




Would you like to...

...Be sure you're enrolled properly and taking full advantage of your benefits and options?

 Then review Section 1, taking special note of the step-by-step enrollment guide on page 4.


...Learn more about the Tax Shelter Plan, which allows you to pay your monthly out-of-pocket premium contribution with pre-tax dollars?

 Then turn to page 3 in Section 1.


...Learn more about your medical benefits?

 Then review Section 2, taking special note of the summary charts.


...Understand what the PPO system is and how it works?

 Then read pages 1 and 2 in Section 2 on medical benefits.


...Understand how to coordinate your benefits if another family member is also employed by 4J?

 Then turn to page 9 in Section 2.

...Understand how to purchase prescriptions?

 Then turn to page 6 in Section 2.

...Learn about the services offered by the Wellness Clinic and the Employee Assistance Program?

 Then review pages 1 through 4 in Section 6.


...Understand how workers' compensation operates and what to do if you're injured on the job?

 Then review Section 6, starting on page 4.

...Understand exactly what steps to take to file a medical claim?

 Then review pages 1 and 2 in Section 7.

...Know how to file claims when traveling or residing out of area?

 Then review page 4 in Section 7.

...Understand how to resolve a problem with a claim?

 Then review page 3 in Section 7.



Look for answers to commonly asked questions at the end of each section.

This booklet is a summary of programs and benefits offered by the 4J School District. It is not complete. Your ODS Medical and Hospital Subscriber Agreement (hereafter referred to as Subscriber Agreement) takes precedence over any information provided in this publication.

4J Employee Benefits Office
200 N. Monroe
Eugene, OR 97402
ph: 687-3491

ODS Medical
P.O. Box 40384
Portland, OR 97240
ph: 1-800-420-7758

ODS Pharmacy Network
P.O. Box 40168
Portland, OR 97240-0168
ph: 1-888-361-1610



Determine Your Eligibility



To enroll in the 4J ODS Health Plan for the first time, you must complete the enrollment form in the front pocket of this booklet, and submit it to the Employee Benefits Office (EBO) before the deadline stated in your notice of eligibility.

If you are already enrolled, look over the pre-printed enrollment form in the front pocket of this booklet to make sure it is accurate. If it is, you do not need to resubmit it. If it is not, make corrections and submit it to the EBO by September 29, 2006.

Change of status during the year? You have 31 days from the date of the change to submit an updated form to the EBO.



Are You Eligible?

To take advantage of the district's benefits program you must have an insurance enrollment form on file at the Employee Benefits Office (EBO). To enroll in the ODS plan, follow the steps outlined in The Enrollment Process (page 1 • 4).

Licensed substitutes meeting eligibility requirements are eligible for medical coverage only. For eligibility information, call the EBO at 687-3491 or refer to your collective bargaining agreement.



Refer to the inside front pocket in this Benefits Overview Booklet for payroll deduction information for ODS Plans.



What About Coverage for Dependents?

Dependents are eligible at the same time you are. Dependent coverage is available at no additional monthly cost for:

- Spouses
- Domestic partners* (subject to imputed tax values)
- Children
- Handicapped adult children (refer to the ODS Member Handbook for more information)

To ensure that your dependents are covered and claim payments are timely, complete an Enrollment Form for them as soon as they become eligible. This form is available from the EBO.



What Is a Dependent?

Dependents include the employee's:

- Spouse (legally married)
- Domestic partner*
- Financially dependent children (including stepchildren of a legal marriage or domestic partnership) or who are full-time students (attend three quarters or two semesters a year) under the age of 25.
- Children age 25 or over incapable of self-support because of a physical handicap or mental retardation. (Refer to the ODS Member Handbook for additional information.)



For more information about coverage when you or family members are traveling or for dependent children who live outside the area of service or who are away at school, review the How to File Out-of-Area Claims chart (page 7•4), call ODS at 1-800-420-7758 or refer to your ODS Member Handbook.

* For information about domestic partner eligibility or to receive a Domestic Partner Information Packet, contact the Employee Benefits Office at 687-3491.



The Tax Shelter Plan



How Does the Tax Shelter Plan Work?

The Tax Shelter Plan allows you to pay monthly contributions toward insurance premiums before state, federal and FICA taxes are deducted. By paying your premium with pre-tax dollars, the insurance deduction takes up a smaller percentage of your paycheck than if it were paid after taxes were deducted. The result is more money in your pocket each pay period. The charts below illustrate how the plan works. They are based on a hypothetical example of an employee who receives \$2,000 per month with approximately 30% deducted for taxes.

Without the Tax-Free Payment Plan		With the Tax-Free Payment Plan	
1. Determine the amount earned.	\$2000	1. Determine the amount earned.	\$2000
2. Deduct 30% for taxes.	$\$2000 \times 30\% = \600 \$1400	2. Deduct \$263 for insurance premium to determine your take-home pay.	$\$2000 - \263 \$1737
3. Deduct \$263 for insurance premium to determine your take-home pay.	$\$1400 - \263 \$1137	3. Deduct 30% for taxes.	$\$1737 \times 30\% =$ \$521.10; \$1215.90
4. Calculate the % of money earned that is left in your pocket after taxes and insurance.	57%	4. Calculate the % of money earned that is left in your pocket after taxes and insurance.	61%
	No Savings	5. Calculate your annual savings. (Subtract line 3 in the left-hand chart from line 3 in the right-hand chart and multiply by 12 pay periods.)	$\$1215.90 -$ $\$1137 = \78.90 $\$78.90 \times 12$ Annual Savings \$946.80



You're Automatically Enrolled

In almost all cases it is to the employee's financial advantage to tax shelter their insurance premiums (as illustrated in the example above). For this reason we automatically extend this benefit to each employee who elects medical coverage. However, in rare cases where an employee qualifies for the Earned Income Tax Credit (EITC), it may be to that employee's financial advantage to opt out of the Tax Shelter Plan. More information about the EITC is available on the IRS web site (www.irs.gov - search for "Earned Income Tax Credit"). Please consult a tax advisor to determine if you qualify for the EITC.



Q & A About the Tax Shelter Plan *



How do I opt out of the Tax Shelter Plan?



If you wish to opt out of the Tax Shelter Plan, you must sign a waiver in the presence of a Human Resources employee during a valid enrollment period. Changes are not allowed mid-plan-year, even if your eligibility for the EITC changes or if you realize you made a mistake. Choose wisely!

*Sometimes you will hear the Tax Shelter Plan referred to as a Section 125 Plan. This refers to the Internal Revenue Service code (Section 125) that allows pre-tax dollars to be applied to insurance premium payments.



Overview of Medical Coverage



What Kind of Coverage Is Provided Through the 4J ODS Health Plans?

The District offers one health care plan, a Preferred Provider Organization (PPO) plan. You may receive medical services from any provider you choose, with your coverage level determined by whether or not the provider is a member of the ODS preferred provider network. More complete information about the two levels of coverage is provided below, but here is an overview of how the coverage works and what your benefit level is in each one:

- **In-Network**—Services from In-Network providers are covered at 75% after annual deductible. A designated primary care physician is not required, nor are referrals for specialist care.
- **Out-of-Network**—Services from Out-of-Network providers are covered at 50% of MPA after an annual deductible. (See below for a definition of MPA.)

Terms and Information You Need To Know

- **Deductible** is the amount of covered services that you, on your own behalf or on behalf of your covered dependent, are responsible for paying before benefits become payable under the policy.
- **Co-insurance** is the percentage of charges for a covered service paid by the insurer (ODS) and the member after deductible is met: In-Network, 75%/25%; Out-of-Network, 50%/50%.
- **MPA** (Maximum Plan Allowance) is the maximum amount on which ODS will base its reimbursement to physicians and providers. Members are responsible for charges above MPA at the Out-of-Network benefit level. Refer to the ODS Member Handbook for additional information.

C.O.B.—Coordination of Benefits

COPEs—Coordinated Outpatient Education and Intervention Services

EAP—Employee Assistance Program

EBO—Employee Benefits Office

EOB—Explanation of Benefits

JBC—Joint Benefits Committee

LTD—Long-Term Disability

PCP—Primary Care Provider or Physician

PPO—Preferred Provider Organization (4J currently uses this type of health plan.)



Review the Coverage Highlight charts (pages 2•3 through 2•5) to compare the benefits of In-Network and Out-of-Network.



Coverage Highlight Charts

Deductibles, Maximums and Pre-Existing Conditions

Item	In-Network	Out-of-Network**
Annual Deductible Per Person Per Family	\$1,500 \$4,500	\$1,500 \$4,500
Lifetime Maximum* Transplant Maximum	\$1,500,000 per person \$500,000 per person	\$250,000 per person \$250,000 per person
Annual Out-of-Pocket Max. Limit (Medical benefits only. Deductible not included.)	\$5,000 per person No family maximum	No individual maximum No family maximum
Pre-Existing Condition Limitations	24 mos. waiting period from plan enrollment date for transplants. (See the ODS Member Handbook or call ODS at 800-420-7758 for additional information.)	

*\$1,500,000 lifetime benefit maximum, of which \$250,000 can be accumulated out of network.

**Members are responsible for charges above MPA (Maximum Plan Allowance) for services.

Basic Coverages: Physician Visits and Related Treatment

Item	In-Network	Out-of-Network**
Preventive Services Women's GYN Annual & Mammogram Routine Physical Exams Well-Baby Care Immunizations	75% , deductible waived* 75% , deductible waived* 75% , deductible waived* No co-pay, deductible waived	50%, deductible waived* Not covered Not covered Not covered
Illness Exams	75% after deductible	50% after deductible
Podiatry Services	75% after deductible	50% after deductible
Lab and X-Ray	75% after deductible	50% after deductible
Allergy Injections	75% after deductible	50% after deductible
Physical Therapy (Subject to limitations)	75% after deductible	50% after deductible

*Frequency of physical exams allowed varies. Refer to the ODS Member Handbook for more information.

**Members are responsible for charges above MPA (Maximum Plan Allowance) for services.

Hospital Coverage

Item	In-Network	Out-of-Network
In-Hospital Care Pre-auth. required (page 2 • 7) Room & Board (Including ICU/CCU) Lab & X-ray Surgeons, Anesthesiologists, Doctor Visits	75% after deductible 75% after deductible 75% after deductible	50% after deductible 50% after deductible 50% after deductible
Out-patient Hospital Care Pre-auth. required (page 2 • 7) Lab, X-ray & Radiation Therapy Surgery (Including doctor)	75% after deductible 75% after deductible	50% after deductible 50% after deductible
Emergency Care (medically necessary*) Emergency Room Ambulance	75% after deductible 75% after deductible	50% after deductible 75% after deductible
Transplant (eligible after 24 mos. cont. coverage**)	75% after deductible	50% after deductible
DME (crutches, hospital beds, etc., Pre-Auth. recommended if over \$500)	75% after deductible if medically necessary	50% after deductible if medically necessary

* Medically necessary emergency room care includes any situation that threatens life or limb, involves uncontrolled bleeding or loss of consciousness or cannot be delayed without serious effects on your health.

** Covered after a 24-month waiting period from date of plan enrollment only if not considered investigative or experimental. Refer to the ODS Member Handbook or call ODS at 1-800-420-7758 for additional information.

Home and Specialized Nursing Care

Item	In-Network	Out-of-Network
Home Care Pre-auth. required (page 2 • 7)	75% after deductible	50% after deductible
Skilled Nursing Facility Pre-auth. required (page 2 • 7) (100 days per calendar year)	75% after deductible	50% after deductible

Maternity and Family Planning Care

Item	In-Network	Out-of-Network
Maternity Care Prenatal Care & Exams Hospital Delivery In-Patient Newborn Post-Natal Care	75% after deductible 75% after deductible 75%, deductible waived 75% after deductible	50% after deductible 50% after deductible 50% after deductible 50% after deductible
Family Planning Contraceptives Vasectomy Tubal Ligation Infertility Services Voluntary Pregnancy Interruption	Covered as a Rx benefit 75% after deductible 75% after deductible Not covered 75% after deductible	Not covered 50% after deductible 50% after deductible Not covered 50% after deductible

Mental Health and Alcohol & Substance Abuse

Item	In-Network	Out-of-Network
Mental Health (Refer to the ODS Member Handbook for coverage for children.)		
In-Patient Care *	75% after deductible (14 day max. in 24 mos.)	50% after deductible (14 day max. in 24 mos.)
Residential Care *	75% after deductible (31 day max. in 24 mos.)	50% after deductible (31 day max. in 24 mos.)
Out-Patient Care *	75% after deductible (35 visits max. in 24 mos.)	50% after deductible (35 visit max. in 24 mos.)
For purposes of calculating days used, a full day or partial day service is counted as one day.		
Alcohol & Drug Abuse Treatment (Refer to the ODS Member Handbook for coverage for children.)		
In-Patient*	75% after deductible (14 day max. in 24 mos.)	50% after deductible (14 day max. in 24 mos.)
Residential Care *	75% after deductible (19 day max. in 24 mos.)	50% after deductible (19 day max. in 24 mos.)
Out-Patient Care *	75% after deductible (32 day max. in 24 mos.)	50% after deductible (32 day max. in 24 mos.)
For purposes of calculating days used, a full day or partial day service is counted as one day.		

* Failure to contact Cascade Centers EAP prior to mental health treatment will result in no benefit. Refer to Mental Health and Substance Abuse Coverage (page 2 • 8) for more information.



The maximums on days and visits indicated above accumulate across coverage levels.



How Is the Cost for Prescription Drugs Covered?

ODS covers part of the cost of prescribed drugs, or their generic equivalent when available, when you purchase at participating pharmacies. You must make your co-payment and present your ODS member card at the time of purchase. Participating pharmacies include several major chain stores and selected independent pharmacies. (Refer to the ODS provider directory at www.odscompanies.com for a list of network pharmacies.)

In addition to local purchase of prescription drugs, you may also buy them through a mail-order program offered by ODS. This program gives you the convenience of home delivery, credit card purchase and 90-day supply availability with two co-pays for all maintenance drugs.

For more information about prescription coverage and exclusions, refer to the ODS Member Handbook or call ODS at 1-800-420-7758.

Prescription Drug Plan Coverage Highlights

Item	In-Network	Out-of-Network
In-Area Pharmacies	\$20 per prescription (34-day supply) or 50%, whichever is greater	No coverage*
Mail-Order Program (maintenance drugs only)	\$40 per prescription (90-day supply) or 50%, whichever is greater	not applicable

*ODS has an extensive network of pharmacies, including national chains. Check the provider directory or call ODS at 1-800-420-7758 to check on the status of a particular pharmacy.



For information about how to submit claims for prescriptions when purchased outside the local area, refer to How to File Out-of-Area Claims (page 7•4).



Out-of-Network Pre-Authorization Requirements and Penalties



If I Choose Out-of-Network Care, What Kind of Pre-Authorization Is Required?

To ensure coverage at Out-of-Network benefit levels, you must pre-authorize all in-patient and out-patient hospital and facility admissions (including skilled nursing). You, not the provider, are personally responsible for obtaining pre-authorization from ODS prior to care.



Call ODS (1-800-258-2037) for pre-authorization no less than five working days before any admission or service. You will receive REDUCED BENEFITS if you're not pre-authorized.



What Is the Penalty if I Don't Pre-Authorize?

Without pre-authorization, coverage will be reduced from 50% to 37.5%. In addition, you will pay an extra \$250 deductible on top of any other deductible that normally applies. All of the additional expenses (higher cost due to a lower coverage percentage and the additional deductible) will not count toward your calendar year deductible or your co-insurance maximum.

Summary of Penalties for Not Pre-Authorizing

- Coverage reduced to 37.5%.
- Extra \$250 deductible on top of any other deductible normally applied.
- All additional expenses do not count toward deductible or co-insurance.



How Long Does Pre-Authorization Take?

Once complete clinical information regarding your condition, history and prior treatment is received by ODS's Health Care Services Department, the authorization process will take one to two business days. ODS will notify you and your physician of its decision.



Coordination of Benefits



If My Spouse Is Also Covered at 4J, Can We Coordinate Benefits?

Yes, the 4J ODS plan coordinates to a lesser or greater extent, depending on the plan design of your spouse or domestic partner. Keep in mind that coordination of benefits (C.O.B.)—or the detailed plan for determining the order of benefit payment—is very complex when a person is covered by two plans.* How C.O.B. Works (below) summarizes key aspects of C.O.B. and will help you understand how benefits coordinate between the plans. If you have any questions or concerns about C.O.B., call ODS Customer Service at 1-800-420-7758.

In reviewing the information about how C.O.B. works, consider these general guidelines:

- The plan that covers the individual as an employee is primary. The plan that covers the individual as a dependent is secondary.
- The spouse whose birthday is earliest in the year, or who has custody of a child, holds the primary coverage for dependent children.
- The primary plan always pays the same benefits as it would if there were no secondary plan.
- Maximum coverage is usually obtained when both parties receive In-Network benefits.

How C.O.B. Works

The Primary Plan (which is the plan that pays benefits first) pays the benefits that it would have paid were there no other insurance available.

The Secondary Plan (which is the plan that pays benefits after the Primary Plan) will limit the benefits it pays so that the sum of its benefit and all other benefits paid by the Primary Plan will not exceed the greater of:

- 100% of the total covered expenses or
- The amount of the benefits it would have paid had it been the Primary Plan.

For additional information on coordination of benefits, refer to the ODS Member Handbook.

Tips for Accurate Timely Payment

For medical, vision and dental services, send the explanation of benefits (EOB) received from the primary carrier and a copy of itemized billings to the secondary carrier with a request for pickup of co-pays or other eligible costs. For pharmacy bills, send your receipt to the secondary carrier for pickup of eligible expenses. If your pharmacy plan provides an EOB, it must also be sent with the receipt. Send a copy of your ODS member card and keep copies of all receipts and statements sent.

*All insurance companies determine the order of benefit payments according to uniform wording specified by state law and monitored by the Department of Insurance.



What happens if I don't meet my deductible by the end of the year?



ODS will apply any amount paid toward your deductible in October, November or December toward your deductible for the next calendar year.

Remember, amounts over MPA (Maximum Plan Allowance), as well as dental, vision care and prescription co-pays from participating pharmacies, are exempt from the deductible.

Call ODS Customer Service at 1-800-420-7758 if you have any questions.



Can you explain to me what co-insurance means?



Co-insurance is the ratio at which the insurance company and you share the cost of covered medical expenses (e.g., 75/25% at In-Network and 50/50% at Out-of-Network). Co-insurance is simply the percentage of your total bill (after you've met your annual deductible) that you must pay. For example, if your visit to an In-Network doctor costs \$68 and you are responsible for a 25% co-insurance payment, you are responsible for paying the physician \$17. ODS pays the remaining 75% of the bill.



Can you explain to me what out-of-pocket means?



Out-of-pocket refers to a specific dollar amount for which you are responsible before ODS pays 100% of covered services. Once you have paid the specific amount out-of-pocket, you are no longer required to cover a portion of the costs for medical care.

In-Network, the calendar year out-of-pocket maximum is \$5,000 per individual. (There is no family maximum, so the \$5,000 is for each individual covered.) You are responsible for 25% of covered charges (commonly referred to as co-insurance) until you have paid out-of-pocket \$5,000 in co-insurance. Covered charges beyond that are paid at 100% by ODS for the balance of the calendar year.

Out-of-Network, the calendar year out-of-pocket maximum is unlimited per individual. You are responsible for 50% of covered charges (commonly referred to as co-insurance).

Note About Deductibles and Prescription Drug Charges

Plan deductibles and prescription drug charges do not apply toward the calendar year out-of-pocket maximum. For additional services that may not apply toward the calendar year maximum, please refer to your ODS Member Handbook.



Overview of the Wellness Clinic



What is the 4J Wellness Clinic?

The Wellness Clinic is a medical clinic run through a joint effort of the District and its employees (via the Joint Benefit Committees) to provide insurance-eligible 4J employees, retirees and their families with pre-paid medical care for routine needs. The clinic has three nurse practitioners and support staff who work together to provide high-quality care.



What Services Does the Clinic Provide?

The clinic provides a full range of primary health care, diagnostic tests, minor surgery and preventative care. Annual physicals are available, as well as school, sports and camp physicals for children. Below is a list of services.

Illness

- Sore throats
- Respiratory infections
- Colds, coughs & flus
- Vaginal infections & other women's health problems
- Rashes
- Urinary tract infections
- Headaches
- Depression
- Ill-defined conditions such as dizziness and pain

Preventive Care

- Routine physical exam
- Annual pap & pelvic exam
- Sports physicals
- School physicals
- Camp physicals
- Blood pressure monitoring
- Cholesterol monitoring
- Flu shots
- Adult immunizations
- Nutrition counseling
- Exercise-related issues

Injury Treatment

- Stitching minor lacerations
- Evaluating strains & sprains
- Wounds
- Burns

Other Services

- Evaluating suspicious skin lesions
- Removal of small warts & moles
- Evaluation and treatment of boils & cysts
- Lab tests as necessary



What Do I Need to Do To Use the Wellness Clinic?

It's easy! Call the clinic at 686-1427 to make an appointment. The clinic, located at 200 N. Monroe Street in the 4J District Office, is open for appointments and scheduling Monday through Friday from 9 a.m. to 6 p.m., including the summer months.

4J Wellness Clinic 686-1427



Overview of the Employee Assistance Program



What Is the 4J Employee Assistance Program?

The 4J Employee Assistance Program (EAP) is a special program offered through a contracting arrangement with the Cascade Centers EAP. It provides 4J employees, retirees and immediate household members with short-term, confidential, professional counseling designed to resolve issues within four or fewer visits.



What Kinds of Help Can I Get From the EAP?

Our EAP provides assistance, such as marital or financial counseling and limited legal consultation, for a wide range of personal problems that affect your personal, family and professional life.



What Do I Do if I Want to See an EAP Counselor?

Call Cascade Centers EAP at 1-800-433-2320. The person you speak with will be able to refer you to local programs and resources and help you choose an appropriate counselor, if necessary. (Regular office hours for the EAP are 7:30 a.m. to 5 p.m. Monday through Friday. However, there is someone on call 24 hours per day to handle emergency situations.)



What if I'm Not Sure if I Should Contact the EAP or a Regular Mental Health Provider?

Call the Cascade Centers EAP at 1-800-433-2320. The mental health professional you speak with will be able to help you and refer you to a counselor if necessary.

Remember, if you don't call the EAP 800 number prior to using any mental health benefits, you will not receive any coverage. For more information about how to use mental health benefits, review Mental Health and Alcohol & Substance Abuse (page 2•8).



What if an Injury or Incident Occurs?

1. Report all on-the-job injuries or incidents to your supervisor immediately. Fill out a Preliminary Accident Report of Employee Injury form and return it to your supervisor or the Workers' Compensation Office (WC Office). Forms are available from your school department secretary or on the 4J Risk Management web site (www.4j.lane.edu/hr/rm).
2. If emergency medical care is required, your supervisor will arrange for transportation through 911. If your supervisor is not available, contact 911. Call the WC Office at 687-3402 to report the injury as soon as possible.
3. If non-emergency care is required, contact one of the following:
 - MedExpress at 744-6111. If MedExpress is called, it's staff will handle the situation or transport you to and from an appropriate care facility (e.g., personal health care provider, urgent-care provider, etc.)
 - Cascade Health Solutions and Cascade Medical Associates at 228-3100, which can provide treatment immediately after an injury. Cascade Medical Associates is the 4J provider. It is located at 2650 Suzanne Way, Suite 200, Eugene (behind PetSmart and across from Costco)
 - A physician of your choice.



The District recommends that you complete and return the accident reporting form to your supervisor, no matter how minor the injury. If the injury develops into something more serious at a later date, proof that the injury is work related will be important.



What Happens After the Injury?

To facilitate a smooth transition back to work, follow these guidelines:

- Call your supervisor and the WC Office at 687-3402 to notify them if you are unable to return to work for your next scheduled shift.
- Call the WC Office each Monday if you continue to be off work due to injuries. It is important to report your current medical status, upcoming doctor's appointments and other related information. The WC Office will coordinate your medical and time loss benefits under workers' compensation and can answer your questions on this subject.
- Always obtain a written statement from the physician returning you to work.
- The District may provide you with temporary work assignments during your recovery. Contact your supervisor or the WC Office for more information.



Q & A About Workers' Compensation



Should I see my regular doctor even though medical care will be covered through workers' compensation?



We recommend that you always see your regular doctor, particularly before seeing a specialist. Going to your regular doctor ensures coverage if for some reason your workers' compensation claim is not accepted.



Q & A About COPES



Will I have out-of-pocket expenses in the COPES program?



There are no costs for RN Coordinator services and classes offered through COPES. Medical treatment is covered by your insurance plan, but you will have the usual co-pay and deductible expenses. However, there will be no surprises; your RN Coordinator will review your treatment plan with you and discuss costs involved.



Will my employer and supervisor know I'm enrolled in the plan?



Not if you don't want them to know.



How long does the program last?



The active enrollment period, when you will be attending classes and appointments determined by your treatment plan, is three months. For nine months after that you will be in contact with your RN Coordinator every three months to go over how you are doing and see if more assistance is needed.



How do I get involved?



It's easy. Call the COPES program at Cascade Health Solutions at 228-3000 any weekday between 8 a.m. and 4:30 p.m.



How to File a Medical Claim: Office and Hospital Visits

In-Network Provider	Out-of-Network Provider*
<p>Office & Specialist Visits</p> <ol style="list-style-type: none"> 1. Show your ODS member card. 2. The provider will bill ODS. 3. You will receive an Explanation of Benefits (EOB) from ODS. Pay the amount shown as your responsibility (25% after deductible). 	<p>Office & Specialist Visits</p> <ol style="list-style-type: none"> 1. Show your ODS member card. 2. Do one of the following: <ol style="list-style-type: none"> A. If your physician bills ODS, wait for an Explanation of Benefits (EOB) from ODS. B. If your physician asks you to pay in advance, submit the bill to the ODS address on your member card. 3. After the bill is processed: <ol style="list-style-type: none"> A. If the provider billed ODS, pay the amount shown on your EOB as your responsibility (50% after deductible, plus anything over MPA*). B. If you paid in advance, you will be reimbursed (50% after deductible, minus anything over MPA*).
<p>Hospital Visits</p> <ol style="list-style-type: none"> 1. Check with the referring physician to be sure he or she has pre-authorized the visit. 2. Show your member card at the time of your visit. 3. You will receive an Explanation of Benefits (EOB) from ODS. Pay the amount shown as your responsibility (25% after deductible). 	<p>Hospital Visits</p> <ol style="list-style-type: none"> 1. Call ODS at (800) 258-2037 for authorization prior to admission. (You must pre-authorize.) 2. Show your ODS member card at the time of admission. 3. Arrange to pay your deductible and 50% co-insurance, by: <ol style="list-style-type: none"> A. Paying the amount shown on the EOB if the provider bills ODS. B. Paying in advance and receiving reimbursement from ODS.

* Members are responsible for charges above MPA (Maximum Plan Allowance) for services.



Important Note

For information about filing procedures for employees or retirees traveling or residing outside the ODS service area, review *How to File Out-of-Area Claims* (page 7•4).



How to File a Medical Claim: Emergency Room Visits and Pharmacy

In-Network Provider	Out-of-Network Provider*
<p>Emergency Room Visits*</p> <ol style="list-style-type: none"> 1. Show your ODS member card at the time you arrive. 2. The provider will bill ODS. 3. You will receive an Explanation of Benefits (EOB) from ODS. Pay the amount shown as your responsibility (25% after deductible). 	<p>Emergency Room Visits*</p> <ol style="list-style-type: none"> 1. Show your ODS member card at the time you arrive. 2. Make one of the following arrangements: <ol style="list-style-type: none"> A. Ask the provider to bill ODS. B. Pay in advance, if the provider will not bill ODS. 3. You will receive an Explanation of Benefits (EOB) from ODS. <ol style="list-style-type: none"> A. If the provider billed ODS, pay the amount shown on your EOB as your responsibility (50% after deductible, plus anything over MPA). B. If you paid in advance, you will be reimbursed (50% after deductible, minus anything over MPA**).
<p>Pharmacy Purchases</p> <ol style="list-style-type: none"> 1. Show your ODS member card and make your co-payment (\$20 or 50%, whichever is greater). 	<p>Pharmacy Purchases</p> <p>No benefit from non-participating pharmacies.</p>

*Use of an emergency room for non-emergencies or for urgent, but non-emergency, care may not be covered at the highest level possible. An emergency is any situation that threatens life or limb, involves uncontrolled bleeding or loss of consciousness, or cannot be delayed without serious side effects on your health.

**Members are responsible for charges above MPA (Maximum Plan Allowance) for services.



For information about filing procedures for employees or retirees traveling or residing outside the ODS service area, review **How to File Out-of-Area Claims** (page 7•4).

Questions about anything? Call ODS Customer Service at 1-800-420-7758.



How to Resolve a Medical or Pharmacy Claim

Before contacting anyone, be ready to provide:

- ODS Member Number and
- Claim Reference Number or
- Date of Service and Provider

To Resolve an Eligibility Issue:	To Resolve a Claims Issue:
<p>1. Call the Employee Benefits Office at (541) 687-3491.</p>	<p>1. Call ODS Customer Service.</p> <p style="padding-left: 20px;">A. For medical issues, call (800) 420-7758.</p> <p style="padding-left: 20px;">B. For pharmacy issues, call (888) 361-1610.</p> <p>If Not Resolved...</p> <p>2. Call Mary Akin, ODS Account Executive, at (800) 578-1402, ext. 5602.</p> <p>If Not Resolved...</p> <p>3. Call the Employee Benefits Office at (541) 687-3491.</p> <p>If Not Resolved...</p> <p>4. Make an appeal.</p> <p style="padding-left: 20px;">A. For medical issues, call (800) 420-7758.</p> <p style="padding-left: 20px;">B. For pharmacy issues, call (888) 361-1610.</p>



You may also file your complaint or seek other assistance from the Oregon Department of Consumer and Business Services, Consumer Protection Section, at (888) 877-4894.



How to File Out-of-Area Claims

The 4J ODS plan provides coverage for:

- Employees and eligible family members who require emergency or urgent-care medical services and prescriptions when traveling outside of the ODS service area.
- Eligible dependents who reside outside the ODS service area.
- Employees and retirees who reside outside the ODS service area.

In-Network	Out-of-Network
<p>Traveling Out of Area Out-of-Network Emergency/Urgent Care</p> <ol style="list-style-type: none"> 1. Make arrangements to have your bill submitted to ODS by: <ol style="list-style-type: none"> A. Asking the provider to submit the bill. B. Submitting the bill to ODS with explanatory information about the nature of the emergency or urgent-care need. 2. Receive coverage at 75% after deductible. You are also responsible for charges over MPA. 	<p>Traveling Out of Area Out-of-Network Emergency/Urgent Care</p> <p>Same as In-Network.</p>
<p>Residing Out of Area</p> <p>Indicate on your ODS enrollment form that you or a covered member will be residing out of area. (Submit a change of status form if mid-year.) Ask the provider to submit bills to ODS or have the covered member submit them. A covered child or student will receive In-Network coverage. Employees, family members and retirees will receive 75% coverage up to MPA*.</p>	<p>Residing Out of Area</p> <p>Same as In-Network.</p>
<p>Pharmacy In-Network Provider</p> <ol style="list-style-type: none"> 1. Show your ODS member card and make your co-payment (\$20 or 50%, whichever is greater). <p>Note: ODS has an extensive nationwide panel of pharmacies, including most major chain stores.</p>	<p>Pharmacy Out-of-Network Provider</p> <p>No benefit from non-participating pharmacies.</p>

*Members are responsible for charges above MPA (Maximum Plan Allowance) for services.