



Welcome

The ODS Companies (ODS) is dedicated to providing superior service to our customers. Part of superior customer service is providing an easy reference tool to assist group administrators in managing their employees' (also referred to as subscriber) health benefits. This guide is intended to help you do just that.

This guide explains our administrative procedures, your billing statements and forms commonly used by ODS. By illustrating common administrative functions, including enrollment and billing as well as eligibility rules and responsibilities, we hope you this guide will be a helpful tool.

In explaining some of our administrative procedures, we've included some provisions usually included in ODS standard contracts. If any provisions printed in this guide differ from those in your contract, the provisions in your contract or member handbook will apply.

All information is subject to change without notice. However, ODS will make every effort to provide advance notice where appropriate. The ODS website www.odscompanies.com is your best resource for the most current up-to-date information.

The partnership between you, as the group administrator and the ODS Billing and Eligibility Specialist is crucial to accurately and efficiently administer your employees' health benefits. Your Billing and Eligibility Specialist will be able to walk you through any part of the process and answer questions related to enrolling members, billing and payment questions.

At ODS, our goal is to make healthcare easier. One of the best ways to do that is to listen to our group administrators. We welcome your feedback regarding our processes and look forward to working with you.

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Web Resources

ODS provides a wide range of web resources for group administrators and our members. You can reach any of the below online resources by accessing our website at www.odscompanies.com.

The ODS Companies Website

You and your employees can obtain the following:

- Member handbooks
- Provider directories
- Enrollment forms
- Claim forms
- Customer Service telephone numbers
- Overview of medical, dental, pharmacy and vision plans
- Plan administration information

Employer Online Services – For Group Administrators

Employer Online Services (EOS) allows group administrators direct access to ODS' eligibility system. You can access EOS via the ODS website through the "an employer" selection. This exciting service is easy to use, available seven days a week, 24 hours a day, and is available at no additional charge. By accessing Employer Online Services, you can:

- Enroll members
- Order ID cards
- Update address and personal information
- Update primary care physician
- Terminate coverage
- View eligibility
- Update pharmacy eligibility for same-day pharmacy pick-up
- View enhanced reporting for large groups
- Provide current group and plan information, such as provider network information, dependent/student stop ages, probationary periods and much more.

Utilizing this valuable resource makes all of our jobs easier. To get more information on this service, contact our web administrator at enroll@odscompanies.com or by dialing 503-265-5691, toll-free at 1-877-277-7075.

Web Resources Available to ODS Members

myODS

myODS is a customized member website, designed with the member in mind. It allows members to get current, accurate and easy-to-understand information about their ODS health plan. Members can access myODS via the ODS website through the “a member” selection. By accessing myODS members can:

- View claims status and payment information
- View current eligibility for themselves and family members
- View detailed benefit information specific to their plan
- Download the member handbook
- Order ID Cards
- Search for participating providers
- Change their address
- Print Explanation of Benefits (EOB)
- E-mail customer service
- Formulary lookup

NexGen Solutions

ODS provides members access to this service to help them stay healthy and make informed decisions about their healthcare. We understand members need more than their plans information to help them take a proactive and positive approach to healthcare. The following resources are available when accessing NexGen Solutions:

Employee Assistance Program (EAP) provides services to members such as behavioral health counseling, stress management, crisis phone line and health awareness.

eDocAmerica allows ODS members to contact board-certified, licensed physicians by e-mail to discuss health-related issues.

Registered Nurse Advice Line allows members to talk to a registered nurse 24 hours a day, seven days a week who will assist members in making informed decisions about their health issues, discuss potential risk factors and identify treatment options.

Personal HealthRx allows members to access detailed claims and benefit information.

Members can receive more information about NexGen Solutions by visiting the ODS website at www.odskompanies.com.

Eligibility

We recognize knowing and understanding eligibility rules is an important part of providing health benefits to our members. As the group administrator for your organization, administering eligibility means applying all the eligibility rules required per your groups contract to enroll members on the plan. Several resources are available for your reference in applying the eligibility rules including the standard medical and dental handbook, the ODS website, www.odscompanies.com, and your Billing and Eligibility Specialist for specific questions.

The ODS Billing and Eligibility Specialist's role is to assist with managing your members enrollment within the ODS system. At times, it may be necessary for us to contact you to clarify effective dates or to obtain additional information. The partnership and open communication between you and your ODS Billing and Eligibility Specialist is critical to effectively manage your enrollment needs.

Who is Eligible?

Employees

Regular full-time employees are eligible for the employer sponsored insurance-based policy. Each employee must satisfy any required waiting period and must work the minimum number of hours per week required by your group contract.

Spouse

If an employee is married, his/her legal spouse is eligible for insurance. A valid marriage certificate must accompany the enrollment form.

Domestic Partners

If your organization has chosen this option and your employee is enrolling a domestic partner an Affidavit of Domestic Partnership must accompany the enrollment form. This form can be found on our website www.odscompanies.com in the Employer and Member sections.

Dependent Children

Unmarried children are eligible if they are under the maximum child age for your policy and are financially dependent upon the employee for support. Children over the maximum child age may be eligible for coverage if they are

incapable of self-support due to a disability. The following are considered dependent children:

A natural child

Your spouse's or domestic partner's child or adopted child

Children placed for adoption with the employee

A newborn child of a covered dependent for the first 31 days of the newborn's life but only if the employee is financially responsible for both the newborn and the covered dependent

Children related to the employee by blood or marriage for which the employee is the legal guardian (the employee will need to provide a court order showing legal guardianship).

Dependents with Disabilities

Coverage may continue beyond the maximum child age limit specified in the contract for an unmarried, dependent child who cannot support himself or herself because of a developmental or physical disability. The child will continue to be eligible as a dependent if all of the following criteria are met:

The child became disabled before reaching the age limit specified in the contract

The child is incapable of self-sustaining employment because of a developmental or physical disability and is principally dependent upon the employee for support

The employee remains covered under the group plan

The employee furnished ODS with certification of disability from the dependent's healthcare provider indicating date of disability and type of disability prior to the child reaching the age limit specified in the contract.

If all of the above information is provided to ODS, it will be sent to an ODS Medical Consultant that will determine if the child is eligible and whether the disability is temporary or permanent. If the disability is deemed temporary, the employee will be informed of that classification. In addition, the employee will be notified of the date of their child's eligibility and directed to send updated medical information from a physician three weeks prior to the last day of the child's eligibility for recertification to take place. If the disability is deemed permanent, the employee will be informed of that classification.

Declining Coverage

If, at the time of initial eligibility, an employee declines coverage for themselves and/or for any eligible dependent, enrollment will not be accepted until the next open enrollment. In most cases, open enrollment occurs once a year at renewal. It is important that all employees and their eligible

dependents complete their enrollment forms within 31 days of eligibility or they risk not being covered.

Employees and their dependents may be eligible for special enrollment rights, which would allow them to enroll in the plan outside open enrollment. The following are considered special enrollment rights:

- Marriage (a valid marriage certificate is required upon enrollment)
- Birth
- Adoption, (adoption paperwork required upon enrollment)
- Loss of other coverage (a Certificate of Creditable Coverage is required upon enrollment)

Employee's wishing to enroll due to a special enrollment right must enroll within 31 days of the event. If the employee does not enroll within the 31 days, they will not be eligible to enroll until the next open enrollment period.

Enrollment

ODS makes the submission of enrollment data for each specific group as convenient as possible. Group administrators can either submit paper enrollment forms or use Employer Online Services, a web-based enrollment application that is easy to use and secure. For large groups, ODS can receive eligibility electronically. ODS' preferred method of receiving electronic eligibility is the HIPAA 834 format. Please contact your Billing & Eligibility Specialist if you wish to use an electronic format.

Application Process

ODS will provide you with the necessary enrollment forms for your employees. Completion of all information on the form is critical to properly enroll your employees.

ODS must receive signed, dated and fully completed enrollment forms within the 31 day window for an individual to be covered. For specific assistance with eligibility requirements, please see the "Eligibility" section of this guide.

In order to administer the contractual agreement between ODS and your organization, it is important that we receive complete and accurate enrollment information on all members.

While the entire application should be completed, ODS is unable to enroll a member if any of the following **required information is missing**:

- Employee's first and last name
- Dependent's first and last name if applying for coverage
- Employee's Social Security Number
- Birth dates of all members applying for coverage
- Dependent's relationship such as child, spouse, ward, etc.
- Gender
- Address
- Type of coverage
- Group name, group ID, subgroup and class
- Qualifying event, accompanied by required supporting documents;
- Dated signature of the employee
- Date of hire

√ **Checklist**

- Have employee complete an ODS enrollment application.
- Mail the completed enrollment application and any required documentation to ODS.

Note: Application must be signed and dated within 31 days of becoming eligible.

Failure to complete applications correctly or in a timely manner may cause a delay in enrolling a new employee or dependent; we may not be able to enroll the new employee or dependent until the next open enrollment period.

Enrollment forms are available online at www.odscompanies.com or you may contact your ODS Billing and Eligibility Specialist for a supply of forms.

Your ODS Billing and Eligibility Specialist may contact you regarding incomplete information or clarification of information provided. Enrollment will not be completed until all requested information is received.

Using Employer Online Services (EOS)

Group administrators have direct access to the ODS eligibility system. Enrollments such as new member additions, terminations and changes can be made 24 hours a day, seven days a week by group administrators. You can access EOS by going to the ODS website at www.odscompanies.com.

When using EOS, employers must retain all enrollment materials, such as enrollment forms and special enrollment right documentation, for a seven year period and provide ODS with reasonable access to such material. If you do not wish to retain the enrollment material, you may submit it to ODS for retention.

√ Checklist

- Complete an ODS enrollment application.
- Log on to EOS.
- Update Employer Online Services with the enrollment information.
- Mail the completed enrollment application and any required documentation to ODS or retain the documentation of the enrollment for seven years.

Enrollment for Newly Acquired Dependents

Employees must enroll their eligible dependents for coverage within 31 days of their eligibility. The employee's premium may increase with this enrollment change.

Newly acquired dependents that are eligible for the plan are as follows:

New spouse: The employee must complete an enrollment application within 31 days of the date of marriage when adding a spouse. A valid marriage certificate is required upon enrollment. Coverage becomes effective the first of the month following the date of marriage.

Domestic Partner: The employee must complete an enrollment application and submit an Affidavit of Domestic Partnership within 31 days of when the employee and his/her partner have signed the affidavit. Coverage becomes effective the first of the month following the signing of the Affidavit of Domestic Partnership.

Spouse's or Domestic Partner's children: The employee must complete an enrollment application within 31 days of the date of marriage or signing of the Affidavit of Domestic Partnership when adding a new spouse's or domestic partner's children. Coverage becomes effective the first of the month following the date of marriage or signing of the Affidavit of Domestic Partnership.

Newborn children: Newborn children will automatically be insured for 31 days after they are born. To continue coverage, the employee must complete and sign a new application within 31 days of the date of birth listing the new child as a dependent.

Adopted children: Adopted children are eligible for coverage from the date of the adoption decree. However, if a child is placed in the home pending the completion of adoption proceedings, the child will be eligible on the date of placement. The employee must complete and sign a new application within 31 days of the date of adoption or placement of adoption listing the new child as a dependent.

<p>Note: Premium is due for all newly acquired dependents starting with the first date of eligibility.</p>

Once you become aware of a newly acquired dependent, you must:

√ **Checklist**

- ❑ Provide enrollment packet to employee and explain the information in the packet.
- ❑ Ask employee to complete an enrollment application and return it to you for review.
- ❑ Ask employee to provide any required documentation supporting the qualifying event such as a Certificate of Creditable Coverage from previous insurance carrier or Marriage Certificate, if applicable.
- ❑ Forward completed enrollment application and all required documentation to your ODS Billing and Eligibility Specialist.

The new enrollment will be reflected on the following months' bill. Dependent's coverage is effective the first of the month following their eligibility waiting period.

Identification Cards

Each employee who enrolls will receive two identification cards. One card is for the employee and the second is for any covered dependents. It is our highest priority to provide our members with their ID cards as quickly as possible in order to ensure hassle-free receipt of services. Our goal for initial new group enrollment is to mail ID cards within 10 business days of receipt of all enrollment applications. For new employees electing coverage or those making any changes to their coverage that affects their ID card, ODS will mail them a new or updated ID card within three business days.

If additional ID cards are needed, you may access Employer Online Services or call your ODS Billing and Eligibility Specialist. Members may access myODS or call our customer service department to request additional ID cards.

Pre-Existing Conditions (Medical Coverage Only):

Any medical condition diagnosed or treated prior to joining an ODS medical insurance plan may be considered a pre-existing condition. ODS excludes coverage on those conditions for a period of six months unless the member was insured for the entire previous six months without a lapse in coverage of 63 days or greater between loss of coverage under the previous plan and enrollment with ODS.

For a list of conditions, services and supplies subject to the six-month pre-existing exclusion please refer to your member handbook.

Pre-existing Condition – A condition for which medical advice, diagnosis, care or treatment was recommended or received during a six-month period immediately preceding the enrollee’s enrollment date. A condition is considered diagnosed whenever a physician communicates to a person that he or she has that condition. Not all conditions will be treated as pre-existing. Pregnancy is not subject to the exclusion period. For other conditions not subject to the exclusion period please see your member handbook.

Exclusion Period – There is a six month exclusion period for pre-existing conditions. The length of the exclusion period can be reduced or eliminated if the individual has prior creditable coverage.

Creditable Coverage Will Reduce the Exclusion Period – The exclusion period will be reduced for insured individuals who have creditable coverage. Each day of creditable coverage that an individual has will reduce the exclusion period by one day. Any period of creditable coverage that is preceded by a significant break in coverage cannot be used to reduce the exclusion period. Significant break in coverage is defined as a period of 63 consecutive days during all of which a covered person did not have creditable coverage. If a member has continuous medical insurance coverage for six months prior to enrolling into an ODS medical plan, the exclusion period will be eliminated.

For new groups, ODS requests that the group administrator submit a copy of the previous carrier’s final bill. This will be used to apply creditable coverage for your members.

For newly acquired employees and/or members a Certificate of Creditable Coverage may be mailed or faxed along with the enrollment form to ODS to reduce or remove the exclusion period. A Certificate of Creditable Coverage can be provided by the previous insurance carrier.

Making Changes

As employee's lives and work situations change, their eligibility for coverage under your company's ODS plan may change. This section of your manual guides you through the process of maintaining proper records. It also serves as a reference tool enabling you to guide your employee when completing necessary forms. Your assistance ensures that the benefit coverage made available by your company remains in force and accurate throughout an employee's relationship with your company and ODS.

It is important that you keep ODS apprised of such changes and keep employees informed of the effect the changes may have on their benefits coverage. ODS requests notification if one of the following relevant changes occurs in an employee's status.

- Employee has a name change
- Experiences a family status change (new enrollment or terminating dependents). This may be due to a birth, death, divorce or adoption
- New address

Such activity may require:

- Enrolling a new member
- Terminating, converting or transferring coverage
- Changing a home address and contact information
- Issuing a new identification card

You may make the following activity changes by accessing Employer Online Services, having the employee complete, sign and date a new enrollment application or by sending your ODS Billing & Eligibility Specialist the appropriate paperwork.

- Name changes
- Address changes
- Employee and/or member additions
- Terminate coverage for an employee and/or member

To terminate coverage, please list the employee and dependent's name on the group billing change form, see page 30 for a sample of the form. This form is included with your monthly bill. Please submit the form reflecting the appropriate changes with your monthly premium payment. The termination (deletion of coverage) will be reflected on the following month's bill. If the change is processed using Employer Online Services please ensure that the

exact date of termination, (last day of employment) is used. This will ensure the correct termination is reflected in the ODS system.

Your employees may make the following changes by accessing myODS or by calling the ODS Customer Service Department.

- Name changes

- Address changes

Retroactive Eligibility

A retroactive eligibility change occurs when any employee and/or dependent is newly enrolled, reinstated or terminated with an effective date prior to the current or “today’s” date. ODS monitors retroactivity on all groups, regardless of contract type or eligibility administration responsibility. The retroactive time limits may vary by contract type.

Summary of retroactive changes allowed – for group administrator error only

Type of Contract	New Enrollment	Reinstatements	Terminations
Insured/Minimum Premium	Up to 90 days retroactive*	Up to 90 days retroactive	Up to 90 days retroactive
Self-Insured	Up to 12 months retroactive*	Up to 12 months retroactive	Up to 12 months retroactive

* A qualifying event must apply.

A. New Enrollment

Employees must sign, date and submit applications to their group administrator within the time frame in their group’s contract, generally 31 days from a qualifying event or eligible date. Group administrators are responsible for forwarding that information to ODS via an enrollment application upon receipt. The retroactive timelines apply only to cases of delays/errors by the group administrator with a qualifying event and if all other eligibility rules are met. Otherwise, a late enrollee must wait for a qualifying event or open enrollment.

B. Reinstatements

The retroactive reinstatement timelines above apply only if there was a group administrator error in the termination of a member and if all other eligibility rules are met. Otherwise, a reinstatement must wait for a qualifying event or open enrollment.

C. Terminations

An employee and/or dependent may be retroactively terminated back beyond the current month, not to exceed 90 days if there was a group administrator error. Otherwise, coverage ends the month in which ODS received termination notification from the group.

I. PREMIUM IMPACT

If the retroactive addition(s) or reinstatement(s) increase the premium/administration fee, the group needs to pay the additional amount due for the month(s) added.

If the retroactive termination(s) decreases premium/administration fee amount owed, the billing will be adjusted to reflect a credit for the extra premium/administration fee paid. Any claims paid during this time will be reprocessed, not to exceed 12 months.

II. RETROACTIVE PCP CHANGES

On standard contracts, PCP changes are effective the first of the month following notification. Upon request, a PCP change can be made effective back to the beginning of the current month if the member has not received care that month.

When Coverage Ends

When an employee or dependent loses coverage, you must notify ODS no later than 31 days after the date they lose their coverage. Coverage for enrolled dependents ends at the same time the employee's coverage ends.

√ **Checklist**

- ❑ Advise employee of cancellation effective date.
- ❑ Advise employee of options to continue benefits.
- ❑ Notify ODS of termination of coverage ending for the employee.
- ❑ Delete employee and/or members from billing statement.

Coverage ends when one or more of the following occurs:

- Group plan termination, voluntary or involuntary
- Death
- Loss of Eligibility
- Divorce
- When a dependent child becomes ineligible

Group Plan Termination

If the plan is terminated, insurance ends for the employee and any insured dependents on the date the Plan ends.

Death

If an employee becomes deceased, insurance for their insured dependents ends on the last day of the month in which the employee's death occurred. However, surviving dependents may extend their insurance for up to three years if they meet the requirements listed in the "Continuation of Coverage" section of this guide. Remember to notify the surviving dependents of their rights to continue coverage. If they choose to continue coverage, you will need to notify your ODS Billing and Eligibility Specialist.

Loss of Eligibility

If employment terminates, it is your responsibility to notify the terminated employee of their rights to continue coverage through continuation of coverage or a Portability plan.

Insurance will normally end for the employee and all insured dependents on the last day of the month in which termination occurred.

Divorce

Insurance ends on the last day of the month in which the divorce decree is final. Please remember to notify the spouse losing coverage of his/her rights to continue coverage.

When Dependent Children Lose Eligibility

Coverage ends for a covered child on the last day of the month in which the child is no longer eligible due to the following reasons:

Marriage;

Upon reaching the dependent maximum child age as specified in your policy;

No longer financially dependent upon the employee; or

The employee is no longer legally required to provide health insurance for the child.

<p>Note: Remember to terminate any covered dependent children from the ODS plan when they lose eligibility and to notify terminated dependents of their rights to continue coverage through Continuation of Coverage, COBRA or Portability plans.</p>
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Notification Guidelines

It is your employee's responsibility to notify you of any change in dependent's status of eligibility. To avoid retroactive adjustments on your billing statement, you will need to notify your ODS Billing and Eligibility Specialist of the termination, via fax, e-mail, enrollment form or by filling out the billing change form. You may also access EOS to terminate coverage for the dependent child. Any claims paid on retroactive eligibility changes will be reprocessed.

Continuation of Coverage

Employees may be eligible for other coverage either through COBRA, Portability or Oregon Continuation plans if applicable. The circumstance that causes individuals to lose coverage is called a “qualifying event” or “triggering event.” Such events might include the following:

- Covered employee’s termination of employment (including retirement)
- Covered employee’s reduction of hours (including a layoff, strike, etc)
- Death of the covered employee
- Divorce or legal separation of the covered employee from his or her spouse
- Employee drops the spouse in anticipation of a divorce or legal separation (this applies to COBRA only)
- The covered employee becomes eligible for Medicare
- A dependent child ceases to be a dependent child
- Employer bankruptcy (this only relates to retiree plans).

COBRA

The Consolidated Omnibus Budget Reconciliation Act of 1985 and later amendments is a federal law that requires employer group health plans of 20 or more employees (except religious groups) to continue coverage through a COBRA plan. Length of coverage depends on the qualifying event.

Qualifying events, maximum of 18 months of COBRA coverage:

Applies to employee, spouse and children

- Covered employee’s termination of employment; or
- Covered employee’s reduction in hours.

Qualifying events, maximum of 36 months of COBRA coverage:

Applies to spouse and covered children

- Death of the covered employee;
- Divorce or legal separation of the covered employee from his or her spouse;
- The covered employee becomes eligible for Medicare; or
- A dependent child ceases to be a dependent child.

Retirees whose former employer files Chapter 11 Bankruptcy may be eligible for benefits for life.

COBRA laws are specific regarding the process for applying for benefits and payment of the premiums. As the group administrator, you are responsible for providing COBRA election notice to your employees within 60 days of the date of the qualifying event or from the date the plan administrator provides

the COBRA election notice. In addition, you are responsible for notifying ODS within 30 days of the qualifying event and collecting premium from your employee within 45 days after the qualified beneficiary elects COBRA.

Eligible employees and their dependents that elect COBRA will need to pay their monthly premiums directly to you, their employer group. Members must pay their premiums within 45 days of the date they elect COBRA and 30 days thereafter for each month's due date, or coverage will terminate without the option to reinstate.

Your ODS Billing and Eligibility Specialist will work with you to enroll your qualified employees and their dependents under the COBRA coverage.

COBRA premiums are based on the premiums charged to plan participants who are not on COBRA. However, the administrator of the employer group may require the COBRA beneficiary to pay the full cost of the premium (no employer contributions) plus an administrative fee of two percent.

- √ **Checklist**
- Notify member of COBRA eligibility.
 - Notify ODS of triggering event.
 - Collect premium from your COBRA member.
 - Notify ODS if payment is not received.
 - Notify ODS when member terminates coverage.

Premiums may also be increased due to a disability extension. COBRA beneficiaries who are receiving 29 months of coverage due to a disability extension may be charged 150 percent of the premium for the 11 months beyond the first 18 months if the disabled individual is also receiving COBRA benefits.

Employees and/or dependents may be eligible to convert from COBRA coverage to an individual Portability plan. Groups should be prepared to provide information on individual Portability plans to their employees upon request.

Portability

When an ODS member discontinues employment with an employer, he or she may be eligible to continue insurance benefits through a Portability plan. Self-insured groups are not eligible for Portability offered through ODS.

Electing Portability means that an individual, in Oregon, with at least 180 days of continuous group health insurance may continue his or her health insurance coverage by enrolling in an individual policy offered through the employer's insurer.

A member will be notified by ODS of his or her eligibility for an individual Portability product. Portability products are available to an individual terminating his or her group coverage if the employee meets the following requirements:

- ODS group coverage is about to end or has ended within the last 63 days
- Must not be eligible for Medicare
- Must not be eligible for coverage under any other group or individual health benefit plan
- Must have been continuously covered for at least 180 days under group health coverage – with the most recent coverage under an ODS plan
- Must be a resident of the state of Oregon

A person is also eligible if they have at least 18 months of aggregate creditable coverage (group and individual) and the most recent coverage was under a group plan.

Once a member converts their coverage, they become responsible for paying monthly premiums from the date they lost their group coverage.

Note: It is important for you to inform your employees that rates and benefits may differ from those of the current group plan.

Once ODS is notified of a termination, we will send members detailed Portability information.

Groups should be prepared to provide details on COBRA or Oregon Continuation to their employees.

If you have any questions about these options, or if you would like informational material, contact your ODS Marketing Representative.

You may access The ODS Companies website to find more information about our Portability plans.

Continued Coverage Under Oregon State Law

If an Oregon group has 20 or fewer employees, or if an Oregon group is not eligible for continuation coverage under COBRA, described above, members of the group may be eligible to continue group coverage for up to six months under state regulations.

To determine whether you are subject to this requirement, the employer must have had fewer than 20 employees during at least 50 percent of the working days during the preceding year. All employees must be included when determining whether this applies, including full-time and part-time regardless of the number of hours worked.

In order to be eligible for state Continuation Coverage, the member has to complete the application within 31 days of the date coverage would have otherwise ended. In addition, the member is not eligible if they are eligible for Medicare or become eligible for other health insurance coverage after losing coverage under their ODS plan.

Certificate of Creditable Coverage

When an enrollee terminates medical coverage through ODS, a Certificate of Creditable Coverage will be provided indicating the period of effective coverage under their group plan. The employee will need this certificate to show proof of continuous medical coverage when they enroll into a new health plan.

Coverage for Spouses Aged 55 Years and Older

The following is applicable to policies issued in Oregon to employers of 20 or more employees. If a spouse is aged 55 or older and his or her eligibility for insurance ends due to:

- Legal separation
- Divorce
- The death of the employee

The spouse will be entitled to continue his or her coverage (including coverage for dependent children) under this plan. For additional information on this continuation of coverage option, please refer to your member handbook.

In order to move a qualified spouse and any dependents into this coverage, please fill out a billing change form. Under the transfer section, in the description of change field please indicate “continued coverage for spouse aged 55 +”.

Billing

ODS strives to make the billing and premium payment process as convenient and easy as possible. Examples of these documents can be found on pages 28 through 32.

What You Will Receive:

The **Billing Statement** will list all active employees, including COBRA participants covered under the plan. Any new enrollment and terminations that ODS received prior to your bill generating will also be reflected. You will see the subscriber listed for the current month's coverage as well as any other retroactive months of coverage that apply.

The **Billing Summary** provides the premium breakdown by subgroup. The amount due to ODS is listed in the column labeled "Total Due." This is your total premium payment. You will receive two copies of the summary. One copy is to be sent in with the premium payment, the other is for you to retain for your records. We encourage you to pay as billed. Changes will be reflected in subsequent month's bills.

The **Billing Change Form** is a method for you to report to ODS any employee changes such as new enrollment, terminations, changes in subgroups, etc. This allows your ODS Billing and Eligibility Specialist to process the requested changes. The changes will be reflected on the next month's billing statement. While you can complete a billing change form and return it to us with your payment, we prefer you send changes to us as you receive them to enable ODS to generate an accurate monthly bill.

Providing all of your changes as they occur and including a full list of changes with your timely payment will ensure that your records are coordinated with ours each month.

√ **Checklist**

- ❑ Review ODS billing statement.
- ❑ Complete the billing change form for new enrollments, terminations and changes.
- ❑ Pay total due shown on billing summary.



Billing Statement

Group/Subgroup: 10000000 0001

601 SW Second Ave
 Portland, OR 97204-3156
 503-228-6554

Billing Date	For Coverage Beginning
07/07/2007	08/01/2007

Class: 0001 **Description: Company Name**

Subscriber ID #	Subscriber SSN	Employee Name	Coverage Date	Medical	Total
A1111111	999999999	Adams, John	08/01/2007	\$120.00	\$120.00
B2222222	888888888	Brown, Greg	08/01/2007	\$120.00	\$120.00
C3333333	777777777	Gore, Geena	08/01/2007	\$120.00	\$120.00
D4444444	666666666	Jones, Alison	08/01/2007	\$120.00	\$120.00

Total for Class 0001: \$480.00

Class: 0002 **Description: Company Name**

Subscriber ID #	Subscriber SSN	Employee Name	Coverage Date	Medical	Total
E5555555	444444444	Aries, Bob	08/01/2007	\$120.00	\$100.00
F6666666	333333333	Camps, Joe	08/01/2007	\$120.00	\$100.00
G7777777	222222222	Hunt, John	08/01/2007	\$120.00	\$100.00
H8888888	111111111	Young, Sally	08/01/2007	\$120.00	\$100.00

Total for Class 0002: \$400.00

Company Name
 Company Name
 Company Address
 City, State, Zip

Invoice Number: 555555555



601 SW Second Ave
 Portland, OR 97204-3156
 503-228-6554

Billing Statement Totals

Group/Subgroup: 10000000 0001

Billing Date	For Coverage Beginning
07/07/2007	08/01/2007

Group Billing Totals

Benefit Type	Subscriber Count	Subscriber Premium	Dependent Count	Dependent Premium
Medical	8	\$880.00		
Dental				
Vision				
Pharmacy				
Total this bill				
\$880.00				
Outstanding Balance				
\$0.00				
As of 07/07/2007				
Due Date:				
08/01/2007				
Please Pay This Amount				
\$880.00				

Company Name
 Company Name
 Company Address
 City, State, Zip

Invoice Number: 555555555



ODS Billing Summary

10000000

Due Date: 08/01/2007

Bill Date: 07/07/2007

Month of Coverage: 08/01/2007

Bill Summary

Adjustment Worksheet

Group	Subgroup	Current Month Amount	Retroactive Amount	Subgroup Total	Outstanding From Prior Month	Total Due	Adjustments only if making adjusted payment – not if paying in full							
							Adjustments for Adds (+)	Adjustments for Terms (-)	Adjustments for Transfers-Out (-)	Adjustments Transfers-In (+)	Adjusted Total (Total due +/- Adjustments)			
10000000	0001	\$880.00	\$0.00	\$880.00	\$0.00	\$880.00								

Please retain this copy for your records.

Company Name
 Company Name
 Company Address
 City, State, Zip

Invoice Number: 555555555



ODS Billing Summary

10000000

Due Date: 08/01/2007

Bill Date: 07/07/2007

Month of Coverage: 08/01/2007

Bill Summary

Adjustment Worksheet

(Complete only if making adjusted payment – not if paying in full)

Group	Subgroup	Current Month Amount	Retroactive Amount	Subgroup Total	Outstanding From Prior Month	Total Due	Adjustments for Adds (+)	Adjustments for Terms (-)	Adjustments for Transfers-Out (-)	Adjustments for Transfers-In (+)	Adjusted Total (Total due +/- Adjustments)
10000000	0001	\$880.00	\$0.00	\$880.00	\$0.00	\$880.00					

**Please return this summary with your payment in the enclosed envelope.
Please make checks payable to: ODS**

Company Name
Company Name
Company Address
City, State, Zip

Invoice Number: 555555555

Group ID: 10000000		Group Name:		Subgroup ID:		Subgroup Name:	
Billing Change Form for Month of							
Adds (New enrollments, dependent adds, and adding coverage) – Applications Required for Adds							
Subgroup	Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment	
				Total for Adds	\$	\$	
Terms (Termination of subscribers, dependents, or coverage)							
Subgroup	Termination Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment	
				Total for Terminations	\$	\$	
Changes (Changes in eligibility, benefits, or subgroup)							
Subgroup	Change Effective Date	Subscriber Name	Subscriber ID / SSN	Description of Change	Adjustment Amount	Comment	
				Total for Changes	\$	\$	
<p>Instructions: Please total changes by subgroup and transfer the amounts to the ODS Billing Summary form. Return Billing Change Forms and the ODS Billing Summary form with your payment. If you have more changes than this form can accommodate, please copy this form.</p>							

Administrative Premium Payment Information

Payment Due Dates

Since your benefit plan is a prepaid health and/or dental plan, it is important to remember that your payment is due to ODS by the first of each month for respective eligibility periods. If payment is not received by the first of the month, your next month's billing statement will not generate and delinquency may take effect.

<p>Note: Payment for June eligibility is due by June 1. If payment is not received within the 15 day grace period, the contract is subject to termination. Please see the Delinquency section below for more detailed information.</p>

Delinquency

Premium is due on the first day of each month. If premium is not received within the grace period stated in the employer group's contract, the employer group is considered delinquent and coverage may be terminated back to the last day of the month in which premiums were received. Standard contracts reflect a 15-day grace period.

If an employer group becomes delinquent in premium payment, ODS will send a reminder letter to the group prior to the end of the grace period. If premium is not received by ODS by the end of the grace period, ODS may terminate coverage pursuant to ORS 743.560 (1) (©).

When a group is delinquent in premium payment, any claims that are submitted for reimbursement will not be paid. An Explanation of Benefits (EOB) will be sent to the member and provider stating, "Information from the employer has not been received." Once premiums are received and the account is current, previously unpaid claims will be identified and re-processed subject to plan provisions.

Final Bills

Upon termination of coverage, ODS will provide a final bill indicating the ending balance. If there are outstanding premiums owed to ODS, you will have 30 days to remit payment.

If money is owed to your group, a refund check will be requested and mailed within 90 days of the termination with ODS. This will allow for any changes in premium due to retroactive eligibility.

Payment Options

Automated Clearing House (ACH)

ODS provides ACH services to you and it is simple to setup. ACH enables ODS to debit your organization's bank account and receive the payment for services and/or claims automatically on the first working day of each month. Please contact your ODS Billing and Eligibility Specialist for more information.

Lock Box

A bank receives mail at a specified post office box, processes the remittances and deposits them to an ODS account. By sending your payment directly to our lock box it ensures that your payment is posted in a timely manner. ODS will include a return envelope with each month's bill for your convenience.

For medical premium payments please forward your payment to the following address:

P.O. Box 40384
Portland, Oregon 97208-4800

For dental premium payments please forward your payment to the following address:

P.O. Box 4800
Portland, Oregon 97208-4800

Reports

ODS provides several reports to ensure your eligibility records are consistent with our records.

Overage Dependent Report

The Overage Dependent report is generated monthly. This report identifies all dependents that will reach the maximum child age within the next 60 days. This report also provides an anticipated termination date, if the dependent will reach the student maximum age or if the appropriate dependent certification is not received.

- √ **Checklist**
- ❑ Review overage dependent list.
 - ❑ Follow up with employees to ensure they return the letter to ODS.

As you receive this report, your employees who have dependents meeting the criteria above will receive a Student Certification letter to be completed on behalf of the respective dependent. The employee must sign, date and return the letter to ODS prior to the last day of the month of the dependent's child age maximum in order to remain eligible under your ODS policy.

- √ **Checklist**
- ❑ Complete the information on the Student Certification letter.
 - ❑ Sign, date and return it to ODS before the end of the month.

In the event that ODS does not receive a completed student certification letter and the dependent is no longer a full-time student, or the dependent is reaching the student maximum age, coverage for the dependent will end on the last day of the month in which he or she reaches the maximum age. An overage dependent with a disability, who on their behalf has had the proper physician certification supplied and has been approved by ODS, will not be included in the Overage Dependent report.

Subscriber Member Report

The Subscriber member report lists eligible members in ODS' system. This report is helpful to use for auditing purposes to ensure your eligibility records and ODS' eligibility records match. You can request this report from your ODS Billing and Eligibility Specialist.

Subscriber ID Numbers

In an effort to protect the privacy of our members, The ODS Companies will assign a non Social Security Number ID (SSN) to each subscriber. The new subscriber ID will be alpha numeric. Example: A1234567.

ODS will continue to receive and retain the SSN for all new and existing subscribers. The SSN will be utilized for internal purposes only and will be suppressed on all external communications with the exception of your ODS billing statement. Your billing statement now has the option of listing Social Security Numbers and/or non Social Security Numbers. Please inform your Billing and Eligibility Specialist which option you prefer. This is beneficial if a member forgets their alternate ID and needs assistance from our customer service team. By maintaining both numbers, ODS can ensure the timely processing of claims, should a provider inadvertently continue to bill under the SSN number. Since ODS assigns the new ID, our system supports the ability to go back and forth between the two numbers to ensure members receive the same level of service.

Turn Around Times

At ODS we strive for excellence in all we do. It is our intention to always provide you with the best customer service. To help us achieve our goal, we have outlined below the standard turn around times for forms and materials submitted to ODS.

Enrollment Forms: Enrollment information will be entered into the ODS system within two business days from the date we receive the forms in our office.

ID Cards: Identification cards will be mailed to the subscriber within three days from the date ODS receives a request.

E-mail Response Time: If you have requested a response to your e-mail, you can expect a return e-mail within 24 hours.

Phone Response Time: You should receive a call within four business hours of having called ODS, either by the end of the day or by noon of the following day, depending upon when you called. If the person you are calling is out of the office, their voice mail will direct you to a team member who has been cross trained as a backup and is familiar with your account. There will always be someone at ODS that can assist you with your questions.

BenefitHelp Solutions

The ODS Companies offers a variety of services to our key customers. BenefitHelp Solutions, an ODS subsidiary, provides full third-party administration services such as Flexible Spending Account (FSA) and COBRA administration. Since BenefitHelp Solutions is an ODS subsidiary, your ODS Billing and Eligibility Specialist and your BenefitHelp Solutions Member Specialist will work in tandem to ensure a smooth transition for your employees to a COBRA policy. For further information please contact your ODS Marketing Representative or refer to www.benefithelpsolutions.com.

Terminology

Automated Clearing House (ACH): Electronic transfer of funds used for monthly premium payments.

Billing change form: Form used by employers to report eligibility changes.

Billing summary: Document sent to employer groups providing a grand total by subgroups and due date for the month billed.

Carrier: An insurance company.

COBRA: Consolidated Omnibus Budget Reconciliation Act of 1985. A federal law that requires employer group health plans of *20 or more* employees to allow people whose coverage would ordinarily end under their group plan to continue coverage under the plan for certain qualifying events.

Continuation: Oregon state insurance law requires that group medical policies allow individuals and their dependents, whose coverage would ordinarily end under their group plan, to continue coverage for up to six months in certain situations. This is called Continuation Coverage and applies to employers who have *fewer than 20* employees.

Coordination of Benefits (COB): An insurance provision whereby responsibility for primary payment for medical services is allocated among carriers when a person is covered by more than one employer-sponsored insurance plan. Also referred to as “other insurance.”

Covered services: A service or supply that is specifically described as a benefit in the Plan.

Dependents: Any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Dual Coverage: Coverage for a member by two or more insurance plans at the same time. Typically, benefits will be coordinated between the two plans.

Eligibility: The determination of whether an individual has insurance coverage at a given point in time.

Eligibility waiting period (also called a probationary period): The period that must pass before the individual is eligible to enroll for benefits under the terms of the plan.

Enrollment: Information confirming that an individual is enrolled in a health insurance plan. Also, the total number of persons covered by the plan.

Lock box: A bank that receives mail at a specific post office box, processes the remittance and deposits them to an ODS account.

Member: A member is defined as the person or persons who are covered under the policy. This term includes the subscriber and covered dependents.

Open enrollment: A specified time period in which subscribers have the opportunity to make changes to their health coverage. During this time period, individuals who are not covered can subscribe without showing evidence of insurability.

Portability: A state mandated plan with specific eligibility requirements, directing that an individual, in Oregon, with at least 180 days of continuous group health insurance, may continue his or her health insurance coverage by enrolling in an individual policy offered through the employer's insurer.

Premium: The cost a group or individual pays for health insurance coverage.

Primary care physician (PCP): Is the participating physician, or women's healthcare provider, whom an individual chooses to be responsible for their continuing medical care.

Provider: Any entity or professional that provides patient care, including a hospital, physician or rehabilitation center.

Qualifying event: An event that causes an individual to lose his/her insurance coverage. For COBRA also known as a triggering event.

Retroactivity: A change to employee/subscriber benefits that has an effective date prior to today's date. Changes include additions, reinstatements and terminations. ODS monitors retroactivity on all groups, regardless of contract type or who administers eligibility. The retroactive time limits vary by contract type (insured or self-insured).

Self funded (also known as Administrated Services Only (ASO): An arrangement between an employer and ODS where ODS provides administrative services (such as the processing of medical claims or communication of benefits to subscribers) to the employee's of the employer. The employer is responsible for paying the cost of the healthcare service provided.

Special Enrollment Right: A qualifying event that makes an individual eligible for a change in benefits.

Subscriber: Usually the term to describe the employee on group policies. For individual policies, subscriber is the term used to describe the policyholder.

Third-party administrator (TPA): An administrative organization, other than the employee benefit plan or healthcare provider, that collects premiums, pays claims, and/or provides administrative services to providers, provider networks, employers or other groups of insured patients.