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**Admin/Non-Rep/Classified Frequently Asked Insurance Questions 2009-2010:**

**1. What is a PPO Plan?**

- a. Preferred Provider Organization Plan, a select group of physicians and medical facilities that have contracted with the insurance company to offer healthcare services at preferred rates. Any amounts billed over and above the contracted rate will be written off by the provider. You don't need referrals or primary care providers (PCP). PPO physicians will assist with preauthorization requirements.

**2. What is a POS Plan?**

- a. Point of Service Plan provides lower cost insurance within a physician network. Referrals out side the network may be made, but you are responsible completing necessary paperwork in order to get reimbursement for medical costs. Coverage for out-of-network services may be covered at a contracted rate rather than a billable rate.

**3. What is an out-of-pocket maximum (OOPM)?**

- a. An out-of-pocket maximum is also referred to as a "stop loss". The point at which you have paid, out of your pocket for covered services, deductibles and co-insurance portions necessary for the insurance company to begin paying 100% of all covered services for the remainder of the benefit year.

**4. OEBB plans will run on a benefit year (October 1- September 30<sup>th</sup>). Will the benefit year continue?**

- a. Yes, Deductibles, OOPMs and benefit maximums will start on Oct 1 and carry through September 30th.

**5. What is a deductible?**

- a. 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 major medical services which have co-insurance coverage. Deductibles are applied each 12 month period.

**Does the deductible go towards the annual out of pocket maximum (OOPM)?**

- a. No, the deductible is not included in the OOPM.

**Do In/Out of network deductibles comingle?**

- a. Yes, in network deductibles apply to out-of-network deductibles. However, out of network deductible don't apply to in network deductibles.

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### **6. What is co-insurance?**

- a. Co-insurance is the percentage you pay after the deductible for covered expenses.

### **7. What is a co-payment?**

- a. Co-payments 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. Co-payments usually don't apply to out-of-pocket maximums or deductibles. They will continue to be required for all services determined at the co-payment level during the benefit year, even if the out-of-pocket maximum is reached.

### **Do co-payments go towards the annual out-of-pocket maximum (OPM)?**

- a. No, co-payments do not apply towards OPMs.

### **Do co-payments continue when the annual OPM is met?**

- a. Yes

### **8. What does in-network and out-of-network mean?**

- a. In-network means a provider/facility participates in an insurance company's health plan network or participating physicians and providers' health care services.
- b. Out-of-network means a provider/facility does not participate in the insurance company's network or participating physicians and providers health care services.

### **9. I have procedures scheduled for after 10/1/08, that have taken a long time to schedule and get pre-authorized; do I have to do anything to ensure coverage for the new plans?**

- a. Yes, it is never advised to schedule procedures during open enrollment as there is always a risk of the insurance companies and plans changing. Each insurance company has their own list of prescriptions and procedures that need pre-authorization. You will need to work with your physician, updating them with your new plan information, and contact the new insurance carrier to check on what actions need to take place prior to procedures. We never recommend procedures are scheduled during open enrollment.

### **10. I take regular prescriptions, will I have issues getting my prescriptions covered or refilled with the new plans?**

- a. Each insurance company has a standard formulary list. The formulary may be different in coverage and pre-authorization requirements. You can contact ODS at 1-877-605-3229 and Providence at 1-800-878-4445 to find out specific benefit information and requirements in regards to your prescriptions. In the event your prescription is not covered on the formulary work with your doctor to find an alternative that is covered on the list. <http://www.odscompanies.com/oebb> and/or <http://providence.org/resources/oebb/pdfs/OEBBFormulary.pdf>

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### **Do I have to go to certain pharmacies?**

- a. Although both ODS and Providence are major carriers with large networks it is always a good idea to run a search of providers in the area you choose to receive services. Each insurance company has their own prescription formulary and pre-authorization list. Please see the following websites or contact the insurance company you choose your benefits with.  
Providence: [https://www.providence.org/PHP\\_ProviderDirectory/](https://www.providence.org/PHP_ProviderDirectory/) ; 800-878-4445  
ODS: <http://egov.oregon.gov/DAS/OEBB/ODS.shtml> ; 877-605-3229

### **11. Do I need to go to certain doctors, hospitals or clinics?**

- a. Both ODS and Providence have in-network and out-of-network coverage for doctors, hospitals and/or clinics. You are not required to choose a primary care physician. See plan specifics regarding pre-authorization requirements for certain procedures.

### **12. Will changing insurance companies cause pre-existing waiting periods?**

- a. No, as long as you had prior coverage with the school district all pre-existing waiting periods will be waived through OEBB for the benefit year 2009-2010.

### **13. I am moving out of state will my new plan cover me?**

- a. Yes, CSD509J is domiciled in Oregon. PPO options allow you to receive services in or out of network. If your relocation does not have in-network providers then you will be covered by the out-of-network benefit level. POS options require services receive prior authorization for out-of-network coverage, much like an HMO. However, Providence utilizes a multi plan PHCS (private healthcare network of providers) network for network providers out of state.

### **14. My dependents are currently covered until the age of 26, will this coverage change?**

- a. Dependents are eligible to the age of 26 as long as the eligible employee, providing coverage, provides over ½ the yearly support.

### **15. What if I need healthcare services while traveling out of the United States?**

- a. As long as your plan provides out of network benefits you can obtain emergency care while traveling anywhere in the world. Usually other countries require payment at the time of service. Therefore, you would pay for the services; request a copy of the claim translated in English and submit a reimbursement claim to the insurance carrier upon returning to the states.

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### **16. Is naturopath, acupuncture, chiropractic and massage therapy covered?**

- a. ODS- Covers Naturopath, acupuncture and chiropractic. Massage therapy is not covered.
- b. Providence- has some limitations and exclusions for naturopath, acupuncture, chiropractic care. See the providence website or call for verification of covered services:  
<http://egov.oregon.gov/DAS/OEBB/docs/Summaryofbenefits/Providence/PHPLimitations.pdf> ; 1-800-878-4445

### **17. Both my spouse and I are employed by CSD and eligible for insurance. What are our options?**

- a. You may pool what the employer premium contribution for each employee would have been towards one health benefit package to enroll as employee + dependent(s); therefore, reducing employee premium portion; **or**
- b. You may enroll separately as employees. If you elect to enroll on your own insurance you will not receive a coordination of premium.

### **OEBB contact Information:**

<http://egov.oregon.gov/DAS/OEBB/index.shtml>

- **Phone:** 888-469-6322
- **Address:**  
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