the benefits, copayments and out-of-network benefits for each plan?**
   Information can be found on the plan comparison documents, located on the OEBB and ODS websites.

3. **Are there any late enrollee penalties?**
   Members who do not enroll when originally eligible can only enroll during the annual open enrollment period. Members who do not enroll in the dental and vision plans when originally eligible and later elect to enroll during open enrollment will be eligible for preventive services only for the first 12 months of coverage. Dental coverage will allow preventive services only and no orthodontia coverage during the 12-month period. Late enrollees who enroll in a vision plan will be covered only for a vision exam for the first 12 months.

4. **Does OEBB or ODS require members to use their social security numbers as identification?**
   Members are not required to use their social security numbers as identification. OEBB will assign unique identification numbers. These numbers also are used by ODS. OEBB members should present their ODS ID cards when receiving services. Providers should bill ODS using the member's unique ID number.

5. **When an OEBB member has dual OEBB coverage, does the deductible have to be satisfied or will it be picked up by the other plan?**
   The deductible still must be satisfied prior to any benefit reimbursement. For example, if a member has dual coverage under OEBB medical plan 3, there is a $100 deductible that must be met. Here is an example of how this would work:

   ODS receives a claim with eligible charges of $120, and $100 is applied to the primary plan's deductible. ODS would reimburse the provider for 90 percent of the remaining balance of $20 (assuming the service was in-network and

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not a copayment service), which equals $18. ODS would then apply the same $100 to the secondary coverage's deductible. ODS would pick up the additional $2 of eligible charges, which was not applied to the deductible, as the secondary carrier. Total member responsibility for this claim would be $100. The deductible is now satisfied on both plans.

6. **If ODS receives a claim for a date of service prior to the effective date of Oct. 1, 2009, what will happen to that claim?**
ODS will deny the claim if services were prior to the effective date. The provider will need to rebill the correct carrier. *Note: This applies to new groups coming on to OEBB effective Oct. 1, 2009, only.*

MEDICAL BENEFITS

1. **Do all expenses apply to a member's medical maximum out-of-pocket cost?**
   No. Expenses applied toward the annual deductible do not apply toward the out-of-pocket maximum (except for plan 9). Fixed-dollar copayments and disallowed charges do not apply toward the annual deductible or out-of-pocket maximum.

   Members are required to pay for the following costs. They do not accrue toward members' out-of-pocket maximum, and members must pay for them even after their out-of-pocket maximum is met:
   - Fixed-dollar copayments
   - The out-of-pocket expenses for transplants performed at out-of-network transplant facilities
   - The service authorization cost containment penalty
   - Disallowed charges

2. **If a member is on a plan that requires some medical copayments, does the deductible need to be met before the benefits with copayments are allowed with just the copayment?**
   Services with copayments always require a copayment, and members do not need to meet the deductible to receive the benefit associated with the service. The exception to this rule is with the emergency room copayment. Members are responsible for the emergency room copayment, and the deductible must be met before any carrier payment is made.

3. **Does the deductible for in- and out-of-network commingle (meaning that there is one deductible for both in- and out-of-network services combined)?**
   Yes.

4. **Does the out-of-pocket maximum for in- and out-of-network service commingle?**
   With plans 3 through 8, services accumulated toward the in-network, out-of-pocket maximum can be used to satisfy both the in- and out-of-network, out-of-pocket maximum. However, services accumulated toward the out-of-network, out-of-pocket maximum cannot be used to satisfy the in-network, out-of-pocket maximum.

With plan 9, a Health Savings Account (HSA)–compliant plan, services accumulated toward both the in- and out-of-network, out-of-pocket maximums can be used to satisfy both the in- and out-of-network, out-of-pocket maximums.

5. What does the term "coinsurance" mean?

Coinsurance enables members to split their eligible healthcare costs with the insurance carrier. For example, if a health plan has an 80/20 in-network coinsurance rate for specific services, after the deductible has been satisfied, the insurance company is then responsible for 80 percent of the eligible charges and the member is responsible for the balance (out-of-network coinsurance levels will differ from in-network coinsurance levels). Once members reach their plan year out-of-pocket maximum, the insurance carrier will pay for 100 percent of the eligible expenses (subject to plan limitations).

6. What are members' benefits while traveling? (nonemergency)

If a member is traveling out of the service area and seeks care from an out-of-network physician or provider, the benefit will be paid at the out-of-network benefit level. The plan will process charges for those services as follows: the maximum amount is the lesser of the amount payable under any supplemental provider fee arrangements and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

7. What if a member is out of the service area and has a medical emergency?

If a member is out of the service area and has a medical emergency, the member should go to the nearest emergency room. Benefits will be paid at the in-network benefit level, subject to maximum plan allowable, for medical emergencies.

8. If a member has a specific rare condition and needs to continue to see a provider that is not in the network, will ODS pay at the in-network benefit level?

ODS will follow its standard Transition of Care healthcare services policy. Transition of Care services may be approved under extraordinary circumstances for a finite period of time for a member who, while actively receiving medically necessary services, moves from a health plan with another carrier to ODS and as a result the ongoing medical services become out of network. The member must complete a Transition of Care form that ODS will review and approve.

9. How does medical plan 9, the HSA–compliant plan, work?

Health Savings Account–compliant plans give consumers incentives to manage their own healthcare costs by coupling a tax-favored savings account used to pay medical expenses with a high-deductible health plan (HDHP) that meets certain requirements for deductibles and out-of-pocket expense limits. HDHPs cover preventive care services (e.g., routine medical exams, immunizations, well-baby visits) without requiring the enrollee to first meet the deductible. The OEBB medical plan 9 is a HSA–compliant plan.

This plan has a high deductible that must be met prior to any benefits being paid out (except for specific preventive services when performed by in-network providers). It is important to understand that the family deductible is an aggregate deductible. Therefore, for any subscriber enrolled with one or more dependents on the plan, the entire family deductible must be satisfied before benefits are payable for services subject to the deductible (basically everything except preventive services.) This is different from how the deductibles work on the other plans, where each individual can separately meet a deductible. Please note: IRS regulations may prohibit coordination of benefits in order to receive HSA benefits tax free.

10. Alternative care is listed on the benefit summaries as a coinsurance amount; however, it also indicates that "services will be covered the same as any other benefit would be under the plan up to the combined benefit maximum." Plans 3 through 6 have an office visit copayment. Does this copayment also apply to alternative care providers?

Yes. If a member seeks services from an alternative care provider, benefits are reimbursed just like any other service up to the combined maximum of $2,500 per plan year. Therefore, office visits on plans 3 through 6 would be subject to the copayment, in lieu of the coinsurance amounts. Lab fees would be subject to coinsurance amounts listed.

11. What disease management programs does ODS offer?

ODS offers the following disease management programs:

- Diabetes
- Coronary artery disease
- Respiratory care
- Depression
- High-risk maternity

12. What benefits are covered under the cardiovascular screening preventive care benefit?

When members go for their yearly physical, the preventive care benefit also includes an EKG and treadmill test.

13. What benefits are covered under the hearing evaluation preventive care benefit?

This benefit is for children and adults. A brief hearing evaluation during a well-child examination is eligible for benefits. An adult hearing evaluation is covered when performed in conjunction with an adult periodic exam.

14. Coordination of benefits is confusing. Can you provide some examples for dual coverage with medical plans so I can get a better understanding of how benefits will be coordinated?

In most cases, once the deductibles are satisfied, members will not have any further out-of-pocket costs, unless limitations or maximums are required. If you seek services from out-of-network providers, you will be responsible for any charges in excess of the ODS maximum plan allowance (MPA). If you have secondary coverage through a non-ODS plan, please check with that plan's insurance carrier on how it handles coordination of benefits. Please see below for sample scenarios.

Medical coverage examples
(Also reference question 9 under the Benefits — general questions section of the FAQ.)

Example #1
An ODS member has dual medical coverage. The primary coverage is through ODS. The member is covered under OEBB plan 3 with a $100 individual deductible and a $300 family deductible. The secondary coverage is through the member's spouse from ABC Company, with a $500 individual deductible and a $1,000 family deductible. The first $100 in eligible charges would apply to both deductibles. Once the $100 deductible is met on the OEBB/ODS plan, ODS would begin to pay benefits. Eligible charges would continue to apply to the secondary plan's $500 individual deductible, until it is met. Once the secondary plan's deductible is met, the primary plan (ODS) would pay its normal benefits and the secondary plan would pay the remainder, leaving a zero dollar balance to the member in most cases.

Example #2
A married couple has dual coverage under the OEBB/ODS plans. The member for the example below has OEBB plan 7 as primary insurance and OEBB plan 3 as secondary insurance.

The member goes to the doctor for an in-network office visit. If the charge for the visit is $200, plan 7 applies $200 to the deductible and pays nothing to the provider. Plan 3, as the secondary plan, pays $190 to the provider (to cover the total office visit cost minus the $10 copayment). The member now has met $200 of the plan 7 deductible and $0 of the plan 3 deductible and must pay the $10 copayment to the provider.

The member goes for another in-network office visit. This time the charge is $350. Plan 7 applies $300 to the deductible and then pays 80 percent of the remaining $50, which would be $40. Patient responsibility under plan 7 would be $310, which is the remaining deductible plus the coinsurance of 20 percent. Plan 3, as the secondary plan, would pay $340 if it were the only plan in place (the total office visit cost minus the $10 copayment), but because the patient responsibility is $310 after plan 7 has been applied, plan 3 would pay the balance of $310.

The member has now met the $500 plan 7 deductible but has not yet met any deductible on plan 3.

15. What are the different ways to enroll in the tobacco cessation program?

An OEBB member can enroll by:

- Directly calling the program: 866-784-8454 or TTY 877-777-6534 (hours of operation: 5 a.m. to midnight Pacific Time)
- Calling ODS Medical Customer Service and asking for the Free & Clear Quit for Life Program
- Logging onto myODS at https://www.odshealthplans.com/myODSWeb or at www.quitnow.net and registering online
- Using myODS to request a call from Free & Clear After logging in to myODS, OEBB members can get information about the Free & Clear Quit For Life Program on the home page or in the myHealth section. A link takes users to an online call back form.
- Faxing an enrollment form from a provider or an ODS clinician with contact information to (800) 483-3114

16. Is a physician referral to the tobacco cessation program necessary?

No. Members can self-refer.

PHARMACY BENEFITS

1. **Is my medication covered under the OEBB Pharmacy benefit plan?**
The coverage for medication is based on the OEBB selected plan design and the placement of the medication on the ODS or Oregon Prescription Drug Program (OPDP) formulary, which can be accessed online by logging into myODS and using the formulary look-up tool under the pharmacy tab. The formulary is updated periodically.

2. **Why are changes sometimes made regarding how my medications are covered?**
At ODS we take pride in actively managing your pharmacy benefits to ensure the OEBB programs provide quality, comprehensive coverage and remain current with industry standards and the changes occurring in the marketplace.

   ODS considers the following when making changes to the pharmacy benefits:
   - How safe is the medication
   - How effective is the medication
   - How cost effective is the medication

   ODS has a clinical team who reviews the OEBB formulary and makes recommendations for program changes throughout the benefit year. This approach allows ODS to make changes when the FDA has approved new medications, generic alternatives are available, or changes occur to existing drug profiles (e.g. dosing, patient safety and/or approved uses).

   Changes that occur are enforced in an effort to maintain a comprehensive benefit, provide OEBB members an open formulary and choice, while balancing the use of utilization management strategies to ensure the ongoing stability of OEBB's pharmacy program.

3. **How do members establish their mail order prescriptions with the ODS/OPDP mail order program?**
To help in the planning process, members should be prepared to submit a new prescription for the medication they would like to have filled through the mail order program.

   Members should ask their doctor(s) for **new** prescriptions, written for up to a 90-day supply, with refills. These prescriptions should be mailed to

Wellpartner with the order form, or a doctor can fax them to Wellpartner at 866-624-5797.

Important notice: Members will need to have their ODS/OEBB ID number to set up a mail order account. Once members receive their ODS/OEBB ID card, they will have the information necessary to begin the registration process with Wellpartner. To set up an account, members should login to their myODS account, then click on the pharmacy tab or contact Wellpartner at 503-726-4672 or toll free at 866-680-4672.

All valid prescriptions will be processed in accordance with plan provisions and will be subject to eligibility at the time the prescription is filled. Members will be charged for the required copayment. Members should not send prescriptions to Wellpartner until they want them filled.

4. Once members' accounts and prescription(s) are established, how do they place orders for refills?

Members can order their prescription refill(s) from Wellpartner online through the pharmacy tab in their personal myODS account, by mail or by telephone. They must initiate refill orders; Wellpartner will not send them automatically.

To use the Mail Order Pharmacy, members can obtain a mail order pharmacy order form from their employer and visit the pharmacy tab of their myODS account. For assistance, members can contact ODS Pharmacy Customer Service at 503-265-2911 or toll free at 866-923-0411.

5. If members order prescriptions through the Wellpartner mail order program, how long will it take for the prescriptions to arrive via mail order?

In most cases, orders arrive within four to seven business days after they order are received. Members should allow more time for new prescriptions. Members can provide payment information via their secure online account through Wellpartner.

6. Are OEBB members required to access specialty medications (e.g., self-injectables, biologics, various other medications, etc.) through an exclusive specialty pharmacy?
Yes. Specialty medications must be accessed through Bioscrip Specialty Pharmacy, arelimited to a 31-day supply and will require prior authorization. Members can obtain a list of eligible medications and get information on the tiering of their medication by clicking the pharmacy tab in their myODS account or by calling ODS Pharmacy Customer Service. To enroll, members can contact Bioscrip directly at 877-316-8921.

7. If a 31-day supply of a preferred drug costs less than the copayment, does the member pay the total cost of the prescription or the copayment?
The member would pay the actual cost of the prescription.

9. If a member is traveling out of state, how does prescription drug coverage work?
For plans 3 through 8, members have access to in-network benefits nationwide, as long as prescriptions are filled through one of the major participating chains. A list of participating pharmacies is available on the ODS website. If a member goes to a non-network pharmacy at anytime for any reason, they will need to submit their claim and receipts to ODS for reimbursement. Members can obtain prescription drug claim forms online through their myODS account. Reimbursement will be based on a "paid as calculated" measure (meaning we will pay based on the maximum allowable).

10. How do I submit a request for reimbursement under ODS OEBB Plans A, B, or C?
Complete the Prescription Drug Claim Form for MedImpact plans. Forms can be found online at www.odscompanies.com through your myODS online account.

Submit claim forms to:
The ODS Companies
Attn: Pharmacy
P.O. Box 40168
Portland, OR 97240-0168

11. When and in what form will I be reimbursed?
ODS will process the claim request and send reimbursement to you in the form of a check. Paper claims are processed on average within 10 business days, and checks are cut daily to ensure timely payment to our members.

12. How much will I be reimbursed under ODS OEBB Plans A, B, or C?
Eligible prescription drugs purchased and paid in full by an enrollee will be reimbursed at the ODS/ OPDP pharmacy contracted rate minus your co-payment, or the maximum plan allowance minus your co-payment, whichever is less. Standard OEBB benefit provisions apply.

13. Am I required to submit the Prescription Drug Claim within a certain date span?
Yes. A claim must be submitted to ODS within 90 days after the date the medication was filled. If you fail to furnish a claim within the time required and it was not reasonably possible to submit the claim within those 90 days, your claim may still be valid, provided it is submitted as soon as reasonably possible. In no event, except absence of legal capacity, is a claim valid if submitted later than one year from the date of fill.

14. If a member has dual pharmacy coverage, will ODS coordinate the pharmacy benefit?
Yes. There are two methods for processing coordination of benefits (COB) claims: electronic submission by the pharmacy and paper submission by the member mailing in a claim (more information is available the Claims Procedures section of the member handbook). The ability for a pharmacy to participate can depend on the capabilities of the pharmacy's claim submission software. If members are unable to have their secondary claim processed electronically, they can manually submit their claim to ODS for secondary processing by following the Claim Procedures Process outlined under the section of the handbook titled "Prescription Drug Plan Benefits."

15. If a member has dual pharmacy coverage, how will secondary claim be paid?
When the primary plan has approved a pharmacy claim and paid towards that claim, the secondary plan will pay up to what would have been covered had the claim been submitted to ODS for primary processing. ODS will not pay more on the secondary claim than a member's total out of pocket expense on the primary claim.

In instances where the primary plan has denied the claim or paid nothing toward the claim (e.g., the cost of the medication is less than the copay), then the secondary plan will process the claim as if it is a primary claim.

16. Are compounded prescription drugs covered under the OEBB plans?

Compounded medications (containing at least one covered drug as an ingredient) are covered.

17. If members receive a name-brand medication that has a generic formulation, what will they be responsible to pay?

If members request a brand-name drug or their provider prescribes a brand-name drug when an equivalent generic formulation is available, they will be required to pay the brand copayment or coinsurance, plus the difference in cost between the generic and brand-name medication.

18. What applies toward the $1,000 plan year out-of-pocket maximum?

The out-of-pocket maximum includes the amount a member pays toward the covered expense on generic, preferred brand and nonpreferred brand-name drugs. If members receive a brand-name medication that has a generic formulation available, the difference in cost between the brand-name and generic medication will not apply toward the plan-year out-of-pocket maximum.

19. How will members know if their medications require prior authorization or have limitations?

A listing of the prescriptions requiring authorization is available online under the benefits tab of myODS . Members also can call ODS Pharmacy Customer Service. Please note that this listing may change periodically.

20. What should members do if their medication requires authorization?

If a medication is listed on the prescriptions requiring authorization document or if a member is taking a specialty medication or receiving a vaccination, the member should call ODS Pharmacy Customer Service. ODS will then work with the member's provider to obtain the necessary information to review the requested medication.

21. How does medical Plan 9, the HSA-compliant plan, work?

ODS and the Oregon Prescription Drug Program have contracted with pharmacies to provide members with a discounted price for prescriptions. A list of OPDP in-network pharmacies is available on the ODS website at www.odscompanies.com.

Members are responsible for paying the cost of their medications at the point of service. To receive the discounted price, members must go to a pharmacy in the OPDP Pharmacy Network and they must present their ODS identification card to the pharmacist prior to having their prescription filled.

As long as OEBB members use their ODS identification card at an OPDP participating pharmacy, they are not required to submit receipts or a claim form to ODS for reimbursement. ODS will automatically track expenses that may accrue toward the member's deductible and out-of-pocket maximum. In addition, ODS will reimburse members for eligible expenses under the prescription benefit.

If members do not use their ID card or if they fill their prescriptions at a nonparticipating pharmacy, they are required to submit a claim form requesting reimbursement from ODS. Follow these steps to request reimbursement:

Complete the Prescription Drug Claim Form for Major Medical plans found online at www.odscompanies.com, through your myODS online account.

Submit claim forms to:
The ODS Companies
Attn: Medical
P.O. Box 40384
Portland, OR 97240-0384

VISION BENEFITS

1. **Are disposable contacts covered?**
   Disposable contacts are covered up to the plan maximums and plan allowable on plans 1 through 4 and up to the type of service maximum on plan 5.

2. **Vision plan 1 has a $10 copayment for a routine eye exam. Is the provider reimbursed for the balance by ODS? Does the amount the provider is reimbursed by ODS go to the plan maximum?**
   Yes. ODS will reimburse up to the plan allowable amount providing it does not exceed the plan maximum. Any amount over the plan maximum is member liability.

3. **How are providers reimbursed for vision services?**
   Contracted providers are reimbursed up to the plan allowable amount for covered services. Noncontracted providers are reimbursed up to billed charges on plans 1 through 4 and up to type of service maximums on plan 5. Noncovered services are not covered under the contract, with no discount, and are the responsibility of the member. A list of noncovered services can be found under the Exclusions section of the vision member handbook.

4. **Will the ODS vision plans pay for polycarbonate lenses for children and adults?**
   Yes. ODS will pay for polycarbonate lenses, up to the plan maximum on plans 1 through 4. On plan 5, ODS will pay for polycarbonate and transitional lenses up to the appropriate lenses plan allowable.

5. **Are prescription sunglasses covered under this plan?**
   No. Prescription and nonprescription sunglasses or polarization are not covered on this plan and are the responsibility of the member.

6. **What is the coverage for frames and lenses under this plan?**
   One pair of lenses per plan year is covered for all ages. One pair of frames per plan year is covered for children under 17, and one pair of frames every two plan years is covered for adults age 17 and older.

Terminology

Plan maximum: A plan maximum is the maximum amount that ODS will pay and is based on the plan coverage that the member chooses.

Plan allowable: Is either the contracted rate (for participating providers) for a procedure or service that a provider agrees to accept as payment in full or billed charges (for nonparticipating providers). If a provider is contracted, he or she will be listed in our online directory and agrees to accept a discount for services provided. The difference between the negotiated rate and the billed rate is a write off and can not be billed to the member. If a provider is not participating and is not listed in our directory, he or she is not required to take any write-off and can balance bill the member for any amount not paid by ODS.

DENTAL BENEFITS

1. **Is a brush biopsy covered under the dental plan?**
   Yes. Once in a six-month period. However, the lab fees are covered under the medical plan.

2. **Is ViziLite covered under the dental plan?**
   No. It is an exclusion.

3. **Are implants covered under the dental plan?**
   Yes. Implants are covered under the prosthodontic services category. The member handbook provides detailed information on implant benefits.

4. **What are the dental benefits when traveling or for dependents residing outside the service area?**
   Through ODS' partnership with Delta Dental, OEBB members who reside out-of-state have access to any of the more than 120,000 Delta Dental providers nationwide.

5. **How does an incentive dental plan work (OEBB plans 1 through 3)?**
   Under a incentive dental plan, benefits start at 70 percent during the first plan-year of coverage. Thereafter, payments increase by 10 percent each plan year (up to a maximum benefit of 100 percent) provided the member has visited the dentist at least once during the previous plan year. Failure to do so will cause a 10 percent reduction in payment the following plan year, although payment will never fall below 70 percent.

6. **How often are cleanings allowed?**
   Prophylaxis (cleaning) or periodontal maintenance is covered once in any six-month period.

7. **Do OEBB members have the Oral Health, Total Health benefit?**
   Yes. Diabetic members enrolled in the Oral Health, Total Health program are allowed a total of four prophylaxes or periodontal maintenance sessions in a benefit year. Pregnant women in their third trimester may be eligible for an additional cleaning. Members can contact ODS Dental Customer Service for enrollment information.

8. **How will incentive dental information transfer?**
ODS will use the employee's date of hire (DOH) to determine incentive level. Effective Oct. 1, 2009, incentive levels will increase by 10 percent (unless the member is already at 100 percent). *Note: This incentive transfer applies to new enrollees with an effective date of Oct. 1, 2009, only.* The above information applies regardless of what type of dental plan members are transferring from constant or incentive.

9. **Effective Oct. 1, 2009, if a current OEBB member moves from a constant plan (plans 4, 5 or 6) to an incentive plan (plans 1, 2 or 3), will their incentive level start at 70 percent, regardless of their original date of hire?**
Yes.

10. **If a member has dual ODS dental coverage under OEBB, does the maximum benefit double as well? For example, on dental plan 2, if two members (husband and wife) have dental plan 2, is their total maximum of $3,000 per member per plan year in lieu of the $1,500 per member per plan year?**
If a member has dual ODS coverage under OEBB with a plan maximum (e.g., dental plan with $1500 plan-year maximum), the primary plan will pay first. The secondary plan will pick up balances on allowable expenses. Once members have met their maximum on the primary plan ($1500 has been paid out), then the secondary plan will pay, as if it is primary, until it too has met the $1500 maximum (dollars paid as secondary, prior to the primary maximum being met, also apply toward the secondary $1,500 maximum).

11. **If members have dual ODS dental coverage under OEBB through ODS and their dentist charges more than the usual and customary allowable, will the other policy pick up the remainder of the charges through coordination of benefits?**
ODS as the secondary plan will pay up to the highest allowable not to exceed the billed amount. If husband and wife both have ODS dental coverage under OEBB, the allowed amount will be the same for both plans. If there is a charge over the allowed amount, members would still be responsible for the extra charge. When a member visits a dentist that is in the **ODS premier network**, the member will not be billed for charges over the contracted fees, because as a participating provider, the provider will write off the amount that is billed over the contract allowance.

12. **If a member is covered under the OEBB orthodontic benefit plan and has a lifetime maximum benefit of $1,500 effective Oct. 1, 2009, how**

will the reimbursement process work?
The following example outlines the process. *Note: This example applies to new enrollees with an effective date of 10/1/2009 only.* OEBB members will receive a new orthodontic lifetime maximum of $1,500 effective Oct. 1, 2009, *however,* if a member is currently in treatment, the orthodontic benefit will be prorated based on the submitted treatment plan.

1. *The prorate is calculated by multiplying the number of ineligible months (number of months beginning the month after the initial banding and ending the month prior to the OEBB effective date of Oct. 1, 2008) by the monthly fee.*

   Monthly fee: $83
   Banding date: Feb. 1, 2009
   OEBB ODS effective date: Oct. 1, 2009
   Ineligible months: seven (March 2009 through September 2009)
   Ineligible month amount **$581** ($83 x 7)

2. *The initial down payment is subtracted from the total treatment fee:*

   Total treatment fee: $3,000
   Initial down payment: $1,000
   Remaining treatment fee: **$2,000**

3. *The ineligible month amount is subtracted from the remaining total treatment fee. The ODS obligation is calculated by applying the plan percentage to the total remaining fee.*

   Remaining treatment fee: $2,000
   Ineligible month amount $ 581
   Total remaining fee (ODS obligation) **$1,419**

   ODS orthodontic benefit = $1,135.20 (80 percent benefit)

ELIGIBILITY

1. What is the dependent stop age for OEBB?

Dependent eligibility varies by school district, and can range up to the age of 26, depending on the bargaining unit. The stop age can be verified with ODS customer service or the school district. To qualify as a dependent, the child must be a full-time student at an accredited college, or live in the home of the eligible employee over six months of the calendar year, with the parents providing over half the yearly support, or qualify as a disabled dependent. Full eligibility requirements can be found under OAR 111-010-0015.

Important notice: Dependent eligibility may vary by a collective bargaining agreement or a documented participating district's policy. Individuals should check with their participating district for confirmation of their dependent eligibility.

2. How will ODS handle students or dependents living out of the service area?

If a student or dependent lives outside of the ODS Plus Network service area, the employee must notify the ODS customer services. The dependent will then be placed in an out of area status beginning the 1st day of the month following the notification to customer service and ODS will allow as follows:

Coverage outside the service area for dependent children

When an insured dependent child under age 19 (or 26 if a full-time student at an accredited college, university or vocational school) resides outside the service area, ODS will extend plan benefits for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services, as if the care were rendered by in-network physicians or providers. Out-of-area dependents must access benefits within a 30-mile radius of the dependent child's residence in order for the benefit level to apply. Fees charged by out-of-area physicians and providers of care will be reimbursed at the maximum plan allowance for those services.

Important notice: Dependent eligibility may vary by a collective bargaining agreement or a documented participating district's policy. Individuals should check with their participating district for confirmation of their dependent eligibility.

3. How does ODS handle disabled, overage dependents?

If a member has a child who has sustained a disability rendering him or her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over the dependent stop age. To be eligible, the child must be unmarried and principally dependent on the member for support. The incapacity must have arisen before the child's 19th birthday. The member must provide ODS with a written physician's statement confirming that these conditions existed continuously prior to the child's 19th birthday. Documentation of the child's medical condition must be reviewed and approved by the ODS medical consultant. Periodic review by the medical consultant also will be required on an ongoing basis.

Dependents on full-time duty in the active military service of the United States are not eligible. This includes members of the Reserve Components serving on active duty or full-time training duty.

Disabled children who live in group homes or other facilities, who are still dependent on their parents for support, continue to be eligible for benefits past age 19 or 26 if they meet the disability criteria.

ODS will continue to provide coverage as long as the dependent meets the appropriate criteria.

4. Does the OEBB contract cover domestic partners?

Registered domestic partners are eligible for coverage. An unregistered domestic partner is eligible for coverage if he or she complies with the Domestic Partner Affidavit provided by the participating district.

Please note: Some participating districts may not offer unregistered domestic partner coverage. Check with your participating district to determine what domestic partner coverage is available.

5. Are there any retiree benefits available?

Eligible retired employees and their eligible dependents enrolled in an OEBB benefit plan or district benefit plan for active employees can continue participation in any OEBB retiree medical and dental insurance plan or plans available to their Employee Group until becoming eligible for Medicare. The exception is when a member has End Stage Renal Disease (ESRD), in which case the member can remain covered under OEBB's early retiree plan for 30 months after diagnosed or until age 65.

If a retiree becomes eligible for Medicare coverage, but his or her currently-enrolled eligible dependents are not, these eligible dependents may continue OEBB medical and dental insurance coverage until such time as they no longer meet OEBB eligibility requirements or become eligible for Medicare coverage, whichever occurs first. The eligible individuals must submit an application for enrollment to the retiree plan administrator within 60 days of the retiree's eligibility for Medicare.

Retirees can continue *dental* coverage under OEBB beyond age 65 if their former employer allowed retirees to continue dental coverage without being enrolled in a retiree medical plan. Their dependents who are no longer eligible to stay on the OEBB medical plans because of Medicare eligibility also can continue with OEBB *dental* coverage. This does not apply to vision coverage.

6. How are newborns added to the plan?

An enrollment form for the addition of a newborn child of the eligible employee or a family member must be furnished to OEBB within 60 days from the date of birth. The member has the option to add the newborn onto the plan permanently or just for the first 31 days. ODS will not load newborn eligibility from a claim or a customer service inquiry, and members will be directed back to their school district to complete the necessary paperwork. When ODS receives the eligibility information from OEBB, any pending claims can be processed.

Addition of the newborn may result in an increase in premium, depending on the current family structure.

7. If a member is an *active* employee and his or her spouse turns 65, is the spouse eligible to stay on the OEBB active plans?

Yes. If a member is actively working (not a retiree) and either the member or his or her spouse turn 65, both are eligible to stay on the active OEBB plans. In this scenario, OEBB coverage would be primary over any Medicare coverage (unless End Stage Renal Disease is applicable, if so, Medicare becomes primary after 30 months of eligibility or entitlement to Medicare).

8. If a member is an OEBB early retiree and he or she goes back to work as an "active" employee, will ODS coordinate benefits between the active coverage and the retiree coverage?

Yes. The active coverage would be primary, and the retiree coverage would be in the secondary position.

NETWORKS

1. **What pharmacy network will be used for OEBB members?**
   OEBB members will be utilizing the Oregon Prescription Drug Plan pharmacy network.

2. **What medical and vision provider networks will be utilized for OEBB members?**
   For active employees and their dependents in Oregon, Alaska, Idaho, southwest Washington and south central Washington: ODS Plus Network

   For retirees and their dependents residing outside the state of Oregon:
   - Washington, excluding southwest and south central Washington — First Choice
   - Idaho — IPN
   - Montana — First Choice – Health InfoNet (HIN)
   - All Other States — PHCS (parent company is Multiplan; when viewing PHCS online, check the PHCS logo box)

3. **What dental provider network will OEBB members use?**
   Active employees, retirees and their dependents will use the ODS Premier Network. This network includes access to the Delta Dental Provider Network nationwide.

4. **How can members find out if their medical provider is in or out of network?**
   OEBB members have access to the ODS Plus Network. This network includes Providence and Legacy Hospitals and physicians, as well as providers contracted in outlier areas. Retirees may have a different network depending on where they reside. See #2 above.

5. **If a specific clinic is not listed on the ODS website, how can members find out if their provider is part of their new medical network with ODS?**
   ODS lists all medical providers on the ODS website provider search by the individual provider name and not by the clinic name.

   The most effective search process is to search by the provider's last name because providers with multiple practice specialties may not be listed under all of their specialties. Members can search for their provider by last name, by provider specialty, or by the city or county in which their provider is located.

6. Can providers be participating even if the clinic they work out of is not?

Yes. It is possible that a physician is participating in the ODS network even if the entire clinic is not.

7. What should members do if they look up their provider by both name and specialty and still cannot find him or her listed? Can members nominate a provider to participate?

Yes. Here's how:

1. On the ODS website at the top, there is a link called Contact Us.
2. Click on E-mail Us.
3. Select send e-mail to MEDICAL.
4. In the Message Regarding Box, type in OEBB .
5. In the Message box, members should note that they would like to nominate their provider to participate in the ODS Network.
6. Members should list their provider's first and last names, clinic name if they have it, and their provider's telephone number.
7. ODS will contact the provider to determine if he or she is interested in contracting with ODS for the ODS Network. If the provider is interested, a contract will be mailed. The member will be notified via e-mail of the provider's interest or that he or she has declined.
8. Please note: Medical providers may indicate the desire to contract with ODS initially but ultimately choose not to contract for a variety of reasons. A request for a contract does not guarantee provider participation.
9. Please note: The contracting cycle for providers averages 30 days for contracting and an additional 45–90 days for credentialing.
10. Once contracted and credentialed, providers are listed on the ODS website Provider Directory, which is updated daily.

8. Can any provider join the ODS Plus Network?

Members can nominate any provider to participate in the ODS Plus Network; however, not all providers will qualify or agree to participate. A provider must be licensed and in good standing with his or her appropriate licensure board. In addition, the provider must pass ODS Credentialing Review if required and must agree to and sign an ODS Participating Provider Agreement.

Once the agreement has been signed and received by ODS and the provider has passed the credentialing review, ODS considers the provider participating and he or she is listed in the ODS Plus Provider Directory.

9. How can members find out when a new provider or hospital joins the ODS Plus Network?

Providers will not be added to the provider directory until they are fully credentialed, which takes an average of 45–90 days after receipt of a signed agreement. For the most up-to-date information, members can continue to review the ODS Plus Network online via the ODS website.

10. What are the names of the major vision chains that ODS contracts with?

Binyons, Oregon Eye Specialists (a.k.a., Optical Shop), Vista Optical, LensCrafters, Wal-Mart Vision Centers

11. If a member is a retiree or COBRA recipient who resides outside of Oregon, Washington, Idaho and Montana, he or she will use the PHCS network. When these members access this network online, they are required to indicate what logo should be on their ID card. If these members do not have an ID card when logging on, what logo should they click on?

The logo on these members' ID card will be the PHCS logo. Members should put a check next to this logo when they review the network online. The logo is indicated below: