



Certified Employees Frequently Asked Insurance Questions 2009-2010

1. What is a PPO Plan?

A PPO (also known as a Preferred Provider Organization Plan) is a type of plan administered by an insurance carrier. The carrier has negotiated contracts with physicians, medical facilities and suppliers to provide services and supplies to covered members. Those participating agree not to charge more than the contracted reimbursement rate. Any amounts billed over and above the contracted rate will be written off by the provider. When you use one of these contracted providers not only will you receive a higher level of benefit but the provider will bill PacificSource directly on your behalf. The plan does not require a referral (to a specialist) nor do you need to name a Primary Care Physician (PCP). Participating physicians will also assist with any preauthorization requirements.

2. What is an out-of-pocket maximum (OOP)?

- This provision helps protect you from excessive medical expenses. Once you have met your individual out of pocket maximum, this plan will pay 100% of eligible charges (subject to all plan provisions).
- Your payments/expenses for the following do not apply to the annual out-of-pocket limit:
 - Copayments
 - Prescription drugs
 - Charges over the allowable fee for services of nonparticipating providers
 - Incurred charges that exceed amounts allowed under this plan
 - Non-covered services

3. Currently our health plan deductibles, OOP (out of pocket maximums) and coinsurance maximums are on a calendar year, Jan-Dec, will this stay the same?

Yes

4. What is a deductible?

A deductible is a specific flat-dollar amount you must pay towards covered expenses before a plan begins to pay towards the expense. The deductible usually applies to most medical services which have coinsurance coverage. Deductibles are applied each calendar year.

5. Does the deductible go towards the annual out of pocket maximum (OOP)?

Yes, the deductible on your plan applies to the OOP maximum

6. Do In/Out of network deductibles comingle?

Yes, in-network deductibles apply to out-of-network deductibles.

7. What is coinsurance?

Coinsurance is the percentage you pay after the deductible for covered expenses.

8. What is a copayment?

Copayments are pre-determined, flat-dollar fees for certain services to be paid at the time of service. Typically the deductible doesn't apply to these services.

9. Do copayments go towards the annual out-of-pocket maximum (OOP)?

No, copayments do not apply towards OOPs.

10. Do copayments continue when the annual OOP is met?

Yes

11. What does in-network and out-of-network mean?

- a. In-network means a provider, facility and/or supplier participates in PacificSource's health plan network (Preferred PSN). *To maximize your plan's benefits, PacificSource's participating providers can be found at www.Pacificsource.com*
- b. Out-of-network means a provider, facility and/or supplier does not participate in the network. When you receive services or supplies from a nonparticipating provider, your out-of-pocket expense is likely to be higher than if you had used a participating provider.

12. Do I have to go to certain pharmacies?

- a. Retail Pharmacy: PacificSource contracts with Caremark[®] pharmacy network which includes approximately 98% of all retail pharmacies in the United States. The network includes all the major pharmacy chains, and chances are, your local pharmacy participates. You can either ask your pharmacy's staff if they participate with Caremark, or look the pharmacy up at www.caremark.com. It also includes *drugstore.com*, an Internet-based pharmacy.
- b. Mail Order Pharmacy: PacificSource contracts with CVS/Caremark and Wellpartner Pharmacy. (NOTE: This is a change 9-1-2009 as Walgreens Mail Order Service will no longer be an option!)
- c. Specialty Drug Pharmacy: PacificSource contracts with Caremark Specialty Pharmacy Services.

13. Do I need to go to certain doctors, hospitals or clinics?

No, both plans offer in-network and out-of-network coverage for doctors, hospitals and suppliers. Using an in-network provider for covered services will enable you to receive the highest benefit level. PacificSource's Preferred PSN Network includes providers throughout Oregon, southwest Washington, and western Idaho. They also have a nationwide agreement with The First Health[®] Network, for members outside the service area.

14. I am moving out of state will my new plan cover me?

Yes, because CSD509J is domiciled in Oregon. PPO options allow you to receive services in or out of network. The First Health[®] Network includes more than 275,000 participating physicians and 3,900 hospitals nationwide. The First Health providers outside the PacificSource service area are also considered in-network. Call (800) 449-9905 or visit www.pacificsource.com to find a First Health provider.

The term "network not available" (NNA) is used when a member does not have reasonable geographic access to an in-network provider for a covered medical service or supply through PacificSource or First Health. If you live in an area without access for a specific service or supply, your in-network copayments and coinsurance will apply up to the PacificSource allowable fees. Contact PacificSource for more information.

15. My dependents are currently covered until the age of 26. Will this coverage change?

No, qualifying dependents are covered until the end of the month in which they turn 26.

16. What if I need healthcare services while traveling out of the United States?

a. To use your PacificSource benefits when traveling outside of the United States:

- Obtain an itemized bill for services you receive to submit to PacificSource.
- Pay for the services yourself.
- Have information translated into English, if possible.
- Submit the claim to PacificSource
- PacificSource will process the claim and send the reimbursement to you.

b. PacificSource also provides travel services through Assist America®. When traveling more than 100 miles from home, they can help you get the care you need should you have a medical emergency. For detailed information visits www.pacificsource.com.

17. Is naturopath, acupuncture, chiropractic and massage therapy covered?

Naturopathic, acupuncture, and chiropractic are covered. These services are subject to \$2500 all inclusive annual maximum. Massage therapy is not covered.

18. Both my spouse and I are employed by CSD 509J and eligible for insurance. Is there a benefit for us coordinating our premiums?

If two employees, eligible for combined insurance, coordinate premiums by enrolling under only one of the employee's names for insurance then the district will apply the waiving pro-rated employer contribution toward the enrolled employee's out-of-pocket premium. This benefit is not applied if both employees enroll on an insurance plan for a coordination of benefits.

19. If I don't make a plan choice and complete my enrollment between September 9 – September 24, 2009 will I lose my benefits?

No. If you do not turn in a new PacificSource plan, your benefits and enrollment will remain the same. Complete the enrollment form in your packet if you'd like to change plans, update information, or change who is currently enrolled under your plan.

20. Mammograms: How are they covered and what is the member's out-of-pocket expense?

Routine/Preventive mammograms are covered under the Routine Gynecological Exam benefit, paid at 100% for participating providers on both plans (for women 35 and over, or as recommended by a physician for women with a high-risk condition).

If billed with a medical diagnosis (not preventive), they fall under the basis lab and x-ray benefit, subject to deductible then paid at plan/provider choice percentage.

21. Emergency Room Services- How does the benefit work when seen by nonparticipating providers or facilities?

Your plan pays benefits at the participating provider level regardless of your location. Your covered expenses are based on the PacificSource allowable fee. If you are admitted to a hospital as an inpatient, your physician or hospital should contact the PacificSource Health Services Department at (888) 691-8209 as soon as possible following the stabilization of your emergency condition to authorize your admission. If you are admitted to a nonparticipating hospital, PacificSource may require you to transfer to a participating facility once your condition is stabilized in order to continue receiving benefits at the participating provider level. If you choose a nonparticipating facility/provider after leaving the ER, your benefits will be paid at the nonparticipating provider level.

The emergency room copayment shown on your Member Benefit Summary (\$100+co-insurance) covers medical screening and any diagnostic tests needed for emergency care, such as radiology, laboratory work, CT scans, and MRIs.

22. In general, how does coordination of benefits work?

For the employee, the Corvallis School District plan will be primary over any other coverage. For your spouse or domestic partner, their employers plan will be primary and the Corvallis School District plan will be secondary. Your children's primary plan is determined by the parent whose birthday (month) falls first in a calendar year, unless a court order is in place.

If your primary and/or secondary coverage include a deductible, you will be required to satisfy each of those deductibles before benefits are available. Both deductibles can be satisfied simultaneously.

Scenario: \$4000 allowed amount billed. First plan is 80+500 so \$500 is applied to satisfy the deductible, leaving \$3500 which will be considered at 80% (\$2800). Payable amount is \$2800, patient balance is \$1200 (500 deductible + 700 (20%). Secondary plan is 90+100. Maximum secondary plan would pay if it were only plan is \$3510. (4000-100=3900 at 80%). \$3510 is greater than \$2800 so full \$2800 would be paid by secondary. Patient balance is \$00 and both deductibles are satisfied.

Scenario: \$600 allowed amount billed. First plan is 80+500 so \$500 is applied to satisfy the deductible, leaving \$100 which will be considered at 80% (\$80). Payable amount is \$80, patient balance is \$520. Secondary plan is 90+100. Maximum secondary plan would pay if it were only plan is \$450. Patient balance is \$70 (520 - 450) and both deductibles are satisfied.

23. What is deductible carryover and how does it work?

If you incur expenses in October, November, or December and do not meet your deductible (i.e. you don't receive a benefit) those expenses will carry over to help meet next year's deductible. Example, \$50 incurred in November – you did not meet your deductible, that \$50 will carry over to help meet next year's deductible.

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