IMPORTANT!

✓ Review Current Enrollment Information

DO NOT ASSUME IT IS CORRECT!
Submit any corrections/changes before the deadline below. Do not submit the enrollment form if no changes are needed.

✓ Enrollment Deadline

FRIDAY, SEPTEMBER 14, 2007

✓ No More Tax Shelter Form
All applicable premiums are now automatically tax sheltered. To opt out, visit the Employee Benefits Office.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a Federal law gives you more choices about your prescription drug coverage. Please see “Medicare Part D - Notice of Creditable Coverage” for more details.
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, vision and dental benefits?
☞ Then review Sections 2, 3 and 4, taking special note of the summary charts in each section.

...Understand what the OSBA/Regence plans are and how they work?
☞ 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 8 in Section 2.

...Understand how to purchase prescriptions?
☞ Then turn to page 5 in Section 2.

...Learn about life insurance and long-term disability benefits?
☞ Then review Section 5.

...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 dental, vision or medical claim?
☞ Then review pages 1 through 3 in Section 7.

...Know how to file claims when traveling or residing out-of-area?
☞ Then review page 5 in Section 7.

...Understand how to resolve a problem with a claim?
☞ Then review page 4 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 OSBA/Regence 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
web: benefits.4j.lane.edu

Regence BlueCross BlueShield of Oregon
100 SW Market Street
PO Box 1271
Portland, OR 97207-1271
ph: 1-800-365-3155
www.or.regence.com

ODS Dental
601 SW 2nd Ave.
Portland, OR 97204
ph: 1-888-217-2365
www.odscompanies.com
Determining Eligibility

Tax Shelter Plan

Step-by-Step Guide to Insurance Enrollment

If a retiree or a retiree's insurance-eligible spouse becomes eligible for Medicare due to disability, the retiree or the retiree's spouse qualifies for Medicare supplemental coverage reimbursement. Eligibility ends when the retiree or spouse reaches age 65.
Determine Your Eligibility

To enroll in one of the Oregon School Boards Association (OSBA)/Regence BlueCross BlueShield of Oregon (Regence BCBSO) Health Plans for the first time, you must complete the enrollment form and submit it to the Employee Benefits Office (EBO) within 31 days of becoming eligible.

IF YOU ARE ALREADY ENROLLED, look over the pre-printed enrollment form 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 14, 2007.

Change of status during the year? Submit an updated form to the EBO within 31 days of the change.

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 one of the OSBA/Regence plans, follow the steps outlined in The Enrollment Process (page 1-4).

As a licensed employee you are:

- Eligible for medical, dental, vision, basic life insurance and long-term disability insurance if you routinely work 20 or more hours per week (.5 FTE).
- Not eligible for any benefits if you work less than 20 hours per week (less than .5 FTE).

When Do My Insurance Benefits Begin?

Your insurance is effective your first day of active work in an insurance-eligible position, with the exceptions of long-term disability and life insurance, which become effective the first of the following month.

Refer to the Licensed Active Employees rate sheet for payroll deduction information for OSBA/Regence BCBSO plans.

Active Employees on Leave

OSBA/Regence BCBSO allows only 3 months of active enrollment for members while on leave. When eligibility ends, the member becomes eligible for COBRA coverage for 18 months. The effect is that a person on leave will no longer be able to remain on the District insurance plan for the entire duration of a two-year leave.
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 OSBA/Regence BCBSO Member Handbook for more information)
- Grandchild (employees must provide proof that they have legal guardianship)

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.

Documentation is required within 31 days** of the qualifying event for these changes in coverage:

- To add dependents, a birth, marriage, domestic partnership or adoption certificate must be submitted to the EBO with the Enrollment Form.
- To remove a former spouse or domestic partner, a divorce decree or Statement of Termination of Domestic Partnership form*** must be submitted to the EBO with the Enrollment Form.

Who Is a Dependent?

Dependents include the employee’s:

- Spouse (legally married)
- Domestic partner*
- Children who are financially dependent for at least 50% of their support under the age of 26 (including stepchildren of a legal marriage or domestic partnership)
- Children age 26 or over incapable of self-support because of a physical handicap or mental retardation (Refer to the OSBA/Regence BCBSO Member Handbook for additional information.)
- Grandchild (employees must provide proof that they have legal guardianship)

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

**You must notify the EBO within 31 days of the qualifying event in order to make changes to your coverage. If you experience delays in attaining the supporting documents, be sure to submit at least the Enrollment Form and discuss the delay with the EBO.

*** Statement of Termination of Domestic Partnership form (Form 3698OSB) is available on the Regence web site (www.or.regence.com) or from the EBO.
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 $3,000 per month with approximately 30% deducted for taxes.

<table>
<thead>
<tr>
<th>Without the Tax-Free Payment Plan</th>
<th>With the Tax-Free Payment Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Determine the amount earned.</td>
<td>$3000</td>
</tr>
<tr>
<td>2. Deduct 30% for taxes.</td>
<td>$3000 x 30% = $900</td>
</tr>
<tr>
<td></td>
<td>$2100</td>
</tr>
<tr>
<td>3. Deduct $85 for insurance</td>
<td>$2100 - $85 = $2015</td>
</tr>
<tr>
<td>premium to determine your</td>
<td></td>
</tr>
<tr>
<td>take-home pay.</td>
<td></td>
</tr>
<tr>
<td>4. Calculate the % of money</td>
<td>67%</td>
</tr>
<tr>
<td>earned that is left in your</td>
<td></td>
</tr>
<tr>
<td>pocket after taxes and insurance.</td>
<td></td>
</tr>
<tr>
<td>No Savings</td>
<td></td>
</tr>
</tbody>
</table>

5. Calculate the annual savings. (Subtract line 3 in the left-hand chart from line 3 in the right-hand chart and multiply by 12 pay periods.)

$2040.50 - $2015 = $25.50
$25.50 x 12
Annual Savings
$306

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*

Q How do I opt out of the Tax Shelter Plan?

A 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.
The Enrollment Process

How Do I Enroll?

Just follow the simple steps below. If you have any questions or problems, call the Employee Benefits Office (EBO) at 687-3491.

<table>
<thead>
<tr>
<th>New Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete the group enrollment form to enroll in one of the OSBA/Regence BCBSO Health Plans.</td>
</tr>
<tr>
<td>To waive coverage, complete a waiver form (available from the EBO).</td>
</tr>
<tr>
<td>2. Submit your enrollment form to the EBO within 31 days of employment date.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Current Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete the group enrollment form to enroll in one of the OSBA/Regence BCBSO Health Plans.</td>
</tr>
<tr>
<td>To waive coverage, complete a waiver form (available from the EBO). Complete a new waiver even if you waived coverage last year.</td>
</tr>
<tr>
<td>2. Submit your enrollment form to the EBO no later than September 14, 2007.</td>
</tr>
<tr>
<td>3. <strong>If you are already enrolled</strong>, look over the pre-printed enrollment form 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 14, 2007.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Retired Employees</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Complete the enrollment form. Designate which coverage you want.</td>
</tr>
<tr>
<td>2. Submit all forms for the year to the EBO no later than September 14, 2007.</td>
</tr>
<tr>
<td>3. <strong>If you are already enrolled</strong>, look over the pre-printed enrollment form 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 14, 2007.</td>
</tr>
</tbody>
</table>

How Can I Move Between Available Plans?

At open enrollment periods:

- active employees may move freely between any offered plan.
- retirees may move only to a lower-option plan—never to a higher-option plan.

Can I Waive Dental Coverage?*

- Active members employed at less than .96 FTE may waive dental coverage for the current plan year.
- Retirees may waive dental coverage permanently for themselves and eligible dependents (waiver is irrevocable).

*Election changes (e.g., waiving dental coverage) are only allowed during valid enrollment periods.
The information in this section, including the overview charts, is a summary of programs and benefits offered by the 4J School District. It is not complete. Your Subscriber Agreement takes precedence over any information provided in this section.
Overview of Medical Coverage

What Kind of Coverage Is Provided Through the OSBA/Regence BCBSO Health Plans?

The District offers a choice of three health care plans—two traditional indemnity plans and a PPO Plan. The two traditional indemnity plans (A-200 and C-500) are 80%/20% co-insurance plans. Co-insurance on the PPO plan is set at 90%/10% for participating PPO providers and 70%/30% for non-participating PPO providers. On the two indemnity plans, the list of participating providers is more extensive than that on the PPO plan. As a member, you are free to use any provider you choose, but when receiving services from a non-participating provider, the co-insurance percentage paid by the insurance company is based on the MPA (Maximum Plan Allowance), meaning that the member may be billed for any additional charges that exceed the MPA. In all plans, the amount that a non-participating provider charges for services that exceed the MPA is the responsibility of the member and is not applied to the deductible or annual out-of-pocket maximums.

Terms and Information You Need to Know

- **Co-pay** is the fixed dollar amount you pay for a covered service.
- **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 (OSBA/Regence BCBSO) and the member after the deductible is met. (Refer to Coverage Highlights Charts.)
- **MPA** (Maximum Plan Allowance) is the maximum amount on which OSBA/Regence BCBSO will base its reimbursement to physicians and providers. Members are responsible for charges above the MPA for non-participating providers only. Participating providers have agreed they will not bill members for amounts over the MPA. Refer to the OSBA/Regence BCBSO 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 (one of three available plans at 4J)
TIP—Traditional Indemnity Plan
UCR—Usual Customary and Reasonable

Review the Coverage Highlight Charts (pages 2•3 through 2•5) to compare the benefits of the three plans.
How Do Participating Providers Benefits Work?

Participating Providers coverage allows you to see any provider in the OSBA/Regence participating provider network. If you are on Plans A-200 or C-500, the 80%/20% co-insurance coverage applies even if you see non-participating providers, but you will be responsible for charges above the MPA. If you are on the PPO plan, you must see a preferred provider in order to receive the 90%/10% co-insurance benefits.

How Do Non-Participating Provider Benefits Work?

Members may go to any licensed provider and receive the same level of co-insurance coverage if they have selected one of the two available Traditional plans (Plan A-200 or Plan C-500). They will receive a lesser amount of coverage for using non-participating PPO providers if they have selected the PPO plan. Under any of the available plans, they are also liable for any amount charged by their non-participating provider that is above the Maximum Plan Allowance (MPA) paid to participating providers. (Those extra charges are not applied to deductibles or annual out-of-pocket maximum amounts.) In addition, for those services that require pre-authorization, the member, not the non-participating provider, is responsible for securing the pre-authorization. Failure to pre-authorize can lead to unexpected, and sometimes large, out-of-pocket costs if OSBA/Regence BCBSO determines that a service is not “medically necessary” and denies coverage. For more detailed information on pre-authorization, see page 2•6.

What Do I Need to Know About the Physician and Providers Panel of Participation?

The physician and provider networks are important for controlling your health care costs. For the best coverage, be sure that the provider is a member of OSBA/Regence BCBSO to avoid extra charges above Usual Customary and Reasonable (UCR). Refer to the provider directory at www.or.regence.com if you have any questions about the status of a particular provider or call OSBA/Regence Customer Service at 1-800-365-3155.

Under the PPO Plan, some specialties in the Eugene/Springfield area may not be represented. Provider panels are subject to change without notice. You are responsible to confirm that your provider is in the panel.
**Coverage Highlight Charts**

### Deductibles and Maximums

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan A-200</th>
<th>Plan C-500</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Medical Deductible</strong></td>
<td>$200 Person</td>
<td>$500 Person</td>
<td>PPO $100 Person/$300 Family Non-PPO $200 Person/$600 Family</td>
</tr>
<tr>
<td></td>
<td>$600 Family</td>
<td>$1500 Family</td>
<td></td>
</tr>
<tr>
<td><strong>Co-Insurance (Carrier Pays)</strong></td>
<td>80% of first $5000, then 100%</td>
<td>80% of first $10,000, then 100%</td>
<td>PPO 90% of first $5000, then 100% Non-PPO 70% of first $5000 (Panels are limited in some specialties)</td>
</tr>
<tr>
<td><strong>Out-of-Pocket Medical Maximum (Member Pays)</strong></td>
<td>$1200 Person</td>
<td>$2500 Person</td>
<td>PPO $600 Person Non-PPO $1700 Person</td>
</tr>
<tr>
<td></td>
<td>$2600 Family</td>
<td>$5000 Family</td>
<td></td>
</tr>
<tr>
<td><strong>Lifetime Maximum</strong></td>
<td>$2,000,000</td>
<td>$2,000,000</td>
<td>$2,000,000</td>
</tr>
</tbody>
</table>

### Basic Coverages: Physician Visits and Related Treatment

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan A-200</th>
<th>Plan C-500</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Physician Services</strong> (Office Visits, Lab, X-Ray, Surgery)</td>
<td>80%</td>
<td>80%</td>
<td>PPO 90% Non-PPO 70%</td>
</tr>
<tr>
<td><strong>Prescriptions</strong></td>
<td>Generic – $10 max co-pay, Preferred Brand† - 80%, Non-preferred Brand – 50% $1000 member co-insurance limit; then 100% Mail Order Option: Generic – $30 max co-pay for 90-day supply</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Preventive Care Services—See Plan Summary Sheet for Preventive Care frequency schedule</strong></td>
<td>100% up to $500 per person per calendar year (deductible waived)</td>
<td>100% – Deductible Waived, not subject to $500 annual limit</td>
<td></td>
</tr>
<tr>
<td><strong>Chiropractic</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Podiatry</strong></td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td><strong>Allergy Injections</strong></td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td><strong>Naturopathic</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Acupuncture</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Physical Therapy</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
</tbody>
</table>

* 30 sessions each calendar year for out-patient rehabilitation or 30 days each calendar year for in-patient.
† To determine if a prescription medication is a Preferred Brand, please visit the Regence Pharmacy Benefit Management web site (www.regencerx.com) or call Pharmacy Benefit Customer Service at 1-800-643-5918.
### Hospital Coverage

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan A-200</th>
<th>Plan C-500</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital Services</strong></td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Non-PPO 70%</td>
</tr>
<tr>
<td><strong>Emergency Room</strong></td>
<td>$100 co-pay (waived if admitted) then 80%</td>
<td>80%</td>
<td>PPO 90% /70% after $100 co-pay (true medical emergencies paid at PPO level) Non-PPO—same (co-pay waived if admitted)</td>
</tr>
<tr>
<td><strong>Ambulance</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td><strong>Transplant</strong></td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td>{eligible after 12 mos. cont. coverage}</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>DME</strong> (crutches, hospital beds, etc. Pre-auth. required)</td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
</tbody>
</table>

### Home and Specialized Nursing Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan A-200</th>
<th>Plan C-500</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Home Care</strong></td>
<td>80%</td>
<td>80%</td>
<td>80%</td>
</tr>
<tr>
<td>(Pre-auth. required)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Skilled Nursing Facility</strong></td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td>(Pre-auth. required)</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Maternity and Family Planning Care

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan A-200</th>
<th>Plan C-500</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Maternity Care</strong></td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td><strong>Preventive Care</strong></td>
<td>(see Preventive Care under Basic Coverages— Page 2 • 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Family Planning</strong></td>
<td>Covered as Rx benefit 80%</td>
<td>Covered as Rx benefit 80%</td>
<td>Covered as Rx benefit PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td>Contraceptives</td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td>Vasectomy</td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>Not covered</td>
<td>Not covered</td>
<td>Not covered</td>
</tr>
<tr>
<td>Infertility Services</td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td>Voluntary Pregnancy Term.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Mental Health and Alcohol & Substance Abuse

<table>
<thead>
<tr>
<th>Benefits</th>
<th>Plan A-200</th>
<th>Plan C-500</th>
<th>PPO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health</td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
<tr>
<td>In-Patient Care</td>
<td></td>
<td></td>
<td>Limitations removed – refer to plan book</td>
</tr>
<tr>
<td>Residential Care</td>
<td></td>
<td></td>
<td>45 days per calendar year</td>
</tr>
<tr>
<td>Out-Patient Care</td>
<td></td>
<td></td>
<td>Limitations removed – refer to plan book</td>
</tr>
<tr>
<td>Chemical Dependency</td>
<td>80%</td>
<td>80%</td>
<td>PPO 90%, Non-PPO 70%</td>
</tr>
</tbody>
</table>

### How Is the Cost for Prescription Drugs Covered?

OSBA/Regence BCBSO covers part of the cost of prescribed drugs, or their generic equivalent when available, when you purchase at retail or mail-order pharmacies. There is no difference between how the claims are processed based on your choice of plans.

**All Plans**—When using a participating pharmacy, the pharmacist will receive on-line point-of-service billing information and collect the required co-insurance amount. A 34-day dispensing limit is available from retail pharmacies. There is no benefit for non-participating pharmacies except for emergency care.

**Mail-Order Pharmacy**—For members who value the convenience of ordering their maintenance medications via the mail, a mail-order pharmacy option is available. There is no price advantage for doing so; however, a 90-day dispensing limit is available. The co-pay and co-insurance percentages that apply for any other retail pharmacy also apply for the mail-order option (i.e., $10 maximum co-pay for generics (x 3 months), 80% coverage for preferred brand and 50% coverage for non-preferred brand).

**NOTE** 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•5).
Pre-Authorization Requirements

How Is Pre-Authorization Handled?

When Using a Participating Provider—The providers are responsible for obtaining pre-authorization. If they fail to do so and the claim is denied, they are required to write off the charges.

When Using a Non-Participating Provider—Although non-participating providers will generally take care of pre-authorization to be sure they are paid for their services, they are not required to do so by contract. It therefore is the responsibility of the member to follow up with OSBA/Regence BCBSO Customer Service to be sure that those services and admissions requiring pre-authorization have been requested and approved.

What Are the Consequences of Not Pre-Authorizing When Receiving Services From a Non-Participating Provider?

If OSBA/Regence BCBSO determines that the services are not eligible for coverage, the member is responsible for the charges. Furthermore, those charges will not be applicable to deductibles or annual out-of-pocket maximums.

How Long Does Pre-Authorization Take?

Our coverage contract with OSBA/Regence BCBSO specifies that notification of the decision will be made within 15 days of receipt. (For a more detailed explanation, see the plan book for the plan you have selected.)

How Do I Contact Regence Regarding Pre-Authorization?

Mail: Regence BCBSO Preauthorization Dept.
PO Box 1271, E-9B
Portland, OR 97207-1271

Phone: 1-800-824-8563
Mental Health and Substance Abuse Coverage

How Is Mental Health and Substance Abuse Coverage Provided?

Coverage in these areas is provided either under the OSBA/Regence BCBSO medical coverage (see Coverage Summary Chart on page 2•5) or under the provisions of the Employee Assistance Program (EAP) (see Overview of the Employee Assistance Program on page 6•3).

What Will Happen When I Call the 800 Number?

The Employee Assistance Program (EAP) is a valuable benefit and resource. When you call Cascade Centers EAP, you will speak with a trained behavioral health specialist about the reasons you are seeking treatment. He or she will either refer you to a local EAP counselor or, if your situation warrants treatment beyond the scope of EAP services, recommend that you seek services under the Mental Health or Substance Abuse provisions of your OSBA/Regence coverage.

NOTE

If you need to seek services under the medical coverage plan rather than the EAP, please refer to the specific information regarding in-patient and out-patient coverage for mental health and substance abuse in the Coverage Summary Chart (page 2•5).
Coordination of Benefits

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

Yes, the OSBA/Regence BCBSO 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 OSBA/Regence BCBSO Customer Service at 1-800-365-3155.

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.

### 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 MPA or
- The amount of the benefits it would have paid had it been the Primary Plan.

For additional information on C.O.B., refer to the OSBA/Regence BCBSO 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 original receipt along with the required reimbursement form (Form 4328) available from EBO or online at [www.or.regence.com](http://www.or.regence.com) to the secondary carrier for pickup of eligible expenses. If your pharmacy plan provides an EOB, it must also be sent with the receipt. 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.*
Q & A About Medical Coverage

Q Do I need to select a Primary Care Physician (PCP)?
A No, selecting a PCP is not required in the OSBA/Regence BCBSO plans.

Q What about referrals in the OSBA/Regence BCBSO Health Plans?
A PCP referrals are not required, although some specialists may choose not to see you without a physician's referral.

Q How do I ensure that I receive the best coverage possible?
A Be sure that the providers you use and those who your family or personal physician sends you to are participating providers on the plan you have selected. This becomes especially important if you have selected the PPO plan since its list of participating PPO providers is more limited and the potential for additional costs above the maximum plan allowances could be more substantial.

Q Are there restrictions on emergency room visits?
A If it is determined that the emergency room visit is not a “medical emergency” (as defined below) the charge for the specific “emergency room service” will be denied (meaning you will be responsible to pay that portion of the charges); however, other charges associated with the care (supplies, diagnostic x-ray and lab, other services and physician fees) will still be covered. Visits to urgent-care facilities do not require a “medical emergency” and are processed in the same manner as regular office visits.

Definition of “Medical Emergency” - the sudden onset, not sudden discovery, of a medical condition manifesting itself by acute symptoms of sufficient severity that the absence of immediate medical care (within 24 hours of onset) would result in permanently placing the member's life in jeopardy or serious and permanent impairment or dysfunction of any bodily parts, functions or organs.
What is meant by co-insurance?

Co-insurance is the ratio at which the insurance carrier and the member share the cost of covered medical expenses (e.g., 80%/20%). Co-insurance is simply the percentage of the total bill for covered services that the member pays after the annual deductible has been met. If, for instance, a visit to the doctor resulted in charges totaling $100, assuming that the deductible had been met, then the member would be billed 20% of the charges ($20) and the rest ($80) would be the responsibility of the insurance carrier.

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

The insurance carrier, OSBA/Regence BCBSO, will apply any amount of the plan's deductible met during October, November and December to the next calendar year's deductible, but only if the member does not meet the entire deductible before December 31. If the entire deductible is met by December 31, then the deductible starts over again January 1.

What does the term “out-of-pocket maximum” mean?

Out-of-pocket maximum refers to the specific amount for which a member is responsible before the insurance carrier, OSBA/Regence BCBSO, pays 100% for covered services. Once the member has met the out-of-pocket maximum for the calendar year, all remaining covered expenses are paid, in total, by the insurance carrier.

The money you pay Non-Participating Providers for charges above UCR does not count toward your deductible.
VISION COVERAGE

Coverage Highlights
Plan Summary Chart
Questions & Answers
Overview of OSBA/Regence BCBSO Vision Coverage

How to File an OSBA/Regence BCBSO Vision Claim

1. Go to any Participating Provider for 100% coverage, up to MPA. Go to any Non-participating Provider for 70% coverage, up to MPA.

2. Show your OSBA/Regence BCBSO member card when you arrive for your visit.

3. Submit the bill to Regence BCBSO if providers indicate they do not handle claim billings. (Send the bill to the address on your OSBA/Regence BCBSO member card.)

4. OSBA/Regence BCBSO will process your claim and send you an explanation of benefits (EOB), which will indicate the amount you owe the provider. The member is responsible for costs above MPA. (Check with your provider about payment policies.)

Exactly What Is Covered?

The chart below summarizes your benefits.

<table>
<thead>
<tr>
<th>Item</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eye Exams &amp; Eye Refractions</td>
<td>One eye exam and one refraction per 12-month period for members under age 19. Every 24-month period for all others. 100% coverage up to MPA.*</td>
</tr>
<tr>
<td>Frames</td>
<td>One set per 24-month period, regardless of age. 100% coverage up to MPA.</td>
</tr>
<tr>
<td>Lenses</td>
<td>Two eyeglass lenses or one set of contacts per 12-month period for members under age 19. Every 24-month period for all others. 100% coverage up to MPA.*</td>
</tr>
</tbody>
</table>

* Members are responsible for charges above MPA (Maximum Plan Allowance) for services.
Q & A About the OSBA/Regence BCBSO Vision Plan

Q If I break my frames or lenses, will my vision insurance pay for replacements?

A There is no special provision for lost or broken frames. OSBA/Regence BCBSO will pay claims only as indicated in the chart on page 3•1.

Q I am 35 years old and had a routine eye exam within the last two years, but now my eyes are giving me trouble. Will my vision insurance cover another exam?

A No. If your eyes are giving you trouble because you need a new lens prescription, you would pay for this exam and the new lenses yourself. However, if there is another reason for your vision problem, such as an injury or eye disease, you may be covered by your medical plan. Your visit to the physician is subject to the annual deductible and medical plan payment schedule.

Q Will the vision plan pay for contact lenses?

A Yes, contacts are a covered benefit. Refer to the Summary of Vision Benefits chart (page 3•1) for more information.
DENTAL COVERAGE

Coverage Highlights
Plan Summary Chart
Questions & Answers
Overview of Dental Coverage

What Kind of Dental Coverage Is Provided in the ODS Plan?

Your dental insurance is designed to cover routine preventive dental care, as well as orthodontia and treatment of a variety of dental problems. (Refer to your ODS Member Handbook for specific information.)

If you have any questions about dental claims, call ODS Customer Service at 1-888-217-2365. Also refer to How to File a Dental Claim (page 7•1) in the Help section.

Do I Need to Pick a Dental Plan?

No, you do not enroll in a specific type of plan. However, you can control your out-of-pocket expenses by using a dentist from the 4J ODS Premier Provider Panel.

What Is the ODS Premier Provider Panel?

ODS contracts with more than 1,800 licensed dentists in Oregon, who are all members of the ODS Premier Provider Panel. More than 180 premier panel providers are in Lane County, all of whom have agreed to bill 4J benefits-eligible employees the maximum amount ODS reimburses for specific services (MPA). This means that when you use a premier provider, you are responsible only for your co-insurance percentage and any deductible that might apply.

If you do not use a premier provider, you are responsible for your co-insurance percentage, any deductible that might apply and the difference between what ODS will reimburse for the service and the dentist’s usual charge for the service.

A list of dentists on the 4J ODS Premier Provider Panel is included on the ODS web site at www.odscompanies.com. Click on “Provider Search” and then on “ODS Dental Premier Providers.”

National Dental Panel

Through the Delta Dental Plan Association, ODS has access to more than 100,000 dental providers nationwide. For information about providers, call an ODS Customer Service Representative at 1-888-217-2365, or go to the ODS web site at www.odscompanies.com and select “Dental (Nationwide).”
# ODS Dental Plan Summary

Please review your ODS Member Handbook for complete information.

<table>
<thead>
<tr>
<th>Item</th>
<th>Coverage</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Annual Deductible</strong></td>
<td>$25 per person</td>
</tr>
<tr>
<td><strong>Co-Insurance</strong></td>
<td>100%/80%/50% (see below)</td>
</tr>
<tr>
<td><strong>Annual Maximum</strong></td>
<td>$1,500 for all care (excluding orthodontia) up to MPA*</td>
</tr>
</tbody>
</table>
| **Diagnostic and Preventive Services** | Oral exams  
                    Teeth cleaning  
                    Fluoride  
                    X-rays  
                    Space maintainers  
                    Sealants  
                    ODS pays 100% (no deductible) |
| **Basic Services**        | Oral surgery  
                    Fillings  
                    Periodontal treatment  
                    Root canals  
                    ODS pays 80% after deductible |
| **Major Services**        | Bridgework  
                    Dentures  
                    Crowns & inlays  
                    Non-surgical TMJ treatment  
                    Repairs to dentures/bridges  
                    ODS pays 50% after deductible |
| **Orthodontic Services**  | Appliances  
                    Adjustments  
                    ODS pays 50% of incurred expenses up to MPA*  
                    $1500 lifetime maximum benefit |

*MPA refers to Maximum Plan Allowance, the maximum amount on which ODS will base its reimbursement to providers. Members who do not use the Premier Provider Panel are responsible for charges above MPA. (Refer to the ODS Member Handbook for additional information.)*

The chart above is only a summary. For a complete list of benefits, refer to the ODS Member Handbook.
Q & A About Dental Coverage

Q My dependent had an accident at school and two teeth were knocked loose. Since it was an accident, do I submit under my medical or dental plan?

A First submit the claim under your OSBA/Regence medical plan. If payment is denied, send a copy of the denial and the bill to ODS for payment under your dental plan.

Medical & Vision Claims: OSBA/Regence, P.O. Box 1271, Portland, OR 97207-1271
Dental Claims: ODS, 601 SW 2nd Ave., Portland, OR 97204

Q I’m not sure a certain dental procedure is covered. What should I do?

A Refer to the ODS Member Handbook or call ODS Customer Service at 1-888-217-2365.

Q My dentist is recommending that I have two teeth extracted. Does this need to be pre-authorized?

A No. However, if you want to know what coverage to expect prior to treatment, you or your dentist may contact ODS Customer Service at 1-888-217-2365 to determine the benefit your coverage will provide.

Q How often can I get my teeth cleaned and examined?

A The plan covers dental exams and prophylaxis once every six months.

Q My dentist has recommended that I have my teeth cleaned more often than every six months. Can extra cleanings be covered?

A If your dental provider submits documentation of your need for extra cleanings, ODS may authorize payment for those services.
Retirees are not eligible for life insurance or long-term disability coverage.
Life Insurance and Disability Coverage

What Kind of Life Insurance Coverage Is Provided in the Regence Plan?

The Regence plan provides a basic coverage of $31,500 for:

• Your designated beneficiary or beneficiaries in the case of your death.
• Yourself in the case of your accidental dismemberment, paralysis or loss of eyesight.

You may name more than one beneficiary. Contact the Employee Benefits Office at 687-3491 to file a multiple beneficiary form. When more than one beneficiary is named, benefits will be awarded equally among the beneficiaries unless you have designated otherwise.

For more information about specific benefits and exclusions, refer to the Regence Certificate of Coverage or contact the EBO at 687-3491.

What Is Provided by the Long-Term Disability (LTD) Insurance?

The LTD coverage is designed to provide income protection should you become disabled on or off the job. You may file a claim if you are unable to continue working or must reduce your hours due to a disability. Contact the EBO for a claim form at 687-3491.

How Does the LTD Coverage Work?

If you become disabled and your claim is accepted, you will receive 60% of your pre-disability gross income up to the monthly maximum of $2750 beginning 90 days after your disability began. Refer to your Regence contract for more information. (Contact the EBO at 687-3491 if you need a copy of the certificate.)
Q & A About Life Insurance and LTD

Q Can I get life insurance for my dependents?
A No, this benefit is only available to employees.

Q Is there a limit on the amount of time I am eligible to receive LTD benefits?
A Yes. If your disability prevents you from continuing only in your own occupation, the coverage lasts 36 months. If, however, your injury prevents you from working at any occupation, even after the first 36 months, then your coverage will continue.

Q Does my age at the time of my disability affect the benefits I receive?
A Yes. If you are 61 years of age or younger, the maximum benefit lasts until you become 65. After age 61, the benefit lasts varying amounts of time, up to age 69. Your Regence contract has more information about this issue.

Q If I don’t need the disability benefit—in other words, if I have some other sources of income—am I still eligible to receive it?
A Yes, but there are offsets for other income sources. Check your Regence contract for more information or contact the EBO at 687-3491.
Wellness Clinic
Employee Assistance Program
Workers’ Compensation Program
COPES
(Coordinated Outpatient Education & Intervention Services)
Flexible Spending Plan
(Available Only to Active Employees)
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 preventive 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.
Q & A About the Wellness Clinic

Q What are the primary objectives of the clinic?

A The clinic makes a contribution to long-term employee health and wellness by making this prepaid, easily accessed service available. In addition, it reduces health care expenses and helps the district control premium costs.

Q Who pays for the clinic?

A All employees contribute to the costs of running the clinic as part of the basic benefits package.

Q Does the clinic provide immunizations for children?

A The clinic is unable to provide this service for children 14 years of age or younger, but does provide immunizations for children 15 years of age and older.

Q How far in advance should I schedule a routine physical?

A About two months.

Q If I can't get an appointment the same day I call, does the clinic have a system for recontacting me if an opening occurs due to cancellation?

A No, the clinic does not offer this service.

Q What happens if I miss my appointment?

A You will be billed $20 for the missed appointment.

Q Is there any cost to visit the clinic?

A No, all services provided during your clinic visit are free of any charges or co-pays. (This includes lab work ordered by the clinic.)
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?

The 4J 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 4J 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.
Q & A About the Employee Assistance Program

Why does the District make this service available?

The program is offered to help retirees, employees and their families deal effectively with the many complex problems encountered in our society today. By helping employees resolve difficulties in their lives, the district can make a contribution to their productivity and happiness both on and off the job.

Who pays for the services? Do I have to pay for my individual sessions?

Employees contribute to the cost of the EAP as part of the basic benefits package. However, you pay nothing when you go for individual EAP counseling sessions, which typically consist of four or fewer visits. If further services are needed through Cascade Centers, co-insurance or co-payments may be required. Please refer to the Mental Health and Alcohol & Substance Abuse coverage benefits overview chart (page 2•5) for more information.

What Is the Workers’ Compensation Program?

If an employee is injured while on the job, the workers’ compensation program provides for:

- Medical coverage outside the employee group medical plan.
- Partial salary or wages if the employee is unable to return to work immediately.
- Temporary or modified work assignments if appropriate.

The program’s goal is to ensure that employees receive the financial and medical assistance needed for a speedy and healthy return to work.
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, its 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 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

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

A 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.
Overview of the COPES Program

What Is the COPES Program?

COPES, which stands for Coordinated Outpatient Education and Intervention Services, is a special program designed to help people with chronic or recurring diseases understand and manage their condition. COPES participants work closely with an RN who develops an individualized treatment plan and coordinates care with the primary care physician and other providers.

What Kinds of Help Will I Get From COPES?

When you start in the COPES program, you’ll meet with an RN Program Coordinator to review your status and personal health care goals. The program incorporates the following:

• An educational component, which involves a series of classes to educate you about your condition, how to manage it and how to live as healthful and productive a life as possible.
• A treatment component in which all your care is coordinated by your RN, who reviews your treatment plan with you, helps you navigate the health care system and is available to answer questions and help you problem-solve.
• A coordination component in which the case manager coordinates your care with your health insurance provider(s).

Who Is Eligible to Participate in COPES?

If you are a 4J School District employee or insurance beneficiary between the ages of 18 and 60 and have a complex chronic or recurring condition or disease that is responsive to self-care management skills, you may be eligible.

When Is the Best Time to Start COPES?

The best time to get involved is as soon as you find out about your condition. Learning about what helps your condition—or makes it worse—can make a big difference in your long-term health and prognosis. Having an RN Coordinator who serves as your advocate and guide can also improve your health outlook.
Q & A About COPES

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

A 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.

Q Will my employer and supervisor know that I’m enrolled in the program?

A Not if you don’t want them to know.

Q How long does the program last?

A The active enrollment period, during which 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 determine if more assistance is needed.

Q How do I get involved?

A 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.
Overview of the Flexible Spending Program

What Is the Flexible Spending Program?

The Flexible Spending Program allows you to have a designated dollar amount of your paycheck put aside and held in an account until you need to use it for out-of-pocket health care or dependent-care expenses. The money is deducted before taxes are paid, allowing you to apply 100% of the money you earn and put aside toward eligible expenses.

What Kinds of Expenses Are Eligible?

The following out-of-pocket expenses are eligible:

- Co-pays (physician, prescription, etc.)
- Dental expenses (co-pays or non-covered expenses)
- Vision expenses (glasses, contacts, lasik eye surgery)
- Day-care expenses (This can be more advantageous than the child-care tax credit now offered by the IRS. Other expenses are also eligible.)

More complete information about eligible expenses is available on the web site of Manley Services, the organization that manages the District’s Flexible Spending Plan. Visit the 4J web site at www.4j.lane.edu/hr/rm. Click on “Flexible Spending,” then select “What Kinds of Expenses are Eligible?” This will link to the Manley Services web site information.

Is the Same Amount Taken Out of My Paycheck Every Month?

Yes, you must select a fixed amount that is deducted each month for one year. The amount accumulates during the year and can be used only during the year it is deducted. At the end of the year, you can specify a new monthly deduction amount. Dependent-care and health-care deductions are held in separate accounts, so you must specify the type of expense and amount to be deducted for each category.

How Do I Get Reimbursed?

It’s easy. The District contracts with Manley Services to manage the Flexible Spending Program. When you have incurred an eligible out-of-pocket expense, simply send a reimbursement request form (downloadable from Manley’s web site at www.manleyserv.com), along with your bill or receipts, to Manley Services. (For a reimbursement request form, you may also visit the 4J web site at www.4j.lane.edu/hr/rm. Click “Flexible Spending,” then select “How Do I Get Reimbursed?” This will link to the downloadable form.)

RETIREES
Special Note

The Flexible Spending Program is not available to retirees.
What if I Don’t Use Up All the Money in My Flexible Spending Account During the Year?

This is the tricky part of participating in the program. Any unused money in the account at the end of the calendar year is forfeited, by IRS law, to the employer. For this reason, it is important to carefully analyze your needs. For example, child-care expenses may be very predictable, allowing you to specify an exact amount to be deducted. Health-care expenses may not be as predictable. You can base your deduction on previous years’ expenses, knowing that you can use excess amounts toward the end of the year to buy new glasses or other items you might have waited to purchase.

What Do I Have to Do to Participate?

If you are a current employee, you can participate by signing up during the program’s open enrollment period. The open enrollment period for the Flexible Spending Program is later in the year because the Flexible Spending Program’s plan year runs from January 1 to December 31. For this reason there are no enrollment forms in this packet. You will receive information from the Employee Benefits Office about enrolling prior to the enrollment period. New employees can enroll at the time of hire. (When you complete your enrollment form, ignore the check-off box for the premium deduction plan since Manley does not administer that program for the District.)

If you would like more information about the program before deciding to enroll, visit the Manley web site (www.manleyserv.com) or call Manley Services at 485-7488 and ask for Stan Manley at ext. 102 or Kim Apo at ext. 106.
Q & A About the Flexible Spending Program

Q Is there a cost to participate in the program?

A No. The Flexible Spending Program is a no-cost benefit the District offers its employees to help offset the increasing cost of health care and child care.

Q Should I include the amount withheld from my check for health insurance when I’m calculating how much to contribute to my healthcare flexible spending account?

A No. Insurance premiums are not considered eligible expenses for the healthcare flexible spending account. (This is true of all insurance premiums, whether they are withheld from your paycheck for the district insurance plans or if you pay an outside carrier for an independent plan.) You should only include expenses for the treatment of actual health conditions – no insurance costs of any kind.

Q Once I’m participating, how can I access my account information?

A Once you enroll, Manley will mail you a personal identification number (PIN), which you can use to enter the MyFlex area of Manley’s web site (www.manleyserv.com). This feature allows you to:

- Access information on the most recent reimbursement payments, including payment dates and amounts
- See payment details, including account type and form of payment
- View recently submitted claims along with their payment status
- Check account balances, annual elections and deposits

Q How do I make changes to my account information (address, election amounts, etc.)?

A All changes must be directed to the Employee Benefits Office (EBO) at (541) 687-3491. The EBO will pass along the appropriate information to Manley Services.
Help Section

How to File Claims

How to Resolve a Claims Issue

How to File Out-of-Area Claims

To avoid confusion and delays, include a copy of your OSBA/Regence BCBSO member card or ODS member card with all correspondence and reimbursement requests.

Medical & Vision Claims
OSBA/Regence BCBSO
P.O. Box 1271
Portland OR 97207-1271

Dental Claims
ODS
601 SW 2nd Ave.
Portland OR 97204
How to File a Dental Claim

<table>
<thead>
<tr>
<th>In-Network Provider*</th>
<th>Out-of-Network Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Show your ODS member card when you arrive for your visit.</td>
<td>1. Show your member card when you arrive for your visit.</td>
</tr>
<tr>
<td>2. The dentist will bill ODS directly.</td>
<td>2. Do one of the following:</td>
</tr>
<tr>
<td>3. You will receive an explanation of benefits from ODS that will include the amount you are responsible for paying the dentist. (You do not pay charges over MPA** when you use a Participating Provider.)</td>
<td>A. Ask the provider to bill ODS.</td>
</tr>
<tr>
<td></td>
<td>B. Pay in advance if the provider will not bill ODS and send a copy of the bill to the ODS address on your ODS member card.</td>
</tr>
<tr>
<td></td>
<td>3. After the bill is processed, you will receive an explanation of benefits from ODS that will include the amount you are responsible for paying the dentist. A reimbursement check will be sent if you overpaid. (You are responsible for any charges over MPA**.)</td>
</tr>
</tbody>
</table>

*To determine if a dentist is an ODS Participating Provider, check with your dentist, call ODS Customer Service at 1-888-217-2365 or visit the ODS web site at [www.odscompanies.com](http://www.odscompanies.com). Click on “Provider Search” and then on “ODS Dental Premier Providers.”

**MPA refers to Maximum Plan Allowance for services as determined by ODS. Members are responsible for charges above MPA.

How to File an OSBA/Regence BCBSO Vision Claim

<table>
<thead>
<tr>
<th>OSBA/Regence BCBSO Vision Plan</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Go to any Participating Provider for 100% coverage, up to the Maximum Plan Allowance (MPA). Go to any Non-Participating Provider for 70% coverage, up to MPA.</td>
</tr>
<tr>
<td>2. Show your OSBA/Regence BCBSO member card when you arrive for your visit.</td>
</tr>
<tr>
<td>3. Submit the bill to Regence BCBSO if the provider indicates that he or she does not handle claim billings. (Send the bill to the address on your OSBA/Regence BCBSO member card.)</td>
</tr>
<tr>
<td>4. OSBA/Regence BCBSO will process your claim and send you an explanation of benefits (EOB), which will indicate the amount you owe the provider. The member is responsible for costs above MPA. (Check with your provider about payment policies.)</td>
</tr>
</tbody>
</table>

Refer to the Summary of Vision Benefits (page 3 •1) for information about the number of visits covered annually.

The procedures and coverages above refer only to routine eye care. Other treatment falls under your medical plan.

Questions about anything? Call OSBA/Regence BCBSO Customer Service at 1-800-365-3155.
How to File a Medical Claim: Office and Hospital Visits

| Participating Provider | Non-Participating Provider *
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Office &amp; Specialist Visits</strong></td>
<td><strong>Office &amp; Specialist Visits</strong></td>
</tr>
<tr>
<td>1. Show your OSBA/Regence BCBSO member card.</td>
<td>1. Show your OSBA/Regence BCBSO member card.</td>
</tr>
<tr>
<td>2. The provider will bill OSBA/Regence.</td>
<td>2. Do one of the following:</td>
</tr>
<tr>
<td>3. You will receive an Explanation of Benefits (EOB) from OSBA/Regence. Pay the amount shown as your responsibility (see Section 2, Medical Coverage).</td>
<td>A. If your physician bills OSBA/Regence, wait for an Explanation of Benefits (EOB) from OSBA/Regence.</td>
</tr>
<tr>
<td></td>
<td>B. If your physician asks you to pay in advance, submit the itemized bill to the OSBA/Regence address on your OSBA/Regence BCBSO member card.</td>
</tr>
<tr>
<td><strong>Hospital Visits</strong></td>
<td><strong>Hospital Visits</strong></td>
</tr>
<tr>
<td>1. Check with the referring physician to be sure he or she has pre-authorized the visit.</td>
<td>1. Call OSBA/Regence at 1-800-824-8563 for authorization prior to admission. (You must pre-authorize.)</td>
</tr>
<tr>
<td>2. Show your OSBA/Regence BCBSO member card at the time of your visit.</td>
<td>2. Show your OSBA/Regence BCBSO member card at the time of admission.</td>
</tr>
<tr>
<td>3. You will receive an Explanation of Benefits (EOB) from OSBA/Regence BCBSO. Pay the amount shown as your responsibility (see page 2 • 4).</td>
<td>3. Arrange to pay your deductible, if applicable, and co-insurance by:</td>
</tr>
<tr>
<td></td>
<td>A. Paying the amount shown on the EOB if the provider bills OSBA/Regence.</td>
</tr>
<tr>
<td></td>
<td>B. Paying in advance and receiving reimbursement from OSBA/Regence.</td>
</tr>
</tbody>
</table>

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

For information about filing procedures for employees or retirees traveling or residing out of area, review How to File Out-of-Area Claims (page 7•5).
### How to File a Medical Claim: Emergency Room Visits and Pharmacy

<table>
<thead>
<tr>
<th>Participating Provider</th>
<th>Non-Participating Provider*</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Emergency Room Visits</strong></td>
<td><strong>Emergency Room Visits</strong></td>
</tr>
<tr>
<td>1. Show your OSBA/Regence BCBSO member card at the time you arrive.</td>
<td></td>
</tr>
<tr>
<td>2. The provider will bill OSBA/Regence.</td>
<td></td>
</tr>
<tr>
<td>3. You will receive an Explanation of Benefits (EOB) from OSBA/Regence. Pay the amount shown as your responsibility (see page 2•4).</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Pharmacy Purchases</th>
<th>Pharmacy Purchases</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Show your OSBA/Regence BCBSO member card and make your co-pay or co-insurance payment.</td>
<td></td>
</tr>
<tr>
<td>No benefit for non-participating pharmacies except for emergency care.</td>
<td></td>
</tr>
</tbody>
</table>

*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.

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*Important Note*

For information about filing procedures for employees or retirees traveling or residing outside the OSBA/Regence BCBSO service area, review How to File Out-of-Area Claims (page 7•5).

For dental coverage questions, call ODS Customer Service at 1-888-217-2365.

For medical/vision coverage questions, call OSBA/Regence BCBSO Customer Service at 1-800-365-3155.
How to Resolve a Medical, Vision or Dental Claim

Before contacting anyone, be ready to provide:

- OSBA/Regence BCBSO Member Number and either
- ODS Dental Member Number
- Claim Reference Number or
- Date of Service and Provider

<table>
<thead>
<tr>
<th>To Resolve an Eligibility Issue</th>
<th>To Resolve a Claims Issue</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A. For medical or vision issues, call (800) 365-3155.</td>
</tr>
<tr>
<td></td>
<td>B. For dental issues, call ODS (888) 217-2365.</td>
</tr>
<tr>
<td>If Not Resolved...</td>
<td>If Not Resolved...</td>
</tr>
<tr>
<td>2. A. For medical or vision issues, call Renee McDonald, OSBA/Regence BCBSO Account Executive, at (800) 365-3155, ext. 5408, (Medical/Vision)</td>
<td>3. Call Julie Wenzl, Licensed Benefits Coordinator, at (541) 687-3244.</td>
</tr>
<tr>
<td>B. For dental issues, call Gretchen St. Claire, ODS Account Executive, at (800) 578-1402, ext. 5602. (Dental)</td>
<td>If Not Resolved...</td>
</tr>
<tr>
<td>If Not Resolved...</td>
<td>4. Make an appeal.</td>
</tr>
<tr>
<td>3. Call Julie Wenzl, Licensed Benefits Coordinator, at (541) 687-3244.</td>
<td>A. For medical or vision issues, call (800) 365-3155.</td>
</tr>
<tr>
<td></td>
<td>B. For dental issues, call (800) 337-3962.</td>
</tr>
</tbody>
</table>

NOTE
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: BlueCard Program

Regence BlueCross BlueShield of Oregon, like all BlueCross and BlueShield licensees ("Plans"), participate in the BlueCard Program. This program benefits enrollees who incur covered expenses outside our service area.

For specifics on the BlueCard Program, refer to your Plan Book.

<table>
<thead>
<tr>
<th>Participating Providers</th>
<th>Non-Participating Providers</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Traveling Out of Area</strong>&lt;br&gt;<strong>Participating Provider Emergency/Urgent Care</strong>&lt;br&gt;1. Make arrangements to have your bill submitted to OSBA/Regence by:&lt;br&gt;   A. Asking the provider to submit the bill.&lt;br&gt;   B. Submitting the bill to OSBA/Regence with explanatory information about the nature of the emergency or urgent-care need.&lt;br&gt;2. Receive coverage after deductible. Pay the amount shown as your responsibility (see page 2•4). You are also responsible for charges over MPA.</td>
<td><strong>Traveling Out of Area</strong>&lt;br&gt;<strong>Non-Participating Provider Emergency/Urgent Care</strong>&lt;br&gt;Same as for Participating Provider.</td>
</tr>
<tr>
<td><strong>Residing Out of Area</strong>&lt;br&gt;Same as for Traveling Out of Area</td>
<td><strong>Residing Out of Area</strong>&lt;br&gt;Same as for Traveling Out of Area</td>
</tr>
<tr>
<td><strong>Pharmacy</strong>&lt;br&gt;<strong>Participating Provider</strong>&lt;br&gt;1. Show your OSBA/Regence BCBSO member card and make your co-pay or co-insurance payment. If the pharmacy is unable to process the prescription without payment of service, pay for the prescription and submit the receipt to OSBA/Regence for reimbursement.&lt;br&gt;Note: OSBA/Regence has an extensive nationwide panel of pharmacies, including most major chain stores.</td>
<td><strong>Pharmacy</strong>&lt;br&gt;<strong>Non-Participating Provider</strong>&lt;br&gt;No benefit for non-participating pharmacies except for emergency care.</td>
</tr>
</tbody>
</table>