

OEBB and ODS FAQs

BENEFITS – GENERAL

Revised 9/09/08

1. **Will the Medical, Vision, Pharmacy, and Dental benefit plans be administered on a calendar-year basis or a plan-year basis?**
All benefits, medical, vision, pharmacy and dental will be administered on a plan-year basis. The Plan year begins October 1st and goes through September 30th.
2. **Will ODS credit any deductible and/or out of pocket maximums from prior carriers?**
No. The plan year begins October 1st, therefore deductibles and out of pocket maximums start over. The OEBB Board made this decision on June 9, 2008.
3. **What are the benefits, copayments, and out of network benefits?**
Information can be found on the plan comparison documents, located on the OEBB and ODS Web sites.
4. **Will there be a medical six-month pre-existing condition exclusion period on the OEBB plans?**
There is no pre-existing condition exclusion period for medical coverage. However, there is an exclusion period for transplants. Please see question #5.
5. **Is there a 24-month exclusion period for transplants?**
Transplants will not be covered during the first 24 months an individual is enrolled in this Plan except as follows:
 - The 24-month exclusion period will not apply if the enrollee has been continuously enrolled in this Plan since birth;
 - The 24-month exclusion period will not apply if the enrollee was continuously enrolled in this Plan together with the Group's prior plan (but only if the prior plan included transplant coverage and would have covered the same services) at least 24 months prior to incurring transplant related expenses. If the enrollee had applicable transplant coverage under a prior health benefit plan, each day of creditable coverage the enrollee had under that prior health benefit plan will reduce the 24-month exclusion period by one day.

An enrollee has the right to demonstrate the existence of prior creditable coverage by providing us with a certificate of creditable coverage from a prior plan. You may request a certificate of creditable coverage from a prior plan or insurer within 24 months of coverage termination. If you have been enrolled in more than one prior plan, submit all certificates of creditable coverage, as



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aggregate periods of creditable coverage can be used to reduce the exclusion period.

6. 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.

7. Will OEBB and/or ODS be using a member social security number?

No. OEBB will be assigning unique identification numbers. These numbers will also be used by ODS. ODS will not be collecting and/or storing a member's social security number. OEBB members should present their ODS ID cards when receiving services. Providers should bill ODS using the member's unique ID number.

8. If ODS receives a claim for a date of service prior to the effective date of October 1, 2008, what will happen to that claim?

ODS will deny the claim as services were prior to the effective date. The provider will need to rebill the correct carrier.

9. 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 is dual covered under OEBB medical Plan 3, there is a \$100 deductible that must be met. The following is an example of how this would work:

ODS receives a claim with eligible charges of \$120.00. \$100.00 is applied to the primary plan's deductible. ODS would reimburse the provider 90% (assuming the service was in-network and not a copayment service) of the remaining balance of \$20.00, which equals \$18.00. ODS would then apply the same \$100 to the secondary coverage's deductible. ODS would pick up the additional \$2.00 of eligible charges, which was not applied to the deductible, as the secondary carrier. Total member responsibility for this claim - \$100.00. Deductible is now satisfied on both plans.



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MEDICAL BENEFITS

1. Do all expenses apply to a member's medical maximum out of pocket?

No. Expenses applied towards 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.

In addition and to provide more clarification, a member is responsible to pay for the following costs (they do not accrue toward the member's out-of-pocket maximum and the member 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; and
- Disallowed charges.

2. If a member is on a plan that has 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 one does not need to meet the deductible to receive the benefit associated with the service (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 (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 commingle?

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.



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Plan 9 (Health Savings Account 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 means members split their eligible healthcare costs with the insurance carrier. For example, if your health plan has an 80/20 in-network (out-of-network coinsurance levels will differ from the in-network coinsurance levels) coinsurance rate for specific services (e.g., OEBS medical plans 3-9), this means 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. Once a member reaches 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 my benefits when traveling?

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

7. What if I am out of the service area and have 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. Are growth hormones a covered benefit?

Growth hormones must be pre-authorized and meet specific medical policy criteria to be covered. If the eligible hormone is injected or dispensed in the provider's office, the reimbursement is covered under the supply benefit of the medical contract. If the eligible hormone is provided to the member as a self-injectable from the specialty pharmacy, Bioscrip, it is covered under the pharmacy benefit.



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9. **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 their standard Transition of Care healthcare services policy. Transition for 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. There is a transition of care form that must be completed and reviewed and approved by ODS.
10. **How does medical Plan 9 — the Health Savings Account (HSA) compliant plan work?**
Health Savings Account (HSA) compliant plans give consumers incentives to manage their own health care 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.
11. **Alternative care is listed on the benefit summaries as a coinsurance amount, however they also indicate “services will be covered the same as any other benefit would be under the plan up to the combined benefit maximum.” Plans 3-6 have an office visit copayment, does this copayment also apply to alternative care providers?**



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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 3-6 would be subject to the copayment, in lieu of the coinsurance amounts. Lab fees would be subject to coinsurance amounts listed.

12. What disease management programs does ODS offer?

ODS offers the following disease management programs.

- Diabetes
- Coronary artery disease
- Asthma
- Depression
- High-risk maternity

13. What benefits are covered under the Cardiovascular Screening preventive care benefit?

When a member goes for their yearly physical, the preventive care benefit also includes an EKG and treadmill test.

14. 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.

15. 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, the member will not have any further out of pocket, unless limitations and/or maximums are met. 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 they handle coordination of benefits. Please see below for sample scenarios.



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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/\$300 family deductible. The secondary coverage is through the member’s spouse, ABC company, with a \$500 individual deductible/\$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’s plan 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 and OEBB plan 3 as secondary.

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 (total office visit cost less the \$10 copayment). The member now has met \$200 of plan 7 deductible, \$0 of plan 3 deductible and pays 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% of the remaining \$50 (\$40). Patient responsibility under plan 7 would be \$310 (remaining deductible + coinsurance of 20%). Plan 3, as the secondary plan, would pay \$340 if it were the only plan in place (total office visit cost less the \$10 copayment), but since 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.



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PHARMACY BENEFITS

1. **Will my medication be 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/OPDP select formulary which can be accessed on the OEBB Web site. The formulary is updated periodically and could change prior to October 1, 2008.

2. **How do I establish my mail order prescriptions with the ODS/OPDP mail order program?**

To help you in the planning process, please be prepared to submit a new prescription for the medications you wish to have filled through the mail order program.

You will need to ask your doctor(s) for **new** prescriptions, as ODS will not have the ability to obtain open prescriptions from your current mail order pharmacy. Please request that the prescription be written for up to a 90-day supply, with refills.

Important Notice: You will need to have your ODS/OEBB identification number in order to set up your mail order account. Once you receive your ODS/OEBB identification card, you will have the information necessary to begin the registration process with Wellpartner, the ODS/OPDP mail order pharmacy.

All valid prescriptions will be processed in accordance with plan provisions and subject to eligibility at the time the prescription is filled. You will be billed for the required copayment. Please do not send prescriptions to Wellpartner until you want them filled.

3. **Once my account and prescription(s) are established, how do I place orders for refills?**

You will be able to order your prescription refill(s) from Wellpartner online through your personal myODS account, by mail, or by telephone. You will need to initiate refill orders. Wellpartner will not send you refill notices.

4. **How will I pay for my mail order prescriptions?**

Payment will be accepted in the form of credit card (American Express, Discover, MasterCard or VISA) or debit card. Payment will be required before your order can be shipped. You will be able to provide payment information via your secure online account through Wellpartner.



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- 5. Are there any medications Wellpartner (mail order) does not dispense?**
Wellpartner does not provide “compounded” or “specialty” medications.
- 6. If I order prescriptions through the Wellpartner mail order program, how long will it take for my prescriptions to arrive via mail order?**
In most cases, your order will arrive within four to seven business days after your order is received. Please allow more time for new prescriptions.
- 7. How long can I use my current mail order pharmacy benefit?**
Please use your current mail order pharmacy benefit through September 30, 2008. It is important to note that prescriptions will not be transferred from your previous mail order pharmacy or from retail pharmacies. The ODS Pharmacy program will not have access to your current prescriptions, prescription history or existing prior authorizations. It is important that you establish your mail order account with Wellpartner as soon as you receive your ODS identification card.
- 8. Will OEBB members be required to access specialty medications (e.g., self-injectables, biologics, select oral oncology medications, etc.) through an exclusive specialty pharmacy?**
Yes. The pharmacy is BioScrip. Please review the ODS web site for a list of specialty drugs. The benefit level for these medications will be limited to a 31-day supply and will be subject to the tiering of the medication on the “select formulary.” Specialty medications require preauthorization.
- 9. If a 30-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.
- 10. If I am traveling out of state, how does my prescription drug coverage work?**
For plans 3-8, members have access to in-network benefits nationwide, as long as prescriptions are filled through one of the major participating chains (e.g., Walgreens). If a member goes to a non-network pharmacy, at anytime, for any reason, they will need to submit their claim for reimbursement via the paper Direct Member Reimbursement process. Reimbursement will be based on a “paid as calculated” measure (meaning we will pay based on maximum allowable).



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Plan 9 has prescription drug coverage reimbursement embedded in the medical plan. The member must pay upfront for their prescriptions and submit a claim reimbursement request to ODS for claims adjudication.

11. If I have dual OEBB coverage will ODS coordinate the pharmacy benefit?

Yes. ODS will coordinate the pharmacy benefit. If ODS is the secondary carrier, the member will need to send in a receipt for reimbursement. ODS will allow up to the primary plan's copayment.

12. If I have dual OEBB pharmacy coverage and both carriers are ODS, will there be "point of service" coordination of benefits for OEBB members?

Yes. It is anticipated there will be electronic coordination of pharmacy benefits at point of service for ODS dual OEBB members (applies to pharmacy plans A, B & C).

13. Are compounded prescription drugs covered under the OEBB plans? If so, at what benefit level are they covered?

Yes. Compounded medications are covered under the OEBB plans. Compounded medications are allowed under the preferred brand name drug reimbursement, as long as there is at least one covered medication as an ingredient.

14. If my provider of service indicates on a prescription "dispense as written" does this mean my prescriptions will be allowed at the generic or brand copayment?

If you request a brand name drug or your provider prescribes a brand name drug when an equivalent generic formulation is available, you will be required to pay the brand copayment/coinsurance, plus the difference in cost between the generic and brand name medication. The only exception to this provision is if there is a declared shortage of the generic medication.



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VISION BENEFITS

- 1. Are disposable contacts covered?**
Disposable contacts are covered up to the plan maximums on plans 1-4 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.
- 3. How are providers reimbursed for vision services?**
Contracted providers are reimbursed up to their contracted amount. Non-contracted providers are reimbursed up to billed charges on Plans 1-4 and up to type of service maximums on Plan 5.
- 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 1-4, and on plan 5, ODS will pay for polycarbonate lenses up to the appropriate lenses scheduled amount.



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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.
- 4. What are my 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 1-3)?**
Under a dental incentive plan, benefits start at 70 percent your 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 6-month period.
- 7. Do OEBB members have the Oral Health, Total Health benefit?**
Yes. Diabetic members covered under the OEBB policy are eligible for a total of four prophylaxis (cleanings) or periodontal maintenance sessions per plan year.

Pregnant members are eligible for a prophylaxis (cleanings) or periodontal maintenance in the third trimester of pregnancy, regardless of normal plan frequency limits.



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8. How will incentive dental information transfer?

ODS will use the employee's date of hire (DOH) to determine incentive level and effective 10/1/2008 incentive levels will be increased by 10 percent (unless of course the member is already at 100 percent).

The above information is regardless of what type of dental plan the member may be transferring from constant or incentive.

9. Effective 10/1/2009, 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 I have dual dental coverage, does the maximum benefit double as well? For example, on dental plan 2, if two members (husband and wife) have dental plan 2, would their total maximum be \$3,000 per member per plan year in lieu of the \$1,500 per member per plan year?

If a member has dual coverage 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 the member has met their maximum on the primary plan (\$1500 has been paid out), then the secondary plan will pay, as if they are primary, until it too has met the \$1500 maximum (dollars paid as secondary, prior to the primary maximum being met, also apply towards the secondary \$1,500 maximum).

11. If I have dual dental coverage through ODS, and my dentist charges more than your 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, the allowed amount will be the same for both plans. If there is a charge over the allowed amount, the member 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 their contract allowance.



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12. **If I am covered under the OEBB orthodontic benefit plan and have a lifetime maximum benefit of \$1,500 effective October 1, 2008, how will the reimbursement process work? The following example outlines the process.**

OEBB members will receive a new orthodontic lifetime maximum of \$1500.00 effective 10/1/08, *however*, if a member is currently in treatment, the orthodontic benefit will be pro-rated based on the submitted treatment plan.

1. *The pro-rate 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 10/1/08) by the monthly fee.*

Monthly fee: \$83.00

Banding Date: 02/01/08

OEBB ODS Effective Date: 10/1/08

Ineligible months: 7 (03/08 through 09/08)

Ineligible month amount **\$581.00** (\$83.00 x 7)

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

Total Treatment Fee: \$3,000.00

Initial Down Payment: \$1,000.00

Remaining Treatment Fee: **\$2,000.00**

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

Remaining Treatment Fee: \$2,000.00

Ineligible Month Amount \$ 581.00

Total remaining fee (ODS Obligation) **\$1,419.00**

ODS Orthodontic Benefit = \$1,135.20 (80% benefit)



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ELIGIBILITY

1. What is the dependent stop age for OEBB?

In most cases, dependent children are eligible until the end of the month after their 19th birthday or until the end of the month after their 26th birthday if they are a full-time student at an accredited college. In addition, dependent children are eligible if living in the home of the eligible employee over six months of the calendar year, and the eligible employee provides over half the yearly support.

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 we handle students/dependents living out of the service area?

If a student/dependent lives outside of the ODS Plus Network service area, the employee must notify the ODS customer service department, as OEBB will not be indicating this information on the weekly electronic file to ODS. If ODS receives information of a student/dependent living outside of the service area, we will allow as follows:

Coverage Outside the Service Area for Dependent Children

When an insured dependent child under age 19 (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's 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.



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3. **How will we handle disabled overage dependents?**

If a member has a child who has sustained a disability rendering him/her physically or mentally incapable of self-support, that child may be eligible for coverage even though he or she is over 19/26 years old. 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 19/26th birthday. The member must provide us with a written physician's statement that confirms that these conditions existed continuously prior to the child's 19/26th birthday. Documentation of the child's medical condition must be reviewed and approved by the ODS medical consultant. Periodic review by the medical consultant will also 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, would continue to be eligible for benefits past age 19/26 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 partner's 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?**

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



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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 the retiree's former employer allowed retirees to continue dental coverage without being enrolled in a retiree medical plan. They can also continue dependents on the OEBB *dental* coverage that are no longer eligible to stay on the OEBB medical plans due to being eligible for Medicare. This does not apply to vision coverage.

6. How are newborns added to the plan?

A newborn child is covered under the OEBB plan for up to 31 days from the date of birth. 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 in order to have coverage extended beyond the 31 day period. ODS will not load newborn eligibility from a claim or a customer service inquiry, member's will be directed back to their school district to complete the necessary paperwork. When ODS receives the eligibility information from OEBB, any pended claims can be processed.

7. If I am an *active* employee and my spouse turns age 65, is my spouse eligible to stay on the OEBB active plans?

Yes. If you are actively working (not a retiree) and you or your spouse turn age 65, you 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 I am an OEBB early retiree and I go 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.



OEBB and ODS FAQs

NETWORKS

- 1. What pharmacy network will be used for OEBB members?**
OEBB members will be utilizing the Oregon Prescription Drug Plan (OPDP) pharmacy network.
- 2. What medical/vision provider networks will be utilized for OEBB members?**
For active employees & their dependents
Oregon, Alaska, and SW Washington — ODS Plus Network

For Retirees & their dependents residing outside the state of Oregon
Washington, excluding SW 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 be utilized for OEBB members?**
Active employees, retirees, and their dependents will utilize the ODS Premier Network. This network includes access to the Delta Dental Provider Network nationwide.
- 4. How do I know if my medical provider is in or out of network?**
OEBB members (retirees may have a different network depending on where they reside, reference #2 above) will have access to the ODS Plus Network. This network includes Providence and Legacy Hospitals and physicians, as well as providers contracted in outlier areas.
- 5. If I cannot find the clinic that my provider works at on the ODS Web site, how do I know if he/she will be part of my new medical network with ODS?**
ODS lists all medical providers on the ODS Web site 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 as providers with multiple practice specialties may not be listed under all of their specialties. You may search for your provider by last name, by provider specialty, by the city or county that your provider is located.



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

Yes. It is possible that your physician may be participating even if the entire clinic is not.

7. I looked up my provider by both name and specialty and cannot find him/her listed. What do I do now? Can I nominate a provider to participate?

- On the ODS Web site at the top there is a link called Contact Us
- Click on Email Us
- Select send email to MEDICAL
- In the Message Regarding Box type in OEBS
- In the Message box please note that you would like to nominate your provider to participate in the ODS Network.
- Please be sure to list your providers first and last name, clinic name if you have it and your provider's telephone number.
- ODS will contact the provider to determine if he/she is interested in contracting with ODS for the ODS Network. If they are, a contract will be mailed and you will be notified via email of the provider's interest or that they have declined.
- 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.
- Please note: The contracting cycle for providers averages 30 days for contracting and an additional 45-90 days for credentialing.
- Once contracted and credentialed providers are listed on the ODS Web site Provider Directory, which is updated daily.

8. Can any provider join the ODS Plus Network?

Members may 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/her appropriate licensure board, the provider must pass ODS Credentialing Review if required and the provider 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 we consider the provider participating and they are listed in the ODS Plus Provider Directory.



OEBB and ODS FAQs

9. **How will I know 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, please continue to review the ODS Plus Network online via the ODS web site.

10. **What are the names of the major vision chains we contract with?**

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

11. **If I am a Retiree or COBRA member who resides outside of Oregon, Washington, Idaho and Montano, I understand the network I will utilize is the PHCS network. When I access this network online, I need to indicate what logo will be on my ID card, however I do not have an ID card at this time. What logo do I click on?**

The logo on your ID card will be the PHCS logo. Please put a check next to this logo when you review the network online. The logo is indicated below:

