



City of Portland Employee Wellness

2012/2013 City of Portland PPA Benefit Handbook



Common Health Plan Terms & Definitions

Chemical Dependency (including alcoholism) means a substance-related disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR), except for those related to foods, tobacco, or tobacco products.

Coinsurance: Coinsurance refers to money that a member is required to pay for services, after a deductible has been paid. Coinsurance is often specified by a percentage. For example, the employee pays 20 percent toward the charges for a service and the employer or insurance company pays 80 percent.

Copayment: Copayment is a predetermined (flat) fee that a member pays for health care services, in addition to what the insurance covers. For example, Kaiser requires a \$10 "copayment" for each office visit, regardless of the type or level of services provided during the visit. Copayments are not usually specified by percentages.

Creditable Coverage means a member's prior healthcare coverage including coverage remaining in force at the time a member obtains new coverage under any of the following:

- a. A group health plan;
- b. Individual insurance coverage including student health plans;
- c. Medicare Part A and B;
- d. Medicaid, other than benefits consisting solely of benefits under Section 1928 (pediatric vaccines);
- e. Tricare;
- f. A medical care program of the Indian Health Service or of a tribal organization;
- g. A State high risk pool;
- h. Federal Employees Health Benefit Plan (FEHBP);
- i. A public health plan (as defined in regulations);
- j. Children's Health Insurance Program (CHIP); or
- k. A health benefits plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Some plans that provide medical care coverage do not qualify as creditable coverage. Such plans are called excepted benefits. The following plans are excepted benefits:

- a. Coverage only for accident, or disability income insurance, or any combination thereof.
- b. Coverage issued as a supplement to liability insurance.
- c. Liability insurance, including general liability insurance and automobile liability insurance.
- d. Workers' Compensation or similar insurance.
- e. Automobile medical payment insurance.
- f. Credit-only insurance.
- g. Coverage for on-site medical clinics.
- h. Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance.

Deductible: The amount a member must pay for health care expenses before insurance (or a self-insured plan) covers the costs. For the City plans, the deductible is an annual amount and must be met each year.

Dependents: Spouse, domestic partner and/or eligible children (whether natural, adopted or step) of an employee participant.

Emergency Services means those healthcare items and services furnished in an emergency department of a hospital, all ancillary services routinely available to the emergency department to the extent they are required for the stabilization of a member, and within the capabilities of the staff and facilities available at the hospital, such further medical examination and treatment as are required to stabilize a member.

Exclusion Period means a period during which specified treatments or services are excluded from coverage.

Exclusions: Medical services that are not covered by the health plan.

Group Eligibility Waiting Period means the period of employment with City of Portland that a prospective enrollee must complete before coverage begins.

In-Network: Providers (physicians and other healthcare professionals) or health care facilities which are part of the health plan's network with which it has negotiated a discount. Members usually pay less when using an in-network provider.

Health Benefit Plan means any hospital and/or medical expense policy or certificate, healthcare service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement, or other benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended

Late Enrollee means an eligible employee and/or any eligible dependent who enrolls subsequent to the initial enrollment period during which they were eligible for coverage but declined to enroll. A person is not a late enrollee if:

- a. The person qualifies for special enrollment as described in section [11.4][12.4];
- b. A court has ordered that coverage be provided for a spouse or minor child under a subscriber's health benefit plan and request for enrollment is made within 30 days after issuance of the court order;
- c. The person is employed by an employer who offers multiple health benefit plans and the person elects a different health benefit plan during an open enrollment period; or
- d. The person's coverage under Medicaid, Medicare, Tricare, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days prior to applying for coverage in a group health benefit plan.

Limitations: A limit on the amount of benefits paid for a particular covered expense.

Maximum Plan Allowance (MPA): is the maximum amount that ODS will reimburse providers.

For an in-network provider, the MPA is the amount the provider has agreed to accept for a particular service.

MPA for an out-of-network provider is the lesser of the amount payable under any supplemental provider fee arrangements ODS may have in place and the 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database.

If a dollar value is not available in the national database, ODS will consider 75% of the billed charge as the MPA. In certain instances, when a dollar value is not available in the database, the claim is reviewed by ODS' medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above.

MPA for emergency services by an out-of-network facility is the greatest of the median in-network rate, the maximum amount as calculated according to this definition for out-of-network facility and the Medicare allowable amount.

When using an out-of-network provider, any amount above the MPA is the member's responsibility.

Medical Services Contract means a contract between an insurer and an independent practice association or a provider. Medical services contract does not include a contract of employment or a contract creating legal entities.

Member means a subscriber, dependent of a subscriber or a person otherwise eligible for a group health benefit plan who has enrolled for coverage under the terms of the Plan.

Mental Health refers to benefits, facilities, programs, levels of care and services related to the assessment and treatment of mental illness, as defined in the Plan.

Mental Illness means all disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR) except for:

- a. Mental Retardation,
- b. Learning Disorders,
- c. Paraphilias,
- d. Gender Identity Disorders in members age 19 or older, and
- e. V-Codes, (this exception does not extend to members 5 years of age or younger for diagnostic codes V61.20, V61.21, and V62.82).

Network: A group of doctors, hospitals and other health care providers contracted to provide services to health plan members for less than their usual fees. For the City plans, the networks offered are the ODS Plus Network/Private Healthcare Systems (PHCS) Network and the Managed Healthcare Northwest (MHN) Network.

Out-of-Network: Refers to physicians, hospitals or other health care providers who are not participants in the plan's networks. Expenses incurred by services provided by out-of-network health professionals may not be covered (Kaiser), or covered after a higher deductible and coinsurance (City plans). You pay more when you use out-of-network providers.

Out-Of-Pocket Maximum: The amount of money that a member must pay out of their own pocket before the plan will pay 100 percent for a member's health care expenses.

Outpatient Mental Health Treatment Episode means a sequence of outpatient visits to a single professional provider, with no interval of 60 or more days without a visit.

Partial Hospitalization or Day Treatment means an appropriately licensed mental health or chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day.

Prior Authorization or Prior Authorized: Approval by ODS for a person to be admitted to a hospital, in-patient facility, partial hospitalization or residential program granted prior to the admittance and for other services rendered. The goal of prior authorization is to ensure that members do not receive services that are not covered by the plan, including services that are not medically necessary. A complete list of services that require prior authorization is available on myODS or by contacting ODS' Customer Service.

Provider means an entity, including a facility, a medical supplier, a program or a professional provider, that is state licensed and approved to provide a covered service or supply to a member. The term "provider" does not include any class of provider not named, and no benefits of the Plan will be paid for their services unless otherwise stated.

Residential Program means a state-licensed program or facility providing an organized full-day or part-day program of treatment. Residential programs provide overnight 24-hour per day care and include programs for treatment of mental illness or chemical dependency. Residential program does not include any program that provides less than 4 hours per day of direct treatment services.

Subscriber means any employee or former employee who is enrolled in the Plan.

CITY OF PORTLAND EMPLOYEE BENEFITS

Welcome to the City of Portland employee benefits program. Every effort has been made to provide a complete and accurate description of the plans. The employee benefits described in this summary are a very important part of your total compensation package from the City of Portland. The benefit program is designed to assist you in maintaining your and your eligible dependents' good health and personal financial security.

**The Federal Newborns and Mothers' Health Protection Act of 1996
Federal Women's Health and Cancer Rights Act of 1998**

Please review information on your rights provided under the Federal Newborns and Mothers' Health Protection Act of 1996 and Federal Women's Health and Cancer Rights Act of 1998 on page 104 of this Handbook.

This Benefit Handbook is designed to provide a quick reference tool for information about the healthcare, life and disability plans and does not imply or constitute an employment agreement. Contracts and other legal documents govern the administration of each plan and any of the plans may change or be replaced or terminated by the City of Portland and any affected bargaining units. In the case of a dispute regarding benefits, the contract or plan document will determine your actual benefits.

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CITY OF PORTLAND EMPLOYEE PLANS AND BENEFITS

The City's benefit program includes a "cafeteria plan" that qualifies under Internal Revenue Code Section 125. This allows you to pay your premium contributions, when applicable, on a pre-tax basis. It also requires that the City adhere to IRC Section 125 regulations concerning such terms as when you may make changes to your elections each year. This means you have to make new elections every year for the pre-tax Medical Expense Reimbursement Plan (MERP) and Dependent Care Assistance Plan (DCAP.) You'll find further information about these terms in this Handbook in the Mid-Year Changes to Enrollment, Qualifying Family Status Changes and Other Status Changes sections. Your premium contributions are automatically deducted on a pre-tax basis. Do not add these costs to your MERP elections.

Health benefits include Medical/Vision and Dental coverage for you and your eligible dependents. Full-time employees pay 5% of the premium costs for these plans. Basic Life Insurance premiums are paid in full by the City of Portland for full-time employees. Eligible part-time employees may elect the City's Medical/Vision and Dental plans. Part-time employees are responsible for paying 50% of the premiums for these plans, in addition to 50% of the cost of Basic Life Insurance, which cannot be waived.

Both full and part-time employees are eligible for several voluntary programs, including Supplemental Life Insurance and pre-tax MERP & DCAP participation.

The City of Portland is committed to providing options so you may readily access quality health care. However, the City is not responsible for the quality of health care received by plan members or for charges in excess of what the applicable plan allows. The City is also not responsible for any claim or damages associated to injuries resulting from medical, dental or vision services or supplies.

Health Insurance Portability and Accountability Act (HIPAA)

Please note that the HIPAA notice addressing privacy issues can be viewed starting at page 114.

Benefit Plan Year

The City of Portland offers you and your family benefit coverage, which protects you against significant health care expenses. Your health care coverage is designed to help you receive the most value for your health care dollars. All of the City of Portland's benefit plans start each year on July 1 and end the following June 30. You can change your benefit plan selections each year during the annual enrollment period and also as a result of qualifying family status outlined later in this summary.

Remember you must notify the Benefits and Wellness Office within 60 days of any changes in family status that result in a current enrollee no longer qualifying for City coverage. Similarly, at any time other than the annual open enrollment period, the addition of any qualified dependent to your benefit coverage must be made within 60 days.

Accuracy of Enrollee Information & Enrollee Eligibility Audit

As we all work toward managing the City's overall health plan costs, it's important that only individuals eligible for City paid benefits are actually enrolled. By paying the costs of only those who should be enrolled, the overall costs are reduced and the long term increases are moderated. This helps make coverage more affordable for active employees, the City and retirees who pay the full cost for their benefits. It is also very important that when someone no longer qualifies for City paid coverage such as a dependent no longer eligible because of age or as a former spouse, the person has the opportunity to continue benefits through COBRA. If the City is not notified within 60 days of a change in family status, the member is no longer eligible for City plans. For reasons such as these, the City will conduct a random audit of employees and dependents to review whether spouses/domestic partners and children are eligible for coverage. Selected employees will be asked to provide information to confirm the dependents met the City's eligibility requirements. If the information is not provided, the employee may be responsible for claims paid on the dependent's behalf and disciplinary action may be taken, up to and including termination of employment.

NEW FOR 2012-13 PLAN YEAR

The City of Portland values your overall health and wellness. The following changes will take effect on July 1, 2012. Any plan design changes required under the Health Care and Education Affordability Reconciliation Act of 2010 will be implemented on the effective dates compliant with the legislation.

CityNet Plan Network Change

The ODS Plus Network now includes Portland Adventist Medical Center. The ODS Plus network now covers all the major hospital centers, including Legacy, Providence, OHSU and now Portland Adventist. Keep in mind that when your doctor refers you to a lab or radiology clinic, that facility must be within your chosen network to receive the in-network benefit levels. If it's not, you will need to pay the higher out-of-network deductible and copays. Because the ODS Plus network is more extensive than MHN's (which includes Legacy and Portland Adventist providers), there are more facilities available through ODS Plus.

Flexible Spending Accounts

- Medical Expense Reimbursement Plan (MERP) limit reduced to \$2,500 annually due to new IRS limits

ODS Dental Plan

- Complete series x-rays or a panoramic film is covered once in any 5-year period.
- Supplementary bitewing x-rays are covered once in any 12-month period
- Topical application of fluoride is covered once in any 6-month period for members age 18 and under. For members age 19 and over, topical application of fluoride is covered once in any 6-month period* if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).
- Cast restorations such as crowns, onlays and lab veneers (including pontics) are covered once in a 7-year period on any tooth.
- A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
- Concerning implants:
 - o The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
 - o Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (only once in any 7-year period); or
 - o The final implant-supported bridge abutment and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 7-year period;
 - o Implant-supported bridges are not covered if one or more of the abutments is supported by a natural tooth;
 - o These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.
- An athletic mouthguard is covered once per year for members age 15 and under and once every 2 years age 16 and over.

2012-13 Benefit Costs & Employee Premium Shares

The City of Portland contributes 95% for medical/vision and dental premium costs for full-time employees for the CityNet medical, dental and vision plans. You will contribute 5% of the cost. For the Kaiser Plans, full time employees pay the difference of the cost of the Kaiser premium and the City's cost for the CityNet plan. This year there is no charge to full time employees for the Kaiser plan. The following table shows the total cost of these benefits and provides employee premium share amounts for plan year 2012-13:

Plan	Total Monthly Benefit Costs		
	Single	Two-Party	Family
CityNet Medical, VSP Vision & ODS Dental	\$702.40	\$1371.94	\$1889.94
CityNet Medical, VSP Vision & Kaiser Dental	\$692.51	\$1354.48	\$1852.12
Kaiser Medical, Vision & Dental	\$569.58	\$1113.59	\$1533.61
Kaiser Medical, Vision & ODS Dental	\$579.47	\$1131.05	\$1571.43
Plan	Your Contribution Per Pay Period (Full Time Employees)		
	Single	Two-Party	Family
CityNet Medical, VSP Vision & ODS Dental	\$17.57	\$34.30	\$47.25
CityNet Medical, VSP Vision & Kaiser Dental	\$17.32	\$33.86	\$46.31
Kaiser Medical, Vision & Dental	\$0	\$0	\$0
Kaiser Medical, Vision & ODS Dental	\$0	\$0	\$0
Plan	Your Contribution Per Pay Period (Part Time Employees)		
	Single	Two-Party	Family
CityNet Medical, VSP Vision & ODS Dental	\$175.59	\$342.98	\$472.48
CityNet Medical, VSP Vision & Kaiser Dental	\$173.12	\$338.62	\$463.03
Kaiser Medical, Vision & Dental	\$142.39	\$278.40	\$383.40
Kaiser Medical, Vision & ODS Dental	\$144.86	\$282.76	\$392.85

Important Contacts

Making sure your benefit questions are answered is important to us. We realize, however, that it is not always possible for you to call during business hours or for the Plan Administrators and the Benefit Office to be available when you call. To help you get the answers you need, you can access your personalized benefit information on our BenefitsOnline website, at www.citybenefits.com (desktop icon in Police Bureau.) You may also call the Benefit Information Line for answers to some frequently asked questions, or you can send an email to HR, Benefits (*be sure to include the space between the comma and the word Benefits*). If you call the Benefit Information Line at 503-823-6031, please leave a message with your name, your questions, your daytime phone number, and the best time to reach you. A Benefit Team member will return your call. Alternatively, you may call the vendor directly at the customer service number(s) listed below:

For...	Contact the following...
City benefit plan information	Personalized benefit information at www.citybenefits.com Benefit Information Line: 503-823-6031 Email: HR, Benefits (internal) or mailto:benefits@portlandoregon.gov (external)
CityNet Medical Plan Customer Service	503-243-3974 or 1-877-337-0649 For inquiries, claims submission or appeals : Medical Claims P.O. Box 40384, Portland, OR 97240-0384 Claims history may be viewed online at www.odskompanies.com/members
ODS Dental Plan Customer Service	503-265-5680 or 1-877-277-7280 Submit claims to : Oregon Dental Service 601 SW Second Avenue, Portland, OR 97204 To look for providers, go to : www.odskompanies.com/members
CityNet Healthcare Services (for prior authorization)	Call 503-243-4496 or 1-800-258-2037 Inpatient or residential Mental Health or Chemical Dependency prior authorization call 503-624-9382 or 1-800-799-9391
CityNet Disease Management & Health Promotion	503-948-5548 or 1-877-337-0649
CityNet Mental Health or Chemical Dependency	503-624-9382 or 1-800-799-9391
ODS/PHCS network choice ODS Plus Network provider directory PHCS Network provider directory	http://www.odskompanies.com or 503-243-3974 - For out of area participating providers, call PHCS at 800-354-8486 or go to www.phcs.com
MHN MHN Network provider directory Healthy Directions Network provider directory	www.mhninc.com or 503-413-5800 or 503-243-3974 - For in-network providers outside the MHN network, call Healthy Directions at 800-678-7427 or go to www.multiplan.com
ODS alternative care providers <i>All CityNet members must use the ODS Plus network to access in-network alternative care (eg. chiropractors, naturopaths and acupuncturists.)</i>	503-243-3974 or 1-877-337-0649 http://www.odskompanies.com/provider_search.html
Prescription drugs (ODS Pharmacy Network)	ODS – 503-243-3960 or 1-888-361-1610 Mail Order Customer Care - 866-487-8744 www.walgreensmail.com
Kaiser Medical Plan, Kaiser Dental Plan, and Kaiser Vision Plan	503-813-2000 or www.kaiserpermanente.org <i>For 24 hour advice nurse:1-800-813-2000</i>
VSP (Vision Service Plan)	1-800-877-7195 or http://www.vsp.com/ Submit out of network vision claims to: VSP, 3333 Quality Drive, Rancho Cordova, CA 95670
BenefitHelp Solutions: Flexible Spending Accounts (FSA) Administration for Medical Expense Reimbursement Plan (MERP) and Dependent Care Assistance Plan (DCAP)	503-219-3679 or 1-888-398-8057 www.benefithelpsolutions.com Fax 1-888-249-5058
EAP: Employee Assistance	www.cascadecenters.com 1-800-433-2320

WHEN COVERAGE BEGINS

Employee Eligibility

Employees are eligible to participate in various benefit plans as set out in collective bargaining agreements, City Administrative Rules, Oregon state statutes and the Plan documents. Eligibility for the Portland Police Association is as follows:

- **Portland Police Association (PPA) full time employees** become eligible to participate in City benefit plans on the first of the month following thirty (30) days of eligible employment in a benefits eligible job class and full-time employment status.
- **Portland Police Association (PPA) Part-time employees** become eligible the first of the month following 174 hours of continuous eligible employment in an eligible job class and part-time employment status.

Continuing Eligibility

City paid benefits will continue for employees each month in which they are actively employed in an eligible job class and employment status (e.g., full-time or part-time) or in a qualified leave status from the City of Portland and they make the required premium contribution. Employees who are on non-paid Military Leave or personal leave without pay do not receive City paid benefits. (See page 92 for a description of the military leave continuation provision.) Any required catch-up premium contribution(s) will be deducted from the first paycheck the employee receives upon returning to paid status.

Unless otherwise required by law or applicable labor agreement, PPA employees must be **paid** at least eighty (80) hours in a calendar month for continued eligibility in a City benefit plan in the following month. The 80 hours of pay must consist of regular work hours, vacation, sick, holiday, jury duty pay or comp time paid for absence from regular work hours. No other type of pay or benefit applies to make up the hours required. For example, lump sum vacation or sick leave payments at retirement or termination, disability payments from the Fire and Police Disability, Retirement and Death Benefit Plan or payments made pursuant to a long term disability plan do not count towards the 80 hour requirement.

Employees who become ineligible for participation in City benefit plans will have the right to continue coverage on a self-pay basis in accordance with state and federal law and any applicable labor agreement.

FMLA, Workers Compensation, Loss of Service or Military Leave Continuation

For information about continuing eligibility during an approved Family or Military Leave, see page **92**. In addition, City paid benefits may continue during an approved work-related disability or other leaves as described in collective bargaining agreements and the City Administrative Rules.

Dependent Eligibility

Active employees, retirees or COBRA participants may enroll their eligible dependents in the City's medical/vision, dental, employee assistance and supplemental life insurance plans. Eligible dependents are limited to:

- **Legal spouse as recognized by the employee's state of residence.** A divorced or legally separated spouse **is not eligible** for coverage as a dependent;
- **Domestic partner**, as defined and declared in the City of Portland's Domestic Partner Affidavit or who is a registered domestic partner as per the Oregon Family Fairness Act of 2007.
- **A child under the age of 26 who is not in active military status**, including the subscriber's:
 - natural child,
 - stepchild,
 - child who is required to be covered by the subscriber or the subscriber's spouse as a result of divorce decree or court order to provide coverage,
 - adopted child or child placed for adoption,

- other child for whom the employee is the court-appointed legal guardian,
- eligible child of an enrolled domestic partner (as declared on the Domestic Partner Affidavit).
- **A newborn child of an Enrolled 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 enrolled dependent. After 31 days, the child of your Enrolled Dependent may be covered only as long as the child's parent is the Employee's eligible and Enrolled Dependent and both grandchild and birth parent reside in the Employee's home.
- **Incapacitated and dependent children** may be covered past the qualifying age of 26 if the incapacitating condition existed prior to the child's first birthday after the qualifying age. An incapacitated child is one who is incapable of self-support because of mental or physical disability. For the purpose of this handbook, mental incapacity means intellectual competence usually characterized by an IQ of less than 70, and physical incapacity means the inability to pursue an occupation or education because of physical impairment. **The disabled child will be covered as long as the child has a Determination of Disability under the Social Security Act, continues to reside with and be primarily supported by the employee.**

Proof of a dependent's initial eligibility and continued eligibility may be requested at any time. Enrollees must be able to provide proof of eligibility for continued coverage. Failure to provide proof of dependent status will result in loss of dependent coverage.

Coverage for eligible dependents becomes effective the first of the month following or coinciding with the later of: (1) the effective date of the employee's coverage, (2) the date the individual becomes a dependent or (3) the date the employee submits completed enrollment forms (or enrolls online) and provides all required documentation to the Benefit Office. The City of Portland does not provide health care coverage for family members not listed above, such as parents or siblings of employees.

State Income Tax and Domestic Partners – Important Health Benefit Coverage Tax Information

Registered Same-Sex Domestic Partners: The cost of benefits provided to same-sex domestic partners registered in the State of Oregon is not taxable for state income tax purposes. Accordingly, the City does not withhold **state** tax for the taxable amount of the benefits provided to registered same-sex domestic partners from your paycheck.

Opposite-Sex and unregistered Same-Sex Domestic Partners: **The State Department of Revenue requires that the value** of benefits provided to opposite-sex and unregistered same-sex domestic partners is taxable income. Accordingly, the City will withhold **state** tax from your paycheck for the amount of the benefits provided to opposite-sex and unregistered same-sex domestic partners that is taxable income.

Federal Income Tax and Domestic Partners

Generally, the Internal Revenue Code considers the cost of benefits provided to domestic partners and same-sex spouses to be taxable income. Hence, for federal tax purposes, the value of health insurance coverage for an employee's domestic partner or same-sex spouse is includable in the employee's federal taxable income unless the domestic partner or same-sex spouse qualifies as the employee's dependent. Because the federal government still considers these benefits as taxable income, the City withholds federal tax for the taxable amount of the benefits from your paycheck. With respect to whether your domestic partner or same-sex spouse qualifies as a dependent, you should consult with your tax adviser to determine whether you qualify. You must complete yearly certification with the City to claim your domestic partner as a tax dependent.

Enrollment Basics

What You Need to Do During *Initial* Enrollment

1. Review the medical/vision plans, Preferred Provider Organization (PPO) network options, and dental plans. Determine which plans and PPO network best meet your needs. (Be sure to check the providers and hospitals.)
2. Carefully estimate your out-of-pocket healthcare and dependent care expenses if you want to participate in the pre-tax flexible spending accounts (MERP and/or DCAP) for the plan year.
3. Review your enrollment instruction materials.
4. Go to BenefitsOnline at www.citybenefits.com (desktop icon in Police Bureau) to enroll in your benefits. You must enroll by the deadline date on your enrollment worksheet. If you have enrolled after the first of the month in which you were eligible for City paid benefits, your coverage will be retroactive back to the first of the month in which you were eligible. If you have missed a premium contribution, your contribution will be charged to you, in addition to your regular premium share contribution, on the first available payroll period. You must submit documentation for domestic partners, spouse and children within 30 days of your online enrollment.
5. When you save your online enrollment, you have the option to print a Confirmation statement, or have one sent to you via email. Your enrollment elections are available to you on the online system to make and or change your elections through the deadline date.

Default Benefits: If You Do Not Complete Your Initial Benefits Enrollment Elections

If you do not complete your enrollment through BenefitsOnline at www.citybenefits.com by the date indicated on your enrollment worksheet, you will be assigned default benefits as follows:

Full-Time Employees:

- You will automatically be enrolled under the CityNet PPO Medical with the Vision Service Plan. In addition, you will be enrolled in the ODS Plus Network. Coverage will be **for employee only. Dependents will not be covered.** Your dependents will not be eligible for coverage until the next annual open enrollment period. Any applicable premium share will be deducted from your paycheck on a pre-tax basis.
- You will automatically be enrolled under the ODS Dental Plan. Coverage will be **for employee only. Dependents will not be covered.** Your dependents will not be eligible for coverage until the next annual open enrollment period.
- You will default to the Basic Life Insurance for employee only and you will have to submit health information if you elect supplemental life benefits at a later time.

Part Time Employees

- You will be enrolled in Basic Life coverage. You will not be enrolled in any City-sponsored medical/vision, dental or voluntary (supplemental) life plans for 2012-13 for yourself or your dependents. You may receive a pro-rated share of the single party opt-out cash if you later provide proof of other group medical coverage through your spouse or domestic partner.

Annual Enrollment

Each spring you will receive notice of your opportunity to change your health plan elections and modify your dependent coverage. This is called the Annual Enrollment period. Any changes you make during this period will become effective July 1. The choices you make during Annual Enrollment will remain in effect through the plan year (July 1 through June 30.) NOTE: IF DEPENDENT ELIGIBILITY CHANGES DURING THE YEAR, YOU MUST NOTIFY THE BENEFITS & WELLNESS OFFICE WITHIN 60 DAYS OF THE EVENT as described on the following page. A change resulting in termination of benefits is retroactive to the last day of the month in which the event occurred.

What You Need to Do During Annual Enrollment

1. Review the medical/vision plans, PPO network options, and dental plans. Determine which plans and which PPO network best meets your needs.
2. Carefully estimate your out-of-pocket healthcare and dependent care expenses if you want to participate in the pre-tax flexible spending accounts (MERP and/or DCAP) for the 2012-13 plan year.
3. Review your enrollment instruction materials.
4. Review the family members you have covered under the Plan. During the annual enrollment period, you are verifying your dependents meet the City's benefit eligibility requirements. (See page 5 to review eligibility requirements.)
5. Go to BenefitsOnline at www.citybenefits.com (desktop icon in Police Bureau) to enroll in your benefits by the Annual Enrollment deadline.
6. When you save your online enrollment, you have the option to print a Confirmation statement, or have one sent to you via email. You will have continued access to the system up until the initial Annual Enrollment election deadline to make any changes or corrections to your enrollment. You will be sent a confirmation statement outlining your 2012-13 benefits. You will have another limited period to change or correct your elections prior to July 1.

Note that when you confirm your benefits, you are confirming that you have reviewed the information online and you are attesting to its accuracy. Read the online "Confirm Your Elections" page carefully.

Default Benefits: If You Do Not Complete Your Annual Online Enrollment

If you do not complete your enrollment by the Annual Enrollment deadline, your City benefit enrollment for the 2012-13 plan year will be defaulted to the medical/vision, opt-out, dental and life plans and tier level (one-party, two-party or family) in effect as of 6/30/2012. MHN network participants will default to the MHN network; ODS/PHCS network participants will default to ODS/PHCS.

MERP & DCAP

You will **not** be enrolled in the MERP and/or DCAP plans, even if you had made an election to participate in 2011-12.

Premium Share

If you are enrolled in default benefits requiring premium contributions, applicable deductions will be taken from your paycheck the first and second pay periods of each month. This amount will be deducted on a pre-tax basis in most cases. (Please see information regarding domestic partnership for additional information on pre-tax/post-tax premium collection.)

Enrolling Dependents After the Initial or Annual Enrollment Periods

Dependents must be enrolled at the same time the employee is enrolled or during the Annual Enrollment period except for the events listed below. To add dependent coverage, log onto BenefitsOnline at www.citybenefits.com (desktop icon in Police Bureau) within 60 days of a qualifying family status event and provide the Benefits Office the required documentation. You then click "Initiate Life Event" and follow the directions online. When permissible by state law, if you do not enroll your dependents within the 60 day timeframe, you must wait until the next Annual Enrollment. The City does not provide health care coverage for family members not listed below (such as parents or siblings of City employees).

Mid-year Changes in Eligible Dependents

If a dependent's eligibility changes during the year, the Benefits Office must be notified within 60 days of the event. Changes made to coverage and/or benefit elections must be consistent with and on account of the specific family status change. For example, if an enrollee gets divorced, the ex-spouse will be terminated from the benefit plans; however, the enrollee cannot switch to a new medical plan.

The City of Portland does not provide health care coverage for family members not listed, such as parents or siblings of enrollees.

The following outlines the reasons ***dependents can be added*** over the course of the year.

- **New Spouse/Eligible Stepchildren** may be added within 60 days from the date of marriage. Coverage will become effective the first of the month following the date you enter the change into BenefitsOnline. You are required to provide the Benefit Office a copy of the marriage certificate, and/or a copy of a birth certificate for each child added (as applicable.) **If the Benefit Office does not receive the required documentation within 30 days of your online election, coverage for your new spouse/eligible stepchildren will terminate retroactively back to the effective date of coverage and you will be held financially responsible for any claims paid on their behalf.**
- **New Domestic Partner/Eligible Domestic Partner Children** may be added within 60 days from the date the employee and partner meet the criteria of the Dependent Domestic Partner Status Affidavit and/or from the date of receipt of Oregon state's Certificate of Registered Domestic Partnership. Coverage will become effective the first of the month following the date you enter the change into Benefits Online. You are required to provide the Benefit Office a completed and notarized Affidavit of Benefit Eligible Dependent Status form for yourself and your partner (or a copy of your Oregon state Certificate of Registered Domestic Partnership) and a copy of a birth certificate for each child added (as applicable.) **If the Benefit Office does not receive the required documentation within 30 days of your online election, coverage for your new partner/eligible stepchildren will terminate retroactively back to the effective date of coverage and you will be held financially responsible for any claims paid on their behalf.**
- **Newborn Children** will be covered from birth and claims will be paid for your newborn for **the first 30 days**. You must go to BenefitsOnline within 60 days of the birth to add your child to your coverage for continued eligibility. You are required to provide the Benefit Office a copy of the hospital or state issued birth certificate. **If the Benefit Office does not receive the required documentation within 30 days of your online election, coverage for your dependent may terminate retroactively back to the 31st day and you will be held financially responsible for any claims paid on the child's behalf.**
- **Adopted Children** may be added within 60 days of being physically placed in the employee's home. Coverage may begin the date the child was placed in the home if the employee is assuming and retaining a legal obligation for financial support of the child. The employee must add the child through BenefitsOnline and a copy of the adoption or placement papers must be sent to the Benefits Office. **If the Benefit Office does not receive the required documentation within 30 days of your online election, coverage for your dependent may be terminated retroactively and you will be held financially responsible for any claims paid on the child's behalf.**
- **A newborn child of an Enrolled Dependent Child will be covered from birth and claims will be** paid for the first 30 days of the newborn's life, but only if the employee is financially responsible for both the newborn and the enrolled dependent. After 30 days, the child of your Enrolled Dependent may be covered only as long as the child's parent is the Employee's eligible and Enrolled Dependent and both grandchild and birth parent

reside in the Employee's home. You must go to BenefitsOnline within 60 days to add your dependent's child to your coverage for continued eligibility. You are required to provide the Benefits & Wellness Office a copy of the hospital or state issued birth certificate. **If the Benefits & Wellness Office does not receive the required documentation within 30 days of your online election, coverage for your dependent's child may terminate retroactively back to the 31st day and you will be held financially responsible for any claims paid on the child's behalf.**

- **Grandchild or other child** may be added within 60 days from the date custody and guardianship are granted. (Refer to eligibility provision for "Grandchild or other child.") The employee must add the child through BenefitsOnline and provide the Benefit Office a copy of the court order granting custody and appointing the guardian and a copy of the letters of guardianship. **If the Benefit Office does not receive the required documentation within 30 days of your online election, coverage for your dependent may terminate retroactively and you will be held financially responsible for any claims paid on the child's behalf.**
- **Qualified Medical Child Support Order:** If a judgment, decree or order, or state administrative order that has the force and effect of law resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for an employee's child, then the employee may change his or her election to (a) add coverage if the order requires coverage for the child under the employee's plan, or (b) drop coverage if the order requires another individual to provide coverage for the child and the coverage is actually provided. **The child's coverage under the Plan will be effective as of the first day of the month following the date that the Plan Administrator determines that applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.**
- **HIPAA Special enrollment Rights:** Mid year changes are allowed if: 1) an individual who was eligible for coverage but who didn't enroll because of preexisting coverage under another health plan at the time of initial enrollment and subsequently lost the other coverage (and loss of coverage was due to reasons other than failing to pay premiums on a timely basis) and 2) an individual becomes a dependent through marriage, birth or adoption or placement for adoption after the initial enrollment period. A change in status form must be returned within 60 days.
- **Medicare or Medicaid:** Mid year changes are allowed if a person becomes entitled to or loses entitlement to Medicare, Medicaid or CHIP. A change in status form must be returned within 60 days of entitlement or loss of entitlement. Documentation from Medicare, Medicaid or CHIP must be provided.

You must provide notice to the Benefits & Wellness Office to drop dependents from coverage within 60 days of the following events. Coverage will end on the last day of the month in which the event occurred.

- **A divorce or legal separation** from a spouse,
- **Termination of a domestic partnership**, as defined and declared in the City of Portland's Domestic Partner Affidavit,
- **When a covered child reaches 26 years of age**
- **An incapacitated and dependent child** who no longer has a Determination of Disability under the Social Security Act and/or who no longer resides with the enrollee and the enrollee does not provide primary support for the child.
- **Grandchild or other child because** the employee and/or spouse or domestic partner no longer has legal custody or is no longer the child's legal guardian.
- **Child of an eligible dependent child** if the dependent child is no longer covered by the enrollee's plan and/or the child of the dependent child is no longer living at the enrollee's residence.

Effective Dates of Mid-Year Changes in Benefits

Coverage for newly eligible dependents becomes effective the first of the month following or coinciding with the later of: (1) the effective date of the new employee's coverage (2) the date the individual becomes a dependent or (3) the date the enrollee submits completed enrollment forms and all required documentation to the City's

Benefit Office. If an enrollee does not return a completed City of Portland Notice of Change in Family Status form to add dependents within 60 days of the status change or does not provide documentation after enrolling the dependent online, then the dependent cannot be added until the next Annual Enrollment period.

Family Status Changes

If you have a qualifying family status change during the plan year, it is your responsibility to report the change within 60 days of the event. Go to BenefitsOnline at www.citybenefits.com (desktop icon in Police Bureau) to initiate the change. Changes made to your coverage and/or benefit elections must be consistent with and on account of the specific family status change.

For example, if you have a new baby you can add the baby to your current coverage but you cannot switch to a new medical plan.

The effective date of the change is generally the first of the month following the qualifying event (see “Dependent Eligibility” section for exceptions) or the first of the month following the date of your online enrollment. When permissible by state law, **if you do not make your online change to add dependents within 60 days of the status change, you will not be allowed to make your change and will have to wait until the next Annual Enrollment period to add your dependent to your coverage and/or benefit elections. If required documentation is not received, any changes made online will be reversed, eligibility terminated and you will need to provide reimbursement to the plan for any claims paid on the dependent’s behalf.**

In the event of a divorce or legal separation, the effective date of the loss of benefits will be retroactive to the date the divorce or legal separation. If you have not notified the Benefits Office within 60 days and claims have been paid for a dependent who should no longer be covered, you will need to provide reimbursement to the Plan.

NOTE: A dependent who loses eligibility due to divorce or for another reason may request information to elect COBRA. (See the COBRA section beginning on page 96 for further information.)

The City reserves the right to require supporting documentation to confirm the status change at any time.

Qualifying Family Status Changes

- Marriage;
- Criteria of Domestic Partner Affidavit is met;
- Addition of eligible dependent e.g., birth, adoption or placement for adoption, or custody and legal guardianship;
- Divorce or Legal Separation, including separation from domestic partner (see the COBRA section beginning on page 96 for further information);
- Death of spouse or domestic partner or dependent;
- Loss of dependent’s eligibility for coverage e.g., exceeds the plan age limit (see the COBRA section beginning on page 96 for further information);
- Spouse’s/domestic partner’s annual enrollment for health care coverage;
- Change of your employment status or your spouse or domestic partner e.g., change in hours or gain/loss of employment;
- Change of residence if relocating out of HMO service area.

Other Status Changes

You may also make mid-year changes for the following reasons, provided you do so within 60 days of the date of change:

- Significant cost changes—if the cost of dependent care significantly increases or decreases during a period of coverage, employees may make corresponding election changes to their DCAP election. You must provide documentation of such change in cost to the Benefits Office.
- Loss of Other Health Coverage—an employee may make a prospective election to add coverage under the cafeteria plan for the employee, spouse or dependent if the employee, spouse or dependent loses

coverage under any group health coverage sponsored by a governmental or educational institution, including a state's children's health insurance program, a medical care program of an Indian tribal government, a state health benefits risk pool, or a foreign government group health plan.

- FMLA Leave—An employee taking leave under the Family Medical Leave Act (FMLA) may revoke an existing election of group health plan coverage and make such other election for the remaining portion of the period of coverage as provided under the FMLA. The employee can catch up on the contributions upon returning from leave.
- Qualified Medical Child Support Order (QMCSO)--Judgments, Decrees or Orders: If a judgment, decree or order or state administrative order that has the force and effect of law resulting from a divorce, legal separation, annulment or change in legal custody requires health coverage for an employee's child, then the employee may change his or her election to (a) add coverage if the order requires coverage for the child under the employee's plan, or (b) drop coverage if the order requires another individual to provide coverage for the child and the coverage is actually provided. The child's coverage under the Plan will be effective as of the first day of the month following the date that the Plan Administrator determines that applicable order qualifies as a QMCSO, and that the child is eligible for enrollment in the Plan.
- HIPAA Special Enrollment Rights—a) individuals who were eligible for coverage but who didn't enroll because of preexisting coverage under another health plan at the time of initial enrollment and subsequently lost the other coverage (and loss of coverage was due to reasons other than failing to pay premiums on a timely basis) or employer contributions to the other coverage were terminated and b) individuals who become dependents through marriage, birth or adoption or placement for adoption after the initial enrollment period.
- Entitlement or loss of entitlement to Medicare or Medicaid.
- The eligible employee's or dependent's prior coverage was under Medicaid or a children's health insurance program (CHIP) and such coverage was terminated due to loss of eligibility. Special enrollment must be requested within 60 days of the termination.
- The eligible employee or dependent becomes eligible for a premium assistance subsidy under Medicaid or a children's health insurance program (CHIP). Special enrollment must be requested within 60 days of the termination.

Frequently Asked Questions:

1. How do I report a family status change to the Benefit Office?

Notify the Benefits Office by going to BenefitsOnline at www.citybenefits.com (desktop icon in Police Bureau.) After logging in, from the Home page, click "Initiate Life Event" and follow the online directions. Call the Benefits Office at 503-823-6031 if you have questions.

2. What happens if I don't report a family status change to the Benefit Office within 60 days of the event?

Marriage/Domestic Partnership Enrollment Delays: Your new spouse or domestic partner may only be added during the next Annual Enrollment period.

Divorce/Dissolution of Domestic Partnership Possible Cost to You: Your ex-spouse or domestic partner's coverage will end on the last day of the month in which your divorce/legal separation becomes final or your domestic partnership ends. ***If you fail to notify the Benefit Office of your divorce or dissolution of domestic partnership within 60 days, the cost of claims incurred by your ex-spouse/ex-partner after the date the divorce or dissolution of partnership is final will become your responsibility. In addition, your ex-spouse will not be eligible for COBRA continuation if the divorce is not reported within 60 days of the event. (NOTE: Your former spouse or domestic partner may contact the Benefits Office within 60 days of the event to elect COBRA.) Finally, if you have not notified the Benefits Office of this change within the 60 day notification period, you may be subject to disciplinary action, up to and including termination of your employment and other actions.***

Birth, Adoption/Guardianship: Possible Claim Payment Delay. Your newborn is automatically covered under your medical plan **for the first 30 days**. When you adopt a child, the child is placed with you for adoption, or you are granted custody and legal guardianship of a child, the child is eligible for coverage upon placement in your home. If you do not complete and return the required documents by the end of the first 60-day period, claims payment will be delayed. Coverage will be reinstated retroactive to the 31st day after the birth or back to the placement date when the Benefit Office receives the completed change form and required documentation.

Dependents who reach certain age requirement Possible costs to you: Your dependents' coverage will end on the last day of the month in which they no longer meet the definition of a dependent. The cost of claims incurred by your dependents after the date benefits should have ended will become your financial responsibility. In addition, your dependent will not be eligible for COBRA continuation if the change is not reported within 60 days of the event. (NOTE: Your former eligible dependent may contact the Benefits Office to elect COBRA.)

Medical Opt Out Dollars

If you have proof of enrollment in a group medical plan through your spouse or domestic partner under another employer's group medical plan or the City's medical plan, you may opt out of the City's medical/vision coverage. In exchange for opting out, you can receive Opt Out Dollars in the form of taxable pay added to your paycheck the first and second pay periods of each month for the plan year or remainder of the plan year, if enrolling mid-year. Or, your Opt Out Dollars can be used to pay for all or part of your other pre-tax benefit elections, including the flexible spending accounts (MERP and/or DCAP).

The amount of your Opt Out Dollars will depend on the coverage tier level of your family. For plan year 2012-13, the City will provide the following Opt Out Dollars. These amounts will be prorated for part-time employees according to their regularly scheduled hours and/or labor agreement.

Coverage Tier Level	Semi-Monthly Opt Out Dollars (Taxable Pay)
Full-time One-party	\$25.00
Full-time Two-party	\$45.00
Full-time Family	\$62.50

Please note: Opt Out Dollar payments will be forfeited during unpaid leaves of absence or qualifying leaves under the Fire & Police Disability and Retirement Fund and will not be added to the remaining pay periods upon your return. Also, if you terminate employment with the City before the end of the plan year, the remainder of your Opt Out Dollar payment will be forfeited.

Cost of Dental Coverage: For plan year 2012-13, the City will pay the monthly premium for dental coverage for full-time employees and any eligible dependents who opt-out of medical coverage. You may choose to opt out of City dental coverage; however there are no additional Opt Out Dollars if you elect to do so.

2012-13 Medical Plans

Benefit-eligible employees are offered two medical plans and two dental plans. The vision plan is dependent on the employee's choice of medical plans and is through VSP or Kaiser. Benefit eligible employees may be eligible to opt out of City medical and vision coverage and receive Opt Out Dollars (see page 13 for more information).

CityNet Preferred Provider (PPO) Medical Plan

The City offers an insured PPO medical plan for benefit-eligible PPA employees. This plan is named CityNet and is currently insured and administered by ODS Health Plan, Inc. The CityNet medical plan offers a broad range of medical coverage as well as a choice of preferred provider networks.

About the CityNet Medical Plan

For most medically necessary covered services, you must satisfy an annual deductible before the plan pays benefits. **You pay a lower deductible and receive a higher level of benefits when you use in-network PPO providers.** The deductible is applied each plan year (July 1 through June 30). However, expenses incurred and applied to the deductible during the last three months of the plan year (April, May and June) will also count towards meeting the following year's annual deductible. There are separate, higher deductibles if services are provided by out-of-network providers.

There are also different annual out-of-pocket maximums and coinsurance amounts for in-network and out-of-network services. Deductibles and out-of-pocket maximums are added separately. This means your in-network deductible expenses do not apply to the out-of-network deductible and vice versa. Prescription copays, emergency room co-pays, disallowed charges and amounts over the maximum plan allowance also do not apply toward annual out-of-pocket maximums.

For most medically necessary covered services, when you use a preferred provider from your elected network, the CityNet PPO Medical Plan will pay 80% of your network's Contracted Fees after you have satisfied the annual in-network deductible (\$150 per person; \$450 per family). When you don't use a network provider, for most medically necessary covered services, the plan will pay 60% of the "maximum plan allowance" (MPA) after you have satisfied the annual out-of-network deductible (\$450 per person and \$1,350 per family of three or more.)

MPA is the maximum amount on which ODS will base its reimbursement to physicians and providers. For out-of-network physicians/providers, the maximum amount is established, reviewed, and updated by a national database. Depending upon the plan provisions, deductibles and copayments or coinsurance may apply.

CityNet PPO Network Choices

Under the CityNet PPO Medical Plan, you must choose a preferred provider network. When you enroll for the 2012-13 plan year, you must choose one network for both hospitals and providers that you want to use for the year. Your enrolled family members must use the same network you elect. Please read this section carefully before you elect your network for the plan year.

The ODS/PHCS Network: The ODS Plus Network includes physicians, hospitals and other providers associated with the Providence Health System, Legacy Health System, Portland Adventist, OHSU Hospital and OHSU physicians. The PHCS Network is included when you elect the ODS Plus Network. The PHCS Network provides access to network providers throughout the United States, except Oregon and SW Washington.

Preventive Care Benefits are Important

The CityNet plan covers certain preventive care services. See the chart on page 20 for scheduled well child and adult physical exams, mammograms, PSA exams for men, and gynecological exams for women. **The deductible will be waived for these services, and coverage will be 100% when you use in-network providers.**

The Managed Healthcare Northwest (MHN) Network. The MHN Network includes physicians, laboratories, hospitals, urgent care clinics and durable medical equipment providers in Oregon/SW Washington who contract with MHN to provide a network of preferred providers. This network includes the Legacy Health System and Portland Adventist providers. When you travel outside the MHN service area, you may receive the in-network benefit level by using an in-network provider from the Healthy Directions Network. The in-network benefit level only applies if members are outside the MHN service area and the travel is not for the purpose of receiving treatment or benefits.

Electing a Network That’s Right for You and Your Family

Before electing a network, be sure to determine whether the majority of doctors and facilities you want to use participate in the network. To help you determine which networks are available to you, review the following Oregon and SW Washington service areas for the ODS Plus and MHN Networks.

The MHN Network is available in the following Oregon and SW Washington counties:

Oregon		SW Washington
Clackamas		Clark
Columbia		Cowlitz
Hood River		Klickitat
Lane		Skamania
Multnomah		
Wasco		
Washington		

The Healthy Directions Network is available when you travel outside the MHN service area.

The ODS Plus Network is available in the following Oregon counties

Baker	Crook	Harney	Lake	Morrow	Union
Benton	Curry	Hood River	Lane	Multnomah	Wallowa
Clackamas	Deschutes	Jackson	Lincoln	Polk	Wasco
Clatsop	Douglas	Jefferson	Linn	Sherman	Washington
Columbia	Gilliam	Josephine	Malheur	Tillamook	Wheeler
Coos	Grant	Klamath	Marion	Umatilla	Yamhill

The ODS Plus Network is available in the following SW Washington counties: Benton, Clark, Cowlitz, Klickitat, Pacific, Skamania, Wahkiakum, and Walla Walla.

The ODS Plus Network is available in the following Idaho counties: Ada, Boise, Canyon, Elmore, Gem, Owyhee, Payette, Twin Falls, Valley, and Washington.

The PHCS Nationwide Network is available outside of Oregon and southwest Washington. When you choose the ODS/PHCS Network you have access to a national preferred provider network.

Alternative Care Providers

Only ODS Plus alternative care network providers are considered in-network for reimbursement of alternative care claims. MHN participants must use the ODS Plus alternative care network for alternative care services to receive the in-network benefit levels. The network of alternative care providers (including chiropractors, naturopaths and acupuncturists) provide medically necessary alternative services within the scope of their licenses at discounted rates. **Only medically necessary care anticipated to improve one’s medical condition is eligible for reimbursement. Maintenance care does not qualify for reimbursement.**

Frequently Asked Questions About the CityNet Plan Networks

1. **Do I have to choose either the MHN Network or the ODS Plus Network or can I seek services under both Networks?** You must elect **one** network (MHN or ODS/PHCS) when you first enroll in the plan. Thereafter, members can change their network election only during Annual Enrollment.
2. **How do I verify whether a medical provider I am interested in seeing is in the preferred provider network I elected?** To confirm if a provider is in your elected network:
 - a. Log into BenefitsOnline at www.citybenefits.com (desktop icon in Police Bureau), then click on Provider Networks to search for providers in the MHN and ODS/PHCS networks. (See also 4. below for more information on alternative care providers.)

Always check the online directories or call ODS prior to seeking services. Paper directories are out of date as soon as they are published and are therefore not to be relied upon as current.

3. **What are Preferred Provider Networks?** Preferred Provider Networks are groups of medical facilities and professionals who have contracted with the managing network group. These healthcare providers agree to contracted fees for services charge to members who belong to a plan that has an agreement with that particular network. Under the CityNet plan, members receive a higher level of reimbursement if they seek services through their elected Preferred Provider Network. Let's assume you've elected the CityNet plan, you've previously met your in-network deductible, and you visit the doctor. If the normal charge is \$100 and you visit a...
 - a. Network provider, the actual charge would be reduced 30% to \$70. If the Plan pays 80%, the City's cost is \$56; you pay the remaining \$14. Without the provider contracted rate, you would have paid \$20 and the City would have paid \$80.00.
 - b. Non-network provider, the charge would remain \$100. After you meet your annual out-of-network deductible, the Plan will pay 60% of the maximum plan allowance, and your cost is at least \$40.

Both you and the Plan save when you use network providers.

4. **Will an MHN alternative care provider (e.g. chiropractor) who is not in the ODS Plus network be considered in-network?** No. In order to receive in-network reimbursement, you must receive alternative care services from an ODS Plus network provider.
5. **Will I be required to use network providers?** No. However, as outlined above, you will receive increased benefits, save money and moderate future rate increases by helping the Plan reduce its costs when you choose to use network providers. Additionally, nothing in the Plan prohibits a physician or provider and you from entering into an agreement for payment by you for medical services that are not covered by the CityNet Plan.
6. **How will I be covered when I'm traveling outside of the country?** When you have an emergency outside of the country, then the coverage will apply as indicated on the next page under "Emergency Care." Remember though, that you will need to pay the providers directly and submit your itemized bills with a claim form to ODS. If you see a physician outside of the country for non-emergent care, you will be subject to the out-of-network deductible and coinsurance.

We encourage you to verify the provider's network participation status every time you make an appointment for yourself or for an eligible dependent. Also, remember to ask your provider to send any lab work or x-rays to a facility in the network you elected so that you get the highest benefit level. It is the patient's responsibility to make sure the provider and/or the provider's office staff know the network you elected so that lab and x-ray services will be sent to an in-network facility.

Benefits for Special Medical Situations

The following chart highlights benefits available under the CityNet plan when certain medical situations occur.

Medical Situation	CityNet Plan pays the following:
<p>Specialist or type of treatment is not provided in your network service area AND you live in the network service area</p>	<p><i>Out-of-network providers:</i> After the annual in-network deductible is met, the plan pays at the in-network benefit level for medically necessary covered services. Eligible charges are subject to the maximum plan allowance (MPA) limits. Services provided through Shriner's hospital and discounted through ODS Supplemental contracts will be paid as in-network and accrue to in-network plan year maximums. You are responsible for the in-network deductible, the in-network coinsurance, and any amounts over the MPA limits. All determinations of when in-network benefits will apply to an out-of-network provider must be medically necessary and pre-certified through the City's healthcare utilization and prior authorization program.</p>
<p>Your eligible dependent child, residing outside the elected network service area, needs health care and you live in the network service area</p>	<p><i>Out-of-network providers:</i> After the annual in-network deductible is met, the plan pays at the in-network benefit level for medically necessary covered services. Eligible charges are subject to MPA limits. You are responsible for the in-network deductible, the in-network coinsurance, and any amounts over the MPA limits. Your copay amounts will accrue towards your out-of-network maximums.</p>
<p>Emergency care</p> <p>Note: Urgent care is not paid the same as emergency care. Regular plan benefits apply to urgent care.</p>	<p><i>Network providers:</i> In-network benefit level applies after \$50 emergency room copay for an emergency (copay is waived if admitted; not subject to deductible). Your 20% coinsurance amounts will accrue towards your in-network maximum.</p> <p><i>Out-of-network providers:</i> In-network benefit level, up to MPA limits, after \$50 emergency room copay for an emergency (copay waived if admitted; not subject to deductible). Your 20% coinsurance amounts will accrue towards your out-of-network maximum except expenses for mental health and chemical dependency will accrue towards your in-network maximum.</p>
<p>Benefit level for employees residing outside their elected network service area</p>	<p>Although the City of Portland has worked to provide network access for all members, there may be some people living outside the service area of the network they elected. If these members choose to travel to see a network provider, they will receive in-network benefits. However, if they do not wish to travel to access a network provider for non-emergent services, the out-of-network benefit level will apply. Under the CityNet plan, the out-of-network benefit for most covered expenses is 60% of the MPA after the annual deductible.</p>

Kaiser Medical Plan Highlights

- Office visit copays are \$10.
- Prescription copays are: \$15 for a 30-day supply at Kaiser pharmacies and \$30 for a 90-day supply of maintenance prescriptions through the Kaiser mail order program.
- Emergency room copays are: \$75 at Kaiser facilities, out-of-plan and out-of-area facilities.
- Ambulance copay is \$75 per trip.
- Immunizations and prescription drugs related to travel are covered.
- Infertility diagnosis and treatment is covered at 50%.

Kaiser Service Area

The Kaiser Medical Plan is available in the following Oregon and Washington counties:

OREGON

- Columbia, Multnomah, Polk, Washington and Yamhill Counties: All zip codes.
- Benton: 97330-31, 97333, 97339, 97370
- Clackamas: 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97086, 97089, 97222, 97267-69
- Hood River: 97014
- Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389
- Marion: 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-12, 97314, 97325, 97342, 97346, 97352, 97362, 97375, 97381, 97383-85, 97392

WASHINGTON

- Clark and Cowlitz Counties: All zip codes.
- Wahkiakum: 98612, 98647
- Skamania: 98639, 98648
- Lewis: 98591, 98593, 98596

For additional Kaiser information, go to <http://www.kaiserpermanente.org/> or call Kaiser at 1-503-813-2000.

Kaiser Student Out-of-Area Benefit

A limited benefit will be offered to dependents of eligible subscribers who are full time registered college students (at least 12 credit hours per term or semester) attending an accredited college or accredited vocational school outside of Kaiser Permanente service areas. The benefit pays up to \$1,200 annually at an 80 percent benefit level for routine, continuing and follow-up care. Urgent or emergency care for out-of-area students will continue to be covered with applicable copayments under their urgent and emergency care benefit. **Services must be provided within the United States.**

Medical Benefits – Plan Comparisons

Use the chart on the following pages to help you determine which medical plan is best for you and your family. If you elect CityNet, you will automatically be enrolled in the Vision Service Plan (VSP.) If you elect the Kaiser HMO, Kaiser will provide vision benefits.

Medical Plan Feature	CityNet Medical Plan		Kaiser Medical Plan
	In-Network	Out-of-Network	
Network Required	Plan offers two networks: the MHN or the ODS/PHCS Network. Each plan year, you elect a network. During the year you can go in-network or out-of-network as you choose. To receive in-network benefits, however, you must use the network you have elected. All family members must use the same network.		You must use Kaiser providers
Maximum Plan Allowance (MPA)	After the deductible, plan pays benefits based on contracted rates.	After the deductible, plan pays benefits based on MPA limits.	Not applicable
Plan Year Deductible	\$150/person; \$450/family maximum	\$450/person; \$1,350/family maximum Excludes in-network expenses. Charges over MPA not applied to deductible.	None
Plan Year Out-of-Pocket Maximum (CityNet excludes prescription drug, emergency room copays and charges over MPA)	\$1,000/person; \$2,500/family maximum (excludes out-of-network expenses)	\$3,600/person; \$9,000/family maximum (excludes in-network expenses)	\$600/person; \$1,200/family maximum each calendar year (Excludes Rx copays)
Essential Benefit Plan Year Maximum	\$2,000,000/person		Unlimited benefits
Prior Authorization	Required for hospitalization. Other services requiring prior authorization are listed beginning on page 37		Handled by Kaiser physician
Wellness Routine Physical Exams, Immunizations (except for travel-related immunizations) & routine colorectal screenings including colonoscopies Non-routine lab work and/or tests and other medically necessary exams are not covered at 100%, but will be covered at regular benefit levels (subject to deductible and coinsurance). Services as required under the Affordable Care Act	100%; no deductible Your Responsibilities: <ul style="list-style-type: none"> ○ When making an appt., double check when your last routine exam occurred to ensure you are eligible for the service at the 100% benefit level. ○ Seek services through an in-network provider. ○ Ensure your provider uses an in-network lab. ○ Read your ODS explanation of benefits to confirm billing & payment to your provider. If there is an error contact ODS & your provider to ensure the correct payment. 	60% of MPA after deductible	100%

Medical Plan Feature	CityNet Medical Plan		Kaiser Medical Plan
	In-Network	Out-of-Network	
Wellness/Routine Physical Exams (continued)	<p><i>Routine physical exam maximum:</i> Newborn 2 hospital exams Infant 6 exams in first 12 months Ages 1 to 4 7 exams Ages 5 and older 1 exam per calendar year Routine vision screening for age 3 to 5 Newborn hearing screening</p> <p><i>Mammogram maximum:</i> Ages 35-39 1 Ages 40+ 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician</p> <p><i>PSA maximum:</i> 1 per 12 months (365 days) <i>Breast & Pelvic Exam and Pap smear maximum:</i> 1 per 12 months (365 days) or at any time when high risk and deemed necessary by physician.</p>		
Outpatient Care Office visits; diagnostic x-rays, lab work, therapeutic x-rays and MRIs; imaging procedures, kidney dialysis, prenatal visits; allergy shots; etc.	80% after deductible	60% of MPA after deductible	100% after \$10 copay (prenatal visits not subject to the \$10 office visit copay) 100% Lab & x-ray and allergy shots & injections
Hospital Inpatient Care Semi-private room and board; physician visits; diagnostic x-rays and lab work; surgeries; miscellaneous services.	80% after deductible	60% of MPA after deductible	100%
Emergency Room (copay waived if admitted as inpatient following emergency)	80% after \$50 copay (not subject to deductibles)	80% of MPA after \$50 copay (not subject to deductibles)	Kaiser facility: 100% after \$75 copay Out-of-plan and out-of-area facility: 100% after \$75 copay
Urgent Care Centers	80% after deductible	60% of MPA after deductible	\$10 copay
Ambulance	80% of MPA; no deductible		100% after \$75 copay
Alternative Care Providers (chiropractic, acupuncture, and naturopathic providers) Must use an ODS Plus alternative care network provider for in-network CityNet benefits.	80% after deductible in ODS network	60% of MPA after deductible	\$10 copay for Kaiser physician-referred acupuncture only.
	35-visit annual maximum for chiropractic.		Chiropractic and naturopathic services are not covered.
Physical Therapy	80% after deductible	60% of MPA after deductible	100% after \$10 copay Limited to 20 visits per therapy, per cal year.

Medical Plan Feature	CityNet Medical Plan		Kaiser Medical Plan
	In-Network	Out-of-Network	
Maternity	Treated the same as any other condition	Treated the same as any other condition	Treated the same as any other condition
Skilled Nursing Facility (30-day plan year maximum)	80% after deductible	60% of MPA after deductible	100%, up to 100 days/calendar year
Durable Medical Equipment	80% after deductible	60% of MPA after deductible	80%
	Prior authorization required if rental exceeds 30 days or cost exceeds \$500		Includes external prosthetic and orthotic devices
Home Healthcare	80% after deductible	60% of MPA after deductible	100% for part-time
	60-visit plan year maximum		130 days max per calendar year for prescribed home health services
Hospice	80% after deductible	60% of MPA after deductible	100%
Refractive Eye Surgery	Not covered	Not covered	Not covered
Hearing Aids (adults age 26 and older)	60% of MPA (no deductible), up to \$1,200 per ear; new hearing aid covered once every 36 months if medically necessary		Not covered
Hearing Aids for enrollees under age 26	80% after deductible	60% of MPA after deductible	Up to \$4,211 in coverage every 48 months for children
	Maximum benefit of \$4,225 every 48 months		
TMJ Treatment	Non-surgical benefit subject to deductible, then paid at 80%. 2 nd surgical appliance subject to prior authorization. Maximum lifetime benefit of \$3000.	Non-surgical benefit subject to deductible, then paid at 60%. 2 nd surgical appliance subject to prior authorization. Maximum lifetime benefit of \$3000.	100% after \$10 copay.
Mental Healthcare Pre-Certification is required for all inpatient, partial hospitalization and residential treatment programs.	80% after deductible	60% of MPA after deductible	100% after \$10 copay for mental health services in an outpatient and/or day treatment setting. Inpatient Hospital & Residential mental health services are covered at 100%

Medical Plan Feature	CityNet Medical Plan		Kaiser Medical Plan
	In-Network	Out-of-Network	
Chemical Dependency Treatment Pre-Certification is required for all inpatient, partial hospitalization and residential treatment programs.	80% after deductible	60% of MPA after deductible	100% after \$10 copay for mental health services in an outpatient and/or day treatment setting. Inpatient hospital and residential treatment services are covered at 100%
Sterilization, Contraceptive Implants (e.g., IUD and Norplant)	80% after deductible	60% of MPA after deductible	Sterilization: \$10 copay Implants: Rx copay varies
Infertility Treatment	Not covered	Not covered	50% Regular copays apply. Member responsible for non-covered services.
Prescription Drugs Network retail pharmacy (up to 30-day supply) Out-of-network pharmacy (up to 30-day supply) Mail order pharmacy (up to 90-day supply) Specialty pharmacy (up to 90-day supply)	In-network pharmacy : – 90% of preferred generic drug cost – 80% of preferred brand drug cost – 70% of non-preferred drug cost (generic or brand name) \$5 minimum – \$35 maximum copay per prescription Out-of-network pharmacy: You pay pharmacy; then submit claims to ODS for 60% reimbursement after out-of-network deductible is met. In-network: Same as in-network retail pharmacy benefit levels shown above, except the maximum copay per prescription is \$50. In-network pharmacy : – 90% of generic drug cost – 80% of brand drug cost \$5 minimum – \$35 maximum copay per prescription Out-of-network pharmacy: You pay pharmacy; then submit claims to ODS for 60% reimbursement after out-of-network deductible is met.	Kaiser pharmacy: \$15 copay per prescription (non-formulary drugs not covered unless medically necessary) Non-Kaiser pharmacy: Not covered Kaiser: \$30 copay for formulary maintenance drugs. Mail delivery not available to members who permanently reside outside of Oregon and Washington.	

CityNet Prescription Drug Program

ODS provides the prescription drug benefit for the CityNet PPO Plan. The retail pharmacy network is extensive and includes most major retail pharmacy chains in the Portland area, such as Costco, Fred Meyer, Rite Aid, Safeway, Walgreens and many independent pharmacies.

The CityNet plan's pharmacy coverage pays benefits based on whether or not the prescription drug is on the preferred drug list (i.e., a broad list of prescription drugs). ODS will pay prescription drug benefits on this basis. And remember, the preferred drug list is not an all-inclusive list. ODS will continually review and update the list on recommendation by a panel of pharmacists and physicians.

Certain drugs require prior authorization to ensure appropriate utilization and cost effectiveness for the plans and members. Should your provider prescribe a drug that requires prior authorization, your provider will call ODS to ensure the most appropriate medication is prescribed. Drugs which require prior authorization include but are not limited to anabolic steroids, growth hormones, tretinoin products (RetinA for members over age 35), amphetamines and Rebif (interferon beta-1).

With ODS you will continue to be encouraged to use preferred and generic medications, and to take advantage of the ODS mail order pharmacy. If you use brand drugs, remember your share of the costs is based on a percentage of the actual costs, not a flat dollar copayment amount. For more information on the pharmacy benefit levels, see the comparison chart above.

How to Use the Mail Order Service

With this service, you get a 90-day supply of your prescription mailed directly to your home. Your copay is based on the total cost of the medication for the 90-day supply at the copay levels shown above. Mail order is ideal for long-term medications. To get started using this program, here's what you need to do:

1. Ask your doctor to write two prescriptions; one for a 30 day supply to fill at a network retail pharmacy and another for a 90-day supply (with up to 3 refills, as appropriate).
2. Fill the prescription for a 30-day supply at your local (in-network) drugstore.
3. For the mail order supply, use an ODS mail order form and a pre-addressed envelope available from your Bureau's Timekeeper or the Benefit Office and enclose the following:
 - o Your copay – it's easiest to charge your copay to your credit card (VISA, MasterCard, Discover or American Express) Include your card number as shown on the form. You also may send a check or money order. (Make checks payable to Walgreens Mail Service) Note: If you send a check or money order it may result in a balance on your account because of the fluctuations in drug costs. Do not send cash.
 - o Your 90-day supply prescription;
 - o A completed ODS mail order form.
4. If two or more prescriptions are sent in for multiple family members, the prescriptions will be shipped as a single order to an adult family member at the address given on the order form unless you prefer different shipping arrangements.

You'll receive your medication approximately 14 days from the date you mailed your order. For an additional charge, you can choose next-day or second-day delivery. If you choose expedited delivery, indicate your preference when you order your medications.

Once you have used about 75% of your prescription, you can request a refill by logging on to <http://www.walgreensmail.com> or by calling 1-800-573-1833 (Monday through Friday - 5:00 a.m. to 7:00 p.m. and Saturday & Sunday - 5:00 a.m. to 2:00 pm). The prescription label will indicate a "Refill After" date, so you will know when you may request a refill. If a prescription has no refills remaining, the "Refill After" date

will not be printed on the label. All you'll need is your prescription number, ZIP code and credit card information. You can also request refills by mail with a ODS order form, but these will take a bit longer to process.

There may be times when there are short delays in filling your prescriptions if the mail order pharmacy is temporarily out of stock. Generally the medication will be available within 72 hours.

A more serious delay could occur if the drug manufacturer has supply problems which have caused a medication to be unavailable nationwide. In this case, the pharmacy will contact you and provide options including:

- Offering to transfer the prescription to a local retail pharmacy with in-stock medication, or
- Offering to contact your doctor to provide a therapeutic alternative.

Important Reminders when using Mail Order

- Because of the fluctuation in drug costs, the mail order pharmacy may be unable to provide an exact cost for your prescription at the time of order. If you pay by check, this may cause a balance due on your mail order account.
- If you have a balance owing on your mail order account, your next prescription cannot be filled until you pay the balance or tell them to charge your credit card account.
- An important part of utilizing mail service is obtaining an appropriately written prescription. Your physician must write the prescription for a 90-day supply with 3 refills in order for the prescription to be valid for a year.
- If your physician writes a prescription for just a 30-day supply and it is submitted to mail order pharmacy, it is only allowed to fill the prescription as the physician prescribed—in this case, a 30-day supply.

CITYNET PPO MEDICAL PLAN

Covered Services

The following services, when medically necessary, are covered under this plan at the levels previously stated (see Medical Benefits Plan Comparisons starting on page 19.) Prior authorization may be required (see "Medical Review Services" beginning on page 37 for a list of procedures and services requiring prior authorization.)

- **Allergy shots** and office visits for allergy testing.
- **Alternative Care.** Medically necessary services by Chiropractors, Naturopaths and Acupuncturists are covered subject to maximums outlined in the Medical Benefits Plan Comparisons chart on page 20. To receive in-network alternative care benefits, services must be provided by an ODS Plus alternative care network provider.
- **Ambulance.** Up to 300 miles per plan year to or from the nearest hospital when medically necessary for non mental health or chemical dependency conditions. Benefits will be paid to the member and the provider or directly to the provider. Services provided by a stretcher car, wheelchair car or other similar methods are considered custodial and are not covered benefits under the Plan.
- **Appliances.** Items used for performing or facilitating the performance of a particular bodily function, including orthopedic braces and compression stockings, are covered when medically necessary. Appliances do not include dental appliances and braces, supporting devices such as corsets, eye glasses or contact lenses;
- **Artificial Limbs/Prosthetic Device.** Prosthetic devices (artificial limb devices or appliances designed to replace in whole or in part an arm or a leg) are covered, including repair or replacement of such devices, if they are medically necessary to restore or maintain the ability to complete activities of daily living or

essential job-related activities. Prosthetic devices which are solely for comfort or convenience are not covered.

- **Chemical Dependency Treatment** (drug and/or alcohol). This benefit does not apply to addiction or dependency on tobacco, tobacco products or foods nor does it include volunteer mutual support groups or educational programs for drinking drivers referred by the judicial system. Inpatient and residential treatment must be prior authorized (except for emergency hospital admissions, which must be authorized within 48 hours of emergency admission).
- **Colorectal Screening** is covered with no deductible or copays. Related charges are also covered. One fecal occult blood test is covered every plan year for members age 50 and over.
- **Contraceptive** device insertion and removal.
- **Diabetes Self Management.** The plan covers a benefit for diabetic education services for covered persons who are diagnosed to have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes, when prescribed by a health care professional legally authorized to prescribe such programs. These services are not subject to a deductible and are covered as in-network regardless of authorized program used. Services must be provided through an education program credentialed or accredited by a state or national entity accrediting such programs or provided by a physician, a registered nurse, a nurse practitioner, a certified diabetes educator or a licensed dietitian with demonstrated expertise in diabetes. The medical benefit will not cover diabetic supplies such as insulin, pumps, strips, etc., normally covered under the prescription drug benefit.
- **Durable medical equipment.** When medically necessary, limited to either the total rental cost or the purchase price of such equipment, whichever is less. Dental appliances are not included.
- **Emergency medical conditions.** Defined as a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy. Prior authorization is not required for emergency medical screening exams or treatment to stabilize an emergency medical condition;
- **Hearing aids for Adults (age 26 and older).** Includes the cost of any maintenance or repairs; subject to benefit maximums as listed in the Medical Plan Comparisons chart on page 21;
- **Hearing Aids – For enrollees under age 26** The Plan covers one hearing aid per hearing impaired ear for enrollees. This benefit is subject to a 48-month maximum which will be adjusted annually as required by Oregon statute. An enrollee must be examined by a physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist.
Covered benefits include the following up to the dollar maximum every 48 months:
 - A hearing aid (monaural or binaural) prescribed as a result of the examination;
 - Ear molds;
 - Hearing aid instruments;
 - Initial batteries, cords and other necessary supplementary equipment;
 - A warranty; and
 - Repairs, servicing, or alteration of the hearing aid equipment.
- **Home Health Care.** Services must be ordered by the attending physician;
- **Hospice Care for medically necessary charges.** When ordered by an attending physician for patients who are terminally ill, (with a life expectancy of six months or less) and provided by a state licensed agency. The Plan will also benefit any covered service rendered at any hospital owned or operated by the state of Oregon.
- **Hospital Services, Inpatient.** Includes:
 - Intensive Care/Coronary Care when medically necessary;

- Room & Board (medically necessary semi-private room and board). Personal comfort items are not covered;
 - Other miscellaneous medically necessary in-patient services and supplies furnished by the hospital which are not included in the room charge;
 - Special Duty Nursing when ordered by the attending physician.
- **Hospital Services, Outpatient.** Includes:
 - Emergency room service when medically necessary and
 - Other medically necessary out-patient hospital charges.
- If an inpatient hospitalization begins while an employee or eligible dependent is covered under the plan, and coverage subsequently ends, coverage for the enrollee will extend for the duration of the confinement, but not for any subsequent hospitalizations.*
- Outpatient hospital charges and general anesthesia for extensive dental treatment for children under 12 years of age, or a patient with mental incapacity, is covered.
- **Imaging Procedures** The Plan covers all standard imaging procedures at subject to applicable deductible and coinsurance when medically necessary and related to treatment of an illness or injury. Advanced imaging procedures require prior authorization.
 - **Inborn Errors of Metabolism** The Plan covers treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism and for which standard methods of diagnosis, treatment and monitoring exist. Coverage includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including but not limited to clinical visits, biochemical analysis and medical foods used in the treatment of such disorders.
 - **Laboratory Services.** Diagnostic laboratory expenses are covered when medically necessary and performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure that referral is made to an in-network PPO service provider.
 - **Maternity Care. For the employee, spouse, domestic partner, and dependent children.** Coverage for the newborn, beyond the initial nursery care, will be allowed if the child meets the City's definition of an eligible dependent. Covered professional providers do not include midwives unless they are also licensed and certified nurse midwives or certified nurse practitioner midwives. The Plan will cover facility charges for maternity care when rendered at a covered facility, including a birthing center.
 - **Maxillofacial Prosthetic Services.** For repair of head and facial structures damaged by trauma, disease, surgery or congenital deformity that cannot be managed with living tissue are covered when medically necessary and unrelated to TMJ treatment or therapy.
 - **Mental health inpatient, partial hospitalization and residential services** which have been prior authorized.
 - **Nonprescription Enteral Formula For Home Use.** When medically necessary and ordered by the doctor for the treatment of severe intestinal malabsorption and must comprise the sole source, or an essential source, of nutrition.
 - **Oral Anti-cancer Medication.** A prescribed, orally administered anticancer medication that is given in the provider's office is covered at the same benefit level as a supply. In addition, oral anti-cancer medication may require prior authorization by ODS or be subject to specific benefit limitations.
 - **Oral Surgery.** Extraction of impacted teeth. Lifetime benefit maximum is \$500.
 - **Organ transplants.** The Plan will pay benefits for medically necessary and appropriate transplant procedures as approved by the Medical Management Program, which conform to accepted medical practice and are not experimental or investigational. (See "Experimental or Investigational Procedures" in the Plan Exclusions on page 32.)

Organ Transplants

A. Definitions

✓ Transplant means:

- A procedure or a series of procedures by which tissue (e.g., solid organ, marrow, stem cells) is removed from the body of one person (donor) and implanted in the body of another person (recipient); and/or
- A procedure or series of procedures by which tissue is removed from one's body and later re-introduced back into the body of the same person.

Corneal transplants and the collection of and/or transfusion of blood or blood products are not considered transplants and may be covered under other sections of the CityNet Plan.

- ✓ Transplant period means the time from the day of admission for transplant conditioning through the day of discharge for a transplant.
- ✓ Complications resulting from a transplant means all medical and surgical treatments except the transplantation of hematopoietic cells or solid organ(s).

B. Covered Benefits

Benefits for transplants are limited as follows:

- ✓ If the Recipient or Self-Donor is enrolled under this Plan donor costs related to a covered transplant are covered in accordance with the Plan's copays and maximums. "Donor costs" means the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed as well as any other necessary charges directly related to locating and procuring the organ. If the donor is covered under this Plan and the recipient is not, no benefits toward donor costs will be paid. Expenses incurred by an enrolled donor which result from complications and unforeseen effects of the donation will be covered as any other sickness. Expenses incurred by a donor not enrolled in the Plan which result from complications and unforeseen effects of the donation are not covered.
- ✓ All transplants must meet the Prior Authorization / Utilization Management Program Criteria. Prior authorization requests for transplants will be reviewed to ensure medical appropriateness and medical necessity of the proposed treatment for the enrollee's medical condition or disease.
 - Physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan are covered;
 - Anti-rejection drugs following the covered transplant are covered according to the benefits for prescriptions drugs, if any, under the Plan.
 - The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

Please note: All transplant procedures must be prior authorized and be medically necessary and appropriate according to criteria established by ODS.
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C. Prior Authorization Requirement

A member's physician must contact ODS' Medical Intake Unit prior to the transplant admission to request authorization. Prior authorization should be obtained as soon as possible after a member has been identified as a possible transplant candidate. To be valid, prior authorization approval must be in writing from ODS.

- **Orthopedic shoes** are covered if they are an integral part of a leg brace or if they are ordered by a professional provider and are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. If such correction or support is accomplished by modification of a mass-produced shoe, then the covered expense will be limited to the cost of the modification. The covered expense will not include the original cost of the shoe. Orthopedic shoes or modifications will not be covered if they are solely for comfort or convenience.

- **Orthotic devices** (defined as a rigid or semi-rigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck) are covered, including repair or replacement of such devices, if they are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. Orthotic devices which are solely for comfort or convenience are not covered.
- **Preventive Care and Well Child Care.** Coverage for preventive care and well child care according to the schedule listed in the Medical Benefits Plan Comparisons chart on page **20**.
- **Professional Services** – Medically necessary services of a professional provider (see page 30 for a list of eligible professional providers) are covered subject to plan limits.
- **Reconstructive surgery after breast cancer.** Includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. All reconstructive procedures must be medically necessary and prior authorized.
- **Routine Costs in Qualified Clinical Trials.** Routine costs for the care of a member who is enrolled in or participating in qualifying clinical trials are covered. Routine costs mean medically necessary conventional care, items or services covered by the Plan if typically provided absent a clinical trial. Routine costs will be subject to the applicable deductible and standard copayments/coinsurance if provided in the absence of a clinical trial. ODS is not liable for any adverse effects of the clinical trials.

Qualified clinical trials are limited to those:

- Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs;
- Conducted as an investigational new drug application, an investigational device exemption or a biologics license application to the United States Food and Drug Administration; or
- Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration.

The Plan does not cover:

- The drug, device or service being tested in the clinical trial unless it would be covered by the Plan if provided outside of a clinical trial;
 - Items or services required solely for the provision of the drug device or service being tested in the clinical trial;
 - Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial;
 - Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial;
 - Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member;
 - Items or services customarily provided by a clinical trial sponsor free or charge to any person participating in the clinical trial; or
 - Items or services that are not covered by the Plan if provided outside of the clinical trial.
- **Short term rehabilitation.** Rehabilitation services include physical, occupational, speech or audiological therapy services necessary to restore or improve lost function caused by illness or injury furnished to a member who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in significant improvement of the member's condition within 60 days from the date the therapy begins. Services must begin within one year of the illness or injury being treated. Recreational or educational therapy, or non-medical self-help or training, services rendered for the treatment of delays or in speech development for members age 18 or older are not included.
 - **Skilled Nursing Facility Care.** Medically necessary skilled nursing care is covered up to a maximum 30 days per plan year. Services must be ordered by the attending physician and require prior authorization. Charges are not covered related to an admission that began before the person was enrolled in the Plan or for a stay where care is provided principally for:

- Senile deterioration;
 - Alzheimer's disease;
 - Mental deficiency or retardation in enrollees age 18 or older; or
 - Mental illness.
- **Tobacco Cessation.** This benefit provides reimbursement to tobacco cessation programs in which a professional provider offers an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. This coverage allows reimbursement for prescription drugs and for tobacco cessation educational meetings and programs. These services are not subject to a deductible and are covered as in network regardless of authorized program used.
 - **Surgical Benefits.**
 - All inpatient procedures and some outpatient surgeries/invasive diagnostic procedures require prior authorization. Covered medically necessary surgical services include: Primary surgeon; assistant surgeon (as requested by the surgeon and only to the extent that hospital staff assistance is not available or appropriate); anesthesiologist (only as required by the surgeon); radio-active therapy, iodine therapy, super-voltage therapy, deep x-ray therapy, burn treatment, fractures and dislocations; Surgeon consultation while an inpatient, as required in the diagnosis or treatment of an illness or injury; outpatient surgical and related services on the day of the surgery; second surgical opinions and medically necessary inpatient lab and x-ray expenses.
 - Ambulatory Surgery. Certain diagnostic and therapeutic procedures can be performed without an in-patient admission or overnight stay in a hospital. Some out-patient or ambulatory services also require prior authorization. Prior authorization must also be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.
 - **Telemedical Health Services** Covered medical services, delivered through a 2-way video communication that allows a physician or professional provider to interact with a member who is at an originating site, are covered. Benefit will be subject to the applicable deductible and standard copayments for the covered medical services.
An originating site includes the following:
 - Hospital;
 - Rural health clinic;
 - Federally qualified health center;
 - Physician's office;
 - Community mental health center;
 - Skilled nursing facility;
 - Renal dialysis center; or
 - Site where public health services are provided.
 If telemedical services are in connection with covered treatment of diabetes, communication can also be delivered via audio, Voice over Internet Protocol, or transmission of telemetry. One of the participants must be a representative of an academic health center.
 - **X-ray Services.** Medically necessary diagnostic x-ray expenses are covered when performed or ordered by a physician due to illness, accident or injury. To maximize benefits it is the patient's responsibility to make sure referral is made to an in-network PPO service provider.

CityNet Plan Professional Providers

A professional provider means any of the following state-licensed professionals, when providing medically necessary covered services within the scope of his/her license. In all cases, the services must be medically necessary and covered under this plan to be eligible for benefits. To be eligible for the in-network level of coverage, services must be rendered by a preferred provider within your elected network or through the alternative care services network. Only the ODS Plus alternative care network is considered in-network for chiropractic, acupuncture and naturopath services. When you don't use a network provider, the plan benefits will be based on the maximum plan allowance (MPA) and subject to a higher deductible and copay.

- A doctor of medicine (M.D.);
- A doctor of osteopathy (D.O.);
- A nurse practitioner;
- A podiatrist;
- A chiropractor (in-network benefit only provided through the ODS Plus alternative care network providers);
- An acupuncturist (in-network benefit only provided through the ODS Plus alternative care network providers);
- A naturopath (in-network benefit only provided through the ODS Plus alternative care network providers);
- A dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue;
- A psychologist;
- A physician assistant;
- A practicing mental health nurse practitioner;
- A clinical social worker;
- A psychologist associate;
- A professional counselor;
- A marriage and family therapist;
- A mental health counselor;
- A clinician providing services under the auspices of a program licensed, approved, established, maintained, contracted with or operated by the Oregon Office of Mental Health & Addiction Services;
- A registered physical, occupational, or speech therapist, but only for rehabilitative services provided upon the written referral of a doctor of medicine or osteopathy;
- A registered nurse or licensed practical nurse, but only for services provided upon the written referral of a doctor of medicine or osteopathy, and only for those services which nurses customarily bill patients;
- A registered nurse first assistant;
- An audiologist; and
- An optometrist.

The term "professional provider" does not include any other class of provider not named above, and no Plan benefits will be paid for their services.

CityNet Plan Essential Benefit Plan Year Maximum

All essential benefits, as defined by the Affordable Care Act, are subject to a plan year maximum. Once the maximum is met, coverage for all essential benefits will cease until the next plan year. Members can call ODS' Medical Customer Service Department to verify if a service or supply is an essential benefit.

CityNet Plan Limitations and Exclusions

CityNet will not cover any expense incurred for which the member is not legally liable or which is not medically necessary. Expenses in excess of what would have been charged in the absence of plan coverage are not covered. Charges specifically excluded from coverage or limited in any way are as follows:

General Exclusions and Limitations:

- Services that are not provided.
- Services received before your effective date of coverage.
- Services that are not a covered service or relate to complications resulting from a non-covered service, even if such service was previously covered under the Plan.
- Services that are not furnished by a qualified provider acting within the scope of his/her license or qualified treatment service.
- Services for which no charge is made or you would not be required to pay if you did not have health plan coverage.
- Charges in excess of the Maximum Plan Allowance (MPA) for services or supplies will be excluded except when required under the Plan's coordination of benefits (COB) rules.
- Services related to injury, illness or condition to the extent a payment or any other benefit including the amount received as a settlement is provided under any workers compensation or City liability on the account of the injury, illness, or condition arising out of the course of gainful employment.
- Services provided by a dentist (doctor of medical dentistry or doctor of dental surgery) but only for treatment of an accidental injury to natural teeth provided within 12 months of the injury or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue.
- Service, War or Insurrection, Riot or Rebellion - The Plan does not cover treatment of any condition caused by or arising out of service in the armed forces of any country or the active participation in a war or insurrection, or the voluntary participation in a riot or rebellion.
- Injury or illness resulting from the plan participant's commission or attempt to commit an assault or other illegal act, a civil revolution or riot.
- Services or supplies not listed as covered services or not considered medically necessary by the Plan.
- Expenses or services provided by a local, state or federal agency and emergency rescue services, except for Medicaid.
- Telemedical Health Services including telephone visits or consultations and telephone psychotherapy except as provided for in the paragraph titled "Telemedical Health Services".
- Out-of-network services by an anesthesiologist, assistant surgeon, radiologist or pathologist, or supplies provided while a patient at an in-network hospital, when ordered by a participating provider, will be covered at the in-network benefit level (subject to MPA) when the covered member has no control over the choice of provider for these services. The out-of-pocket expenses (except for those charges in excess of MPA) will apply to the in-network out-of-pocket maximum.
- Services, prescription drugs, and supplies you or your dependent receive while in the custody of any state or federal law enforcement authorities or while in jail or prison.
- Services provided by a relative –Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.
- Third party liability claims – services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member, whether or not such benefits are requested. More information can be found in the "Third Party Liability" section.

- Experimental or Investigational Procedures: services, prescription drugs, and supplies that are:
 - a. those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;
 - b. those not recognized by the medical community in the service area in which they are received;
 - c. those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
 - d. those for which scientific or medical assessment has not been completed and the effectiveness of the treatment has not been generally established;
 - e. those rendered in the service area only as part of clinical trial or research program for the illness or condition being treated;
 - f. those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program except for routine costs of certain clinical trials; and
 - g. those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription drugs, and supplies.
- Services, Prescription Drugs, Supplies, and/or Treatment Not Medically Necessary; including
 - a. Services, prescription drugs, and supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition or that of your dependent;
 - b. Services, prescription drugs, and supplies that are inappropriate with regard to standards of good medical practice in the service area;
 - c. Services, prescription drugs, and supplies that are primarily rendered for the convenience of you or your dependents or a physician or provider of services or supplies; and/or
 - d. Services that are not the least costly of the alternative supplies or levels of service, which can be safely provided to you or your dependent. For example, coverage would not be allowed for an inpatient hospital stay when the same level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility.
- Court-ordered services related to criminal behavior by the member, including a sex offender treatment program and a screening interview or treatment program related to driving under the influence of intoxicants for members age 18 or older. This exclusion does not apply to chemical dependency services for members age 17 or younger or to services provided pursuant to civil commitment proceedings for mental illness.
- Any illness or injury arising from ionizing radiation, pollution or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel, and the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or component, unless otherwise required by law.

Exclusions Related to Miscellaneous Services and Items:

- Support Education including Level 0.5 educational programs, voluntary mutual support groups, such as Alcoholics Anonymous, or family education or support groups, except for support groups rated A or B by the United States Preventive Services Taskforce.
- Enrichment programs, psychological or lifestyle enrichment, including self-help programs, educational programs, assertiveness training, marathon group therapy, and sensitivity training.
- Routine optometric eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, vision therapy, eye exercises, or fundus photography. Vision benefits may be available through the Vision Service Plan (VSP) and are subject to the terms of that Plan.
- Refractive surgery, laser vision correction, and any other procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. Includes, radial keratotomy, corneal rings, LASIK, PRK, procedures using the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revision of any procedures that alter the refractive character of the eye and any complications of these procedures.

- Reversal of sterilization procedures.
- Miscellaneous services, including (but not limited to):
 - a. Custodial Care, including routine nursing care and hospitalization for environmental change;
 - b. Private Nursing Services even if related to a condition which is otherwise covered by the Plan;
 - c. Services provided by volunteer workers;
 - d. Supplies intended for use outside hospital settings or considered personal in nature;
 - e. Routine miniature chest x-ray films or full body scans;
 - f. Other services and supplies not directly connected to the diagnosis or curative treatment of an illness or injury.
- Supportive environmental materials, or any service or product that is primarily promoted as a personal convenience item; is prescribed or recommended by a healthcare provider and does not meet industry treatment standards or protocols or is a product or service that may be purchased or obtained by the general public without a prescription. Including, but are not limited to, hand rails, ramps, bath benches, cervical pillows, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, saunas, whirlpools, hot tubs, fitness equipment, telephones, home furnishings and costs associated with local or distant travel, even if related to a condition otherwise covered by the Plan.
- Normal necessities of living, including but not limited to food, clothing and household supplies.
- Separate charges for the completion of reports or claim forms and the cost of records.
- Ambulance services exceeding 300 miles per plan year for non mental health and chemical dependency conditions.
- Biofeedback therapy services are limited to medically necessary treatment of tension or migraine headaches and the Plan will pay for no more than 10 visits during the member's lifetime.
- Cosmetic Surgery: Any procedure requested for the purpose of improving appearance without restoring bodily function or correcting physical impairment, including breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser) and rhinoplasty. Exceptions are provided for reconstructive surgery following a mastectomy and complications of reconstructive surgeries if medically necessary, clinically distinct and not specifically excluded.
- In alternative healthcare environments, only traditional medical testing will be covered by the plan.
- Expenses for routine nursing care, non-medical self-help or training, personal hygiene or custodial care are not covered under this Plan.
- Any services related to the treatment of infertility and/or the cause of infertility are excluded from coverage under the Plan. This includes artificial insemination procedures, including, but not limited to, in-vitro fertilization (IVF), Gamete intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET). Only the initial visit and initial diagnostics to determine infertility are covered.
- Replacement of lost hearing aids or batteries for hearing aids for enrollees age 26 and older are not covered.
- Hearing Aids – for enrollees under age 26: Including:
 - Implantable hearing aids and surgical procedure to implant them;
 - Replacement of a hearing aid, for any reason, in a 48-month period after the maximum is met;
 - Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid;
 - A hearing aid exceeding the specifications prescribed for correction of hearing loss; and
 - Expenses incurred after coverage ends, unless the hearing aid is ordered before coverage terminated and it is received within 90 days of the end date.
- Non-surgical treatment of oral diseases or other medical conditions, extraction of erupted teeth, and dental repair are not covered under the Oral Surgery benefit.
- Over-the-counter medications, including nutritional supplements, herbal and homeopathic remedies, and contraceptive products are not covered.

- Treatments defined as holistic and/or are treatments outside of industry-recognized standards of care.
- Services of a massage therapist, even if related to a condition otherwise covered by the Plan.
- Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment.
- Services/supplies requiring prior authorization are not covered under this plan unless certified as medically necessary through the City's contracted Prior Authorization Program.
- Services and supplies provided for the treatment of obesity or weight reduction. The plan will cover services and supplies that are necessary for the treatment of established medical conditions that may be caused by or made worse by obesity, but services and supplies that do so by treating the obesity directly, even if morbid obesity is present are not covered, except for those rated A or B by the United States Preventive Services Taskforce. Services specifically excluded from this plan include, but are not limited to the following:
 - a. Surgical: Gastric restrictive procedures with or without gastric bypass, or the revision of such procedures.
 - b. Weight Management: Weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, or any form of relaxation training as well as subliminal suggestion used to modify eating behaviors.
 - c. Pharmaceutical: Any drug or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by your physician.
- Services to alter a member's physical characteristics to that of the opposite sex, including Sexual Reassignment Surgery and related therapies.
- Chelation therapy is not covered under the Plan, except for acute arsenic, gold, mercury or lead poisoning.
- Transplant donor related services or supplies provided to an insured Donor if the Recipient is not enrolled under this Plan and eligible for transplant benefits. This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.
- Services or supplies for any transplant not covered by the Plan including transplant of animal organs or artificial organs.
- Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically covered by the Plan.
- Orthognathic surgery and services or supplies to add to or reduce the upper or lower jaw.
- Genetic testing or counseling unless medically necessary and prior authorized through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.
- Services and supplies for speech therapy, unless provided by a licensed speech therapist and rendered within one year of the onset of the illness/injury, congenital abnormality, or previous therapeutic process. Services rendered for the treatment of delays in speech development for members age 18 and above are not covered.
- Counseling related to family, marriage, sex, career and "at risk" individuals, in the absence of medical necessity/illness;
- Vocational, pastoral or spiritual counseling;
- Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting.
- Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, EMDR, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation and Z therapy.
- Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy.
- Therapy performed to maintain a current level of functioning without documentation of significant improvement is considered maintenance therapy and is not covered. Maintenance programs that prevent

regression of a condition or function are not covered. Recreational or educational therapy, educational testing or training, non-medical self-help or training, services related to treatment, testing or training for learning disabilities, testing or treatment for mental retardation for members age 18 or older, or hippotherapy are not covered.

- Treatment related to mental retardation for enrollees age 18 or older and custodial services or supplies provided by an institution for the mentally retarded are not covered. Treatment for learning disabilities are not covered.
- Routine foot care including the following services unless required by the member's medical condition (e.g. diabetes):
 - a. Paring or cutting of benign hyperkeratotic lesion (e.g. corn or callus);
 - b. Trimming of dystrophic and non-dystrophic nails; and
 - c. Debridement of nail by any method.
- Routine physical exams for employment, licensing, insurance coverage, participating in sports or other activities, or court order or required for parole or probation.
- Designated Blood Donations-collection, processing and storage of blood donated by donors designated by plan members and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.
- Hypnotherapy.
- Never Events - Services and supplies related to never events, which are events that should never happen while receiving services in a hospital or facility including but not limited to the wrong surgery, surgery on the wrong body part, or surgery on the wrong patient. These also apply to any hospital acquired condition, as that term is defined in the Centers for Medicare and Medicaid Services (CMS) guidelines, which includes but is not limited to serious preventable events

CityNet Prescription Drug Program Exclusions

1. Drugs or medications purchased or obtained without a physician's written prescription;
2. "Over-the-counter" products (with the exception of insulin, syringes and needles;)
3. Nose drops or nasal preparations that do not require a physician's written prescription;
4. Immunization agents for travel;
5. Non-drug items, dietary supplements, vitamins (other than prescription pre-natal vitamins) or health and beauty aids;
6. Drugs dispensed by a hospital, nursing care facility, health care center, urgent or immediate care center, ambulatory surgical center, doctor's office, or other institution;
7. Drugs obtained after eligibility and/or coverage terminates;
8. Any refill of a prescription that exceeds the number specified by the prescribing physician or that is dispensed after one year from the date of the prescription;
9. Drugs prescribed or used for cosmetic purposes.
10. Services and supplies subject to the "Plan Limitation and Exclusion" section of this plan (see above);
11. Non-legend or over-the-counter (OTC) drugs;
12. Prescriptions which are covered by workers' compensation laws, the Fire & Police Disability Retirement Fund, or other county, state or federal programs;
13. Compounds unless the prescription includes at least one legend drug that is an essential ingredient;
14. Naturopathic supplements including when prescribed as a compound drug;
15. Drugs that are experimental or investigational or that are labeled: "Caution-Limited by federal law to investigational use."
16. Drugs prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission, are not covered. ODS may evaluate individual requests for coverage.
17. Charges over the maximum pan allowance.

18. Drug administration. A charge for administration or injection of a drug or medicine, except for selected immunizations at in-network pharmacies.
19. Foreign drug claims. Drugs purchased for non-U.S. mail order or online pharmacies or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies.
20. Off-label Use. Drugs prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission.
21. Repackaged medications.

CityNet Coverage Frequently Asked Questions:

1. **Who do I call when I have a question about how a service will be covered or how a claim was paid for the CityNet plan?** If you have a question about how a service will be covered or how a covered service was paid, please call ODS Customer Service at 503-243-3974.
2. **Do I need to designate a primary care physician (PCP) under CityNet?** No. The CityNet plan does not require you to designate a primary care physician (PCP.)
3. **What is my coverage level if I have an emergency and I am taken (by ambulance) to the nearest hospital, but that hospital is out-of-network?** Emergency Care will be covered at the in-network rate. You will pay the emergency room copay and your services will be paid at the in-network rate up to MPA. You would be financially responsible for any charges above MPA.
4. **What is an Emergency Medical Condition?** This means that you or a covered eligible dependent has a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy.
5. **The benefit for Women's Annual Exams and Mammograms indicate the benefit is every 12 months, if I go one month early is it covered?** There is a 30-day variance for appointments within a twelve-month period of time. It's best for you to double check when your last routine exam occurred.
6. **Are Full Body Scans covered under the CityNet plan?** Full Body Scans are not covered under the CityNet medical plan.

Medical and Behavioral Management Services

The City's Medical and Behavioral Health (mental health and chemical dependency) Management programs cover a range of services designed to assist you and your family with your health care needs and to assure that medical treatments are medically necessary, appropriate and reasonable. Programs include: prior authorization for specified services, medical review of complex or high cost claims, case management of complex or high cost claims, disease management assistance for chronic conditions plus wellness and health promotion services.

The following information describes the different programs and identifies the services that must be utilized in order to receive the maximum benefits under CityNet such as prior authorization for hospitalization.

WHO PERFORMS THE MEDICAL MANAGEMENT SERVICES?

ODS Healthcare Services department's registered nurses or behavioral health clinicians covering all major specialties, in conjunction with qualified physician consultants, work with you and your physician to develop and implement customized treatment plans for you or your covered dependents. The purpose of the program is to ensure that you are provided the highest quality health care in the most cost effective manner. These medical and behavioral management services will also help moderate health care costs.

WHAT DO YOU DO?

Taking an active role in your health care is increasingly important. To participate in this program, you or your physician should call the program if any of the following conditions occur:

- 1) When your physician recommends an inpatient hospitalization;
- 2) Within 48 hours of an emergency admission, the first working day following a weekend or holiday admission or as soon as reasonably possible;
- 3) If your physician recommends any of the health care services that require prior authorization. These services are listed under "Medical Review Services" below;
- 4) When a mental health or chemical dependency admission has been recommended;
- 5) By the fourth month of pregnancy (end of first trimester).

To access medical management staff, call ODS Customer Service Monday through Friday, from 7:30 a.m. to 5:30 p.m. Pacific time by calling 503-243-3974 (in Portland Metropolitan Area) or 1-877-337-0649 (other areas inside and outside Oregon). Behavioral management staff can be reached Monday through Friday 7:30 a.m. to 5:30 p.m. Pacific time by calling 503-624-9382 (in Portland Metropolitan Area) or 1-800-799-9391 (other areas inside and outside Oregon). For assistance with hearing and speech impaired, call the Telecommunications Relay Service at 711.

MEDICAL REVIEW SERVICES

Services Requiring Prior Authorization - Review of your recommended care for eligibility, benefits and medical necessity prior to the date services occur is required on all covered services listed below. *Failure to follow the prior authorization procedure described below for the following services will result in an initial denial of services. If your claim is denied you must request a retrospective authorization. If the retrospective authorization is approved your claim will be adjusted. You will still be responsible for any applicable in or out-of-network deductibles, coinsurance, and charges in excess of what would have been authorized by the Plan*

-  Chemical dependency inpatient, partial hospitalization and residential services
-  Durable medical equipment rental and purchases (rental exceeds 30 days or cost is over \$500)
-  Home health care
-  Hospice care

- ☎ Hospital inpatient admissions and rehabilitation stays
- ☎ Transportation in lieu of ambulance
- ☎ Mental health services inpatient, partial hospitalization and residential services
- ☎ Organ transplants
- ☎ Skilled nursing facility care
- ☎ Special duty nursing
- ☎ Surgical procedures (inpatient and outpatient operative and cutting procedures requiring hospitalization or surgical center)
- ☎ All elective surgery (operative and cutting procedures), inpatient or outpatient, excluding surgeries performed in a doctor's office
- ☎ Colonoscopy for patients under age 50. In these cases, only those with medical or family history diagnosis will be eligible for plan benefits. No pre-certification is required for colonoscopy if age 50+.
- ☎ Magnetic resonance imaging (MRI) or magnetic resonance angiography (MRA);
- ☎ Computerized axial tomography (CT or CAT) or computed tomography angiogram (CTA);
- ☎ Positron emission tomography (PET);
- ☎ Single photon emission computed tomography (SPECT); and
- ☎ Nuclear cardiology studies.
- ☎ Genetic testing
- ☎ 2nd sleep studies and sleep apnea treatments
- ☎ Anesthesia/out patient hospital for dental procedures
- ☎ Speech therapy (after initial evaluation) rendered as a result of congenital abnormality, previous therapeutic process or injury or illness within one year of the onset of the injury/illness. Services rendered for the treatment of delays in speech development are not covered for members age 18 or older.
- ☎ Infusion services, dialysis, radiation and chemotherapy treatment

Prior Authorization Procedures

The following procedures will apply to all covered services that require prior authorization, unless otherwise noted. While the physician or hospital can complete the prior authorization procedure on the member's behalf, it is the responsibility of the member to ensure that proper authorization is obtained.

Non-Emergency Prior Authorization Procedure

In the event a member requires a non-emergency service or treatment that has a prior authorization requirement, the following procedure must be followed ***prior*** to receiving the service or treatment:

- 1) Your physician must call for prior authorization before admission at 503-243-4496 (in the Portland Metropolitan Area) or 1-800-258-2037 (other areas inside and outside Oregon).
- 2) Provide the covered member's name and identification number, covered patient's name, date and place of admission, physician's name and telephone number, diagnosis and surgery or procedure.
- 3) The physician and/or hospital will be contacted for further information regarding diagnosis, proposed length of stay, reason for admission, surgical procedure, nature of prescribed service or treatment, etc. Once the service or treatment is determined to be a covered

benefit and medically necessary, a prior authorization approval is entered into the ODS claims payment system. An authorization letter is sent to the member, treating provider, and facility if applicable.

Calling ODS promptly whenever hospitalization or services requiring a prior authorization are recommended for you by your health care provider will ensure the most appropriate use of your health care benefits. If you fail to follow the prior authorization procedure, you will be responsible for charges in excess of what would have been reimbursed under the Plan.

CityNet may require an independent consultation to confirm that non-emergency surgery is medically necessary. The Plan will pay the cost of this second opinion consultation at 100%, deductible waived. These consultations must be given by a physician who is certified by the American Board of Medical Specialists in a field related to the proposed surgery. The physician giving the opinion must also be independent of the physician who first advised surgery and is also excluded from performing the surgery.

Emergency Procedure Authorization:

Authorization for emergency hospital admission must be obtained by calling ODS at 503-243-4496 (in the Portland Metropolitan Area) or 1-800-258-2037 (other areas inside and outside Oregon) within 48 hours of the emergency hospital admission (or as soon as is reasonably possible).

During your hospitalization, a registered nurse in collaboration with your physician and the facility discharge planners will perform the following functions:

Concurrent Review: Review of your progress during a hospitalization and verification of the appropriate level of care for continued stay.

Discharge Planning: Coordination of discharge planning needs between all health care providers and your family to facilitate your return home or transfer to an appropriate facility.

High Risk Pregnancy: Prenatal screening.

CARE COORDINATION SERVICES (Care Management)

Care Coordination (case management) is performed by nurses. They work to create an individualized treatment program for you or your family member diagnosed with complex or high risk medical or mental health conditions, or if there are unusual and serious complications from a medical condition under treatment. Examples of when you may require case management services include, but are not limited to:

- Catastrophic illness/injury;
- Organ transplant coordination, including medical therapies not available locally;
- Chronic conditions which generate high use of outpatient services or frequent re-admissions to inpatient facility;
- Referral coordination services;
- Lengthy hospitalizations; and
- High-risk pregnancies.

If you believe that you may qualify for this service, please call ODS directly at 503-948-5548 or 1-877-337-0649 or 711 for Relay Service.

DISEASE MANAGEMENT/HEALTH PROMOTION

Disease Management and Health Promotion services are provided by Health Coaches as an important component of the City's Care Coordination program. The program goals are to optimize health status for you and your family members through individualized telephone consultations and educational interventions.

Disease Management programs provide individualized education plans for those with a chronic disease such as asthma or diabetes. Health Promotion activities focus on wellness, prevention of illness and

early diagnosis including immunization reminders and maternity wellness. You can also request information on specific diseases or other medical concerns. Specifically, the program can:

- Answer questions about medical concerns
- Assist with the management of ongoing medical needs
- Help you understand your medications
- Clarify healthcare benefit options
- Offer preventive wellness programs
- Work with you to set personal health goals
- Identify appropriate health-related community resources
- Provide customized health or medical educational tools.

If you believe that you may qualify for this service, please call ODS at 503-948-5548 or 1-800-592-8283 or 711 for Relay Service.

- **Post-service claim** means any claim for a benefit under the Plan for care or services that have already been received by a member.
- **Pre-service claim** means any claim for a benefit under the Plan for care or services that require prior authorization.
- **Claim Involving Urgent Care** means any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could seriously jeopardize a member's life or health or ability to regain maximum function, or, in the opinion of a physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the requested care or treatment.
- **Utilization Review** means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, prior authorization of ambulatory procedures, and retrospective review. An adverse benefit determination that the item or service is not medically necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

Note:

The timelines addressed in the paragraphs below do not apply when:

- The member does not reasonably cooperate; or
- Circumstances beyond the control of either party prevents that party from complying with the standards set but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise.

First Level Appeal

You must submit an appeal in writing to ODS and ask for a review. If you need assistance on filing an appeal, contact ODS Medical Customer Service Department at (503) 243-3974 or toll-free at 1-877-337-0649, or the Pharmacy Drug Benefit Customer Service at (503) 243-3960 or toll-free at 1-888-361-1610 for pharmacy claims. You may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on your behalf. ODS will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not involved in the original determination.

An appeal related to an urgent care claim will be entitled to expedited review upon request. An expedited review will be completed no later than 72 hours after receipt of the appeal by ODS, unless you fail to provide sufficient information for ODS to make a decision. In this case, ODS will notify you within 24 hours of receipt of the appeal of the specific information necessary to make a decision. You will have 48 hours to provide the specified information. The investigation of an urgent care claim will be completed no later than 48 hours following the earlier of (a) ODS' receipt of the specified information, or (b) the end of the period provided to submit the specified additional information.

Investigation of a pre-service appeal will be completed within 15 days. Investigation of a post-service appeal will be completed within 30 days. When an investigation has been completed, ODS will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal.

Second Level Appeal

If you disagree with the decision regarding the First Level Appeal, you may request a Second Level Appeal by persons who were not involved in the review of the First Level Appeal. You must submit your Second Level Appeal in writing within 60 days of the date of the ODS action on your First Level Appeal.

Investigations and responses to a Second Level Appeal will be by persons who were not involved in the initial determinations, and will follow the same timelines as those for a First Level Appeal. You may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on your behalf. If new or additional evidence or rationale is used by ODS in connection with the claim, it will be provided to you, in advance and free of charge, before any final internal adverse benefit determination. You may respond to this information before ODS' determination is finalized. ODS will notify you in writing of the decision, the basis for the decision, and if applicable, information on the right to request an external review.

External Review

If you are not satisfied with the outcome of the Second Level Appeal, and your claim meets the criteria below, you may request that the claim be reviewed by an independent review organization, appointed by Oregon Insurance Division.

1. The dispute must relate to an adverse benefit determination based on a utilization review decision or whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care under this Plan; or cases in which ODS fails to meet the internal timeline for review or to provide all of the information and notices required under federal law for appeals regarding those issues;
2. You must request for external review in writing no more than 180 days after receipt of the final internal adverse benefit determination. For an urgent care claim or when the dispute concerns a condition for which a member received emergency services and is still hospitalized, a request for external review may be expedited or simultaneous with a request for internal appeal review;
3. You must sign a waiver granting the independent review organization access to your medical records;
4. You must have exhausted the appeal process described in this section. However, ODS may waive this requirement and have a dispute referred directly to the external review with your consent; and
5. You shall provide complete and accurate information to the independent review organization in a timely manner.

The decision of the independent review organization is binding except to the extent other remedies are available to the member under state or federal law. If ODS fails to comply with the decision, the member may initiate a suit against ODS.

A final internal adverse benefit determination based on specific exclusions or limitations on the amount, duration, or scope of coverage that does not involve medical judgment or a decision on whether a person is a member under the Plan does not qualify for external review. A complaint decision does not qualify for external review.

Complaints

ODS will investigate complaints regarding the following issues when submitted in writing within 180 days from the date of the claim.

1. Availability, delivery or quality of a health care service;
2. Claims payment, handling or reimbursement for health care services that is not disputing an adverse benefit determination; or
3. Matters pertaining to the contractual relationship between a member and ODS.

Investigation of a complaint will be completed within 30 days. If additional time is needed ODS will notify the member and have an additional 15 days to make a decision.

Additional Enrollee Rights

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division.

Assistance is available:

By calling: (503) 947-7984 or toll-free 888-877-4894

By writing: Oregon Insurance Division

PO Box 14480

Salem, Oregon 97309-0405

By internet: <http://www.cbs.state.or.us/ins/consumer/consumer.html>

Information is subject to change upon notice from the Director of the Oregon Insurance Division.

CONTINUITY OF CARE

Continuity of care allows a member who is receiving care from an individual professional provider to continue with care with the individual professional provider for a limited period of time after the medical services contract terminates.

ODS will provide continuity of care if a medical services contract or other contract for a professional provider's services is terminated, the provider no longer participates in the provider panel, and the Plan does not cover services when services are provided to members by the professional provider or covers services at a benefit level below the benefit level specified in the plan for out-of-network professional providers.

Medical Services Contract means a contract between an insurer and an independent practice association or a provider. Medical services contract does not include a contract of employment or a contract creating legal entities.

Continuity of care requires the individual professional provider to be willing to adhere to the medical services contract that had most recently been in effect between the physician or provider and ODS and to accept the contractual reimbursement rate applicable at the time of contract termination, or if the contractual reimbursement rate was not based on a fee for service, a rate equivalent to the contractual rate.

For a member to receive continuity of care, all of the following conditions must be satisfied:

1. The member must request continuity of care from ODS;
2. The member is undergoing an active course of treatment that is medically necessary and, by agreement of the individual provider and the member, it is desirable to maintain continuity of care; and
3. The contractual relationship between the professional provider and ODS, with respect to the plan covering the member has ended. However, ODS will not be required to provide continuity of care when the contractual relationship between the professional provider and ODS ends under one of the following circumstances:
 - a) has retired;
 - b) has died;
 - c) no longer holds an active license;
 - d) has relocated out of the service area;
 - e) has gone on sabbatical; or
 - f) is prevented from continuing to care for patients because of other circumstances; or
 - g) the contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual physician or provider have been exhausted.

ODS will not provide continuity of care if the member leaves the Plan or if the Group discontinues the Plan in which the member is enrolled.

Length of Continuity of Care

Except in the case of pregnancy, continuity of care will end on the earlier of the following dates:

- The day following the date on which the active course of treatment entitling the Enrollee to continuity of care is completed; or
- The 120th day after the date of notification by ODS to the Enrollee of the termination of the contractual relationship with the professional provider.

Continuity of care will end for a member who is undergoing care for pregnancy, and who becomes entitled to continuity of care after commencement of the second trimester of the pregnancy, on the later of the following dates:

- The 45th day after the birth; or
- As long as the Enrollee continues under an active course of treatment, but not later than the 120th day after the date of notification by the insurer to the Enrollee of the termination of the contractual relationship with the professional provider

Notice Requirement

ODS will give written notice of the termination of the contractual relationship with a professional provider and of the right to obtain continuity of care to those Enrollees that ODS knows or reasonably should know are under the care of the professional provider. The notice shall be given to the Enrollees no later than the 10th day after the date on which the termination of the contractual relationship takes effect or no later

than the 10th day after ODS first learns the identity of an affected Enrollee after the date of termination of the contractual relationship.

If the professional provider belongs to a provider group, the provider group may deliver the notice if the notice clearly provides the information that the Plan is required to provide to the affected Enrollee.

For purposes of notifying a member of the termination of the contractual relationship between ODS and the professional provider and the right to obtain continuity of care, the date of notification by ODS is the earlier of the date on which the member receives the notice or the date on which ODS receives or approves the request for continuity of care.

CityNet Plan Coordination of Benefits

An employee and/or dependent may be covered under more than one health care plan. For example, a husband and wife/domestic partner both work, and may be covered under a medical, dental and/or vision plan at his and her places of employment. If each spouse or domestic partner covers the other and/or their children, stepchildren or domestic partner's children, there might be questions as to which plan should pay what amount in the event of illness or injury.

Coordination of Benefits is a method of determining the amount that each plan should pay when there is coverage under two or more health care plans. This provision considers a "plan" to include group coverage, most government programs, any coverage specified by law, any labor-management trustee plan, union welfare plan, employer organization plan or employee benefit organization plan, and any individual automobile no-fault insurance plan.

A. For purposes of COB, plan includes:

1. Group insurance contracts and group-type contracts;
2. HMO (Health Maintenance Organization) coverage;
3. Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
4. Medical care components of group long-term care contracts, such as skilled nursing care;
5. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or
6. Other arrangements of insured or self-insured group or group-type coverage.

B. For purposes of COB, plan does not include:

1. Hospital indemnity coverage or other fixed indemnity coverage;
2. Accident-only coverage;
3. Specified disease or specified accident coverage;
4. School accident coverage;
5. Benefits for non-medical components of group long-term care policies;
6. Medicare supplement policies;
7. Medicaid policies, or;
8. Coverage under other federal governmental plans, unless permitted by law.

C. Each contract or other arrangement for coverage described above is a separate plan. If a plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate plan.

For purposes of this section on Coordination of Benefits, the following definitions apply:

- A. An Allowable Expense means a healthcare expense, including deductibles and copayments, that is covered at least in part by any plan covering the member. When a plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an allowable expense and a benefit paid. An expense that is not covered by any plan covering the member is not an allowable expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an allowable expense.

1. The following are examples of expenses that are **not** allowable expenses:

(a) The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses;

(b) The amount of the reduction by the primary plan because a member has failed to comply with the plan provisions concerning second surgical opinions or prior authorization of admissions or services, or because the member has a lower benefit because that claimant did not use an in-network provider;

(c) Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;

(d) Any amount in excess of the highest of the negotiated fees, if a member is covered by two or more plans that provide benefits or services on the basis of negotiated fees;

(e) If a member is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.

(f) If a plan is advised by a member that all plans covering the member are high-deductible health plans and the member intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any healthcare expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C).

B. Complying Plan is a plan that complies with these COB rules.

C. Non-complying Plan is a plan that does not comply with these COB rules.

D. Claim means a request that benefits of a plan be provided or paid.

E. Member means the enrollee for whom the claim is made.

F. This Plan is the part of this group health plan funded by the Group that provides benefits for healthcare expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the group health plan providing healthcare benefits is separate from this Plan. A group health plan may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

G. Closed Panel Plan is a plan that provides healthcare benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

H. Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

Coordination of Benefit- Payment of Claims

If the member is covered by another plan or plans, the benefits under this Plan and the other plan(s) will be coordinated. This means one plan pays its full benefits first, and then the other plan(s) pay(s). The order of benefit determination rules govern the order in which each plan will pay a claim for benefits.

1. The Primary Plan (the plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.
2. The Secondary Plan (the plan(s) that pay(s) benefits after the primary plan) will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.
3. This Plan will coordinate with a plan that is “excess” or “always secondary” or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:
 - A. If this Plan is primary, it will provide its benefits first.
 - B. If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan’s benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
 - C. If the non-complying plan reduces its benefits so that the member receives less in benefits than he or she would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that this Plan will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the member against the non-complying plan.
5. Order of Claim Payments for Eligible Participants: The first of the following rules that applies will govern:
 - A. Non-dependent/Dependent. If a plan covers the member as other than a dependent, for example, an employee, member of an organization, subscriber, or retiree, then that plan will determine its benefits before a plan which covers the person as a dependent. However, if the member is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g. a retired employee), then the order of benefits between the two plans is reversed.
 - B. Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together. If the member is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the 'Birthday Rule'.)
 - C. Dependent Child/Parents Separated or Divorced or Not Living Together. If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:
 1. If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the plan of that parent has actual knowledge of those terms, that plan is primary. This rule applies to plan years commencing after the plan is given notice of the court decree.
 2. If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.
 3. If there is not a court decree allocating responsibility for the child’s healthcare expenses, the order of benefits is as follows:

- (a) The plan covering the custodial parent;
- (b) The plan covering the spouse or domestic partner of the custodial parent;
- (c) The plan covering the non-custodial parent; and then
- (d) The plan covering the spouse or domestic partner of the non-custodial parent.

D. Dependent Child Covered by Individual Other than Parent. For a dependent child covered under more than one plan of persons who are not the parents of the child, the first applicable provision (#B or #C) above shall determine the order of benefits as if those persons were the parents of the child.

E. Active/Retired or Laid Off Employee. The plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a plan that covers a member as a laid off or retired employee (or as that employee's dependent). If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

F. COBRA or State Continuation Coverage. If a member whose coverage is provided under COBRA or under a right of continuation provided by state or other federal law is covered under another plan, the plan covering that member as an employee, member of an organization, subscriber, or retiree or covering the person as a dependent of an employee, member, subscriber, or retiree, is the primary plan and the COBRA or other continuation coverage is the secondary plan. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of the benefits, this rule is ignored.

G. Longer/Shorter Length of Coverage. The plan that covered a member longer is the primary plan and the plan that covered the claimant for the shorter period of time is the secondary plan.

H. None of the Above. If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

Effect of COB on City Plan Benefits

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other healthcare coverage and apply that calculated amount to any allowable expense under its plan that is unpaid by the primary plan. The secondary plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other healthcare coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

The Right To Collect And Release Needed Information

In order to receive benefits, the member must give ODS any information needed to pay benefits. ODS may release to or collect from any person or organization any needed information about the member.

Correction Of Payments

If benefits that this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the Plan's liability.

Right Of Recovery

If the Plan pays more for a covered expense than is required by the Plan the excess payment may be recovered from:

1. The subscriber;
2. Any person to whom the payment was made; or
3. Any insurance company, service plan or any other organization which should have made payment.

PATIENT PROTECTION ACT

The intent of the Patient Protection Act is to assure, among other things, that patients and providers are informed about their health insurance plans. This section outlines some important terms and conditions. **(NOTE: Kaiser Permanente is subject to the same law. Contact Kaiser for the details of its Patient Protection provisions)**

1. What are an Enrollee's rights and responsibilities?

Enrollees have the right to:

- Be treated with respect and recognition of their dignity and need for privacy.
- Have access to urgent and emergency services, 24 hours a day, 7 days a week.
- Know what their rights and responsibilities are. Members will be given information about their health plan and how to use it and about the providers who will care for them. This information will be provided in a way that members can understand.
- Participate in decision making regarding their healthcare. This includes a discussion of appropriate or medically necessary treatment options for their conditions, whether or not the cost is covered the plan, and the right to refuse care and be advised of the medical result of their refusal.
- Receive services as described in their plan handbooks.
- Have their medical and personal information remain private. Personal information will be handled in compliance with state and federal law, and will be given to third parties only as necessary to administer the plan, as required by law, or as permitted by the member.
 - File a complaint or appeal about any aspect of the plan and to receive a timely response. Members are welcome to make suggestions to ODS.
 - Obtain free language assistance services, including verbal interpretation services, when communicating with ODS.
- Have a statement of wishes for treatment, known as an Advance Directive, on file with their professional providers. Members also have the right to file a power of attorney which allows the member to give someone else the right to make healthcare choices when the member is unable to make these decisions.

Members have the responsibility to:

- Read the plan handbook to make sure they understand the Plan. Members are advised to call Medical Customer Service or Pharmacy Drug Benefit Customer Service with any questions.
- Treat all physicians and providers and their staff with courtesy and respect.
- Provide all the information needed for their physician or provider to provide good healthcare.
- Participate in making decisions about their medical care and forming a treatment plan.
- Follow instructions for care they have agreed to with their physician or provider.
- Use urgent and emergency services appropriately.
- Present their medical identification card when seeking medical care.
- Notify physicians and providers of any other insurance policies that may provide coverage.
- Reimburse ODS from any third party payments you may receive.
 - Keep appointments and be on time. If this is not possible, members must call ahead to let the provider know they will be late or cannot keep their appointment.
 - Seek regular health checkups and preventive services.
 - Provide adequate information to the plan to properly administer benefits and resolve any issues or concerns that may arise.

Members may call the ODS Customer Department for questions about these rights and responsibilities.

2. What do I do if I have a medical emergency?

If you believe you have a medical emergency, you should call 9-1-1 or seek care from the nearest appropriate physician or provider, such as a physician's office or clinic, urgent care facility or emergency room.

3. How will I know if benefits are changed or terminated?

It is the responsibility of your Employer to notify you of benefit changes or termination of coverage. If your Group contract terminates and your Employer does not replace the coverage with another group contract, your Employer is required by law to inform you in writing of the termination.

4. If I am not satisfied with my health plan, how do I file an appeal?

You can file an appeal by contacting the ODS Customer Service or by writing a letter to ODS, (P.O. Box 40384, Portland, Oregon 97240). See the booklet section titled "Appeals" for complete information.

You may also contact the Oregon Insurance Division:

By calling: (503) 947-7984 or 888-877-4894

By writing: Oregon Insurance Division

PO Box 14480

Salem, Oregon 97309-0405

By internet: <http://www.cbs.state.or.us/ins/consumer/consumer.html>

By email: cp.ins@state.or.us

5. What are ODS' prior authorization and utilization review criteria?

Prior authorization is the process ODS uses to determine whether a service is covered under the Plan (including whether it is medically necessary) prior to the service being rendered. Members may contact ODS Customer Service Department, visit myODS, or review the CityNet prior authorization section in this booklet to request information on the list of services that require prior authorization. Many types of treatment may be available for certain conditions; the prior authorization process helps determine which treatment is covered under the Plan.

Obtaining a prior authorization is your assurance that the services and supplies recommended by your provider are medically necessary and covered under your health plan. Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity shall be binding if obtained no more than 30 days prior to the date the service is provided, and prior authorization for member eligibility shall be binding if obtained no more than 5 business days prior to the date the service is provided.

Utilization review is the process of reviewing services after they are rendered to ensure that they were medically necessary and appropriate with regard to widely accepted standards of good medical practice.

For a written summary of information that may be included in the ODS utilization review of a particular condition or disease, call the ODS' Customer Service.

6. How are important documents, such as my medical records, kept confidential?

ODS protects your information in several ways:

- ODS has a written policy to protect the confidentiality of health information.
- Only employees who need to access your information in order to perform their job functions are allowed to do so.
- Disclosure outside ODS is permitted only when necessary to perform functions related to providing coverage and/or when otherwise allowed by law.
- Most documentation is stored securely in electronic files with designated access.

7. How can a member participate in the development of ODS' corporate policies and practices?

Member feedback is very important to ODS. ODS welcomes any suggestions for improvements about its health benefit plans or its services. ODS has formed advisory committees – including the Group Advisory Committee for employers and the Quality Council for health care professionals – to allow participation in the development of corporate policies and to provide feedback. The committees generally meet two times per year.

Please note that committee membership is limited. For more information, contact ODS at:

ODS

601 S.W. Second Avenue

Portland, Oregon 97204

www.odskompanies.com

8. How can non-English speaking members get information about the plan?

A representative will coordinate the services of an interpreter over the phone when a member calls.

9. What additional information can I get upon request?

The following documents are available by calling a ODS' Customer Service:

1. A copy of ODS' annual report on complaints and appeals.
2. A description of ODS' efforts to monitor and improve the quality of health services.
3. Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for a member's care.
4. Information about ODS' prior authorization and utilization review procedures.

10. What information about ODS is available from the Oregon Insurance Division?

The following information regarding the ODS health benefit plans is available from the Oregon Insurance Division:

1. The results of all publicly available accreditation surveys.
2. A summary of ODS' health promotion and disease prevention activities.
3. An annual summary of appeals.
4. An annual summary of utilization review policies.
5. An annual summary of quality assessment activities.
6. An annual summary of scope of network and accessibility of services.

Contact:

Oregon Insurance Division

PO Box 14480

Salem, Oregon 97309-0405

503-947-7984 or toll-free at 888-877-4894

<http://www.cbs.state.or.us/ins/consumer/consumer.html>

cp.ins@state.or.us

KAISER PERMANENTE NW MEDICAL PLAN (HMO)

Kaiser Permanente provides services directly to members through an integrated medical care program. If you live or work in specific geographic areas, you may elect medical coverage under Kaiser Permanente. When you choose Kaiser Permanente you agree to receive all of your medical care from the physicians, specialists, hospitals, pharmacies, and labs associated with Kaiser Permanente. Kaiser Permanente provides services both through its own hospitals and medical offices, and through qualified community facilities.

Most care begins with primary care physicians. If your condition requires a specialist, the primary care physician can make the necessary referral. Although you may seek care at any Kaiser Permanente medical office, your primary care physician generally will be in the best position to see that you get the medical services you need.

When you choose Kaiser Permanente as your medical plan, your vision benefits are also through Kaiser. Refer to the vision section in this summary for a description of your vision coverage.

As a participant of Kaiser Permanente, you avoid deductibles and claim forms. Some services (such as office visits or lab tests) may require a copayment, which is due when you receive care. This summary gives you general information and the copayments you pay for services are listed in the "Medical Benefits Plan Comparisons" section in this summary on pages **19-22**. For more specific information about your coverage or for a summary of your benefit plan, contact Kaiser Permanente's Membership Services at 503-813-2000 or 800-813-2000.

KAISER EMERGENCY AND URGENT CARE COVERAGE

Emergency Medical Condition means a condition (including a psychiatric condition) in which the immediate onset of symptoms, including severe pain, would lead a prudent layperson with an average knowledge of health and medicine to reasonably believe that immediate medical attention is needed to:

- Avoid serious impairment of organs or bodily functions, or serious dysfunction of a bodily organ or part.
- Avoid a serious threat to the health of the individual or her fetus.

Examples of Emergency Medical Conditions may include suspected heart attack or stroke, sudden or extreme difficulty in breathing, sudden loss of consciousness, severe bleeding or severe abdominal pain or injuries to one or both eyes.

Urgent care is for problems that are not emergencies but which come up suddenly and require attention to prevent them from becoming serious.

Outside the service area: When you need emergency and urgent care when you are outside the Kaiser Permanente service area, go to the nearest medical facility. You do not need to get care in an emergency department for your coverage to apply. But remember, your emergency benefit does not cover the following services at facilities not affiliated with Kaiser Permanente: follow-up care, routine or continuing care, care you could have received before you left the service area, or childbirth within 31 days of your expected due date. For more detailed information on care away from home, request a travel packet from Kaiser's Customer Service. It contains a brochure, a claim form, and lists Group Health facilities in Washington state and Kaiser Permanente facilities around the country.

Inside the service area: When you are inside the Kaiser Permanente service area, you must receive emergency care at an emergency facility owned by or affiliated with Kaiser Permanente for your benefits to apply, unless the extra travel time to reach a Kaiser Permanente facility would result in serious medical consequence, such as risk of death.

FOR QUESTIONS OR PROBLEMS WITH KAISER CARE OR SERVICE

If you are dissatisfied with your medical treatment, discuss it with your care provider when the problem occurs. For problems with service or care, ask to speak with an administrator before you leave the medical office. If you are not satisfied, contact Member Relations at 503-813-4468, or refer to the Member Satisfaction section of your Kaiser Permanente Benefits book.

KAISER NW LIMITATIONS AND EXCLUSIONS:

Exclusions

The general exclusions set forth in this section apply to services and benefits otherwise covered under the City's agreement with Kaiser Permanente and are in addition to any exclusions specific to a particular benefit that are stated in the relevant sections in your Kaiser packet. As used in all exclusions in this section, "service" means any treatment, therapeutic or diagnostic procedure, drug, facility, equipment, device or supply. When a particular service is excluded, all services that are necessary or related to the excluded service are also excluded.

Chiropractic Services received without a referral by Kaiser Permanente.

Custodial care: Non-skilled, personal services such as help with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine);

Cosmetic Services: Cosmetic services that mean those Services that are intended primarily to change or maintain your appearance and that will not result in significant improvement in physical function. This exclusion does not apply to Services that are covered in "Reconstructive Surgery" in the Kaiser "Benefits, Copayments and Coinsurance" section.

Dental Services: Dental care and dental X-rays, such as dental services following accidental injury to teeth; dental appliances; dental implants; orthodontia; and dental services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment, except that this exclusion does not apply to dental Emergency Care or to extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.

Designated Blood Donations: Collection, processing and storage of blood donated by donors whom you designate, and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.

Detained or Confined Members. Services provided or arranged by criminal justice officials or institutions for detained or confined Members, unless the Services meet the requirements for care that would be covered as Emergency Care.

Employer or Governmental Responsibility

- a) Employer responsibility: Kaiser does not reimburse the employer for any services that the law requires an employer to provide. When Kaiser covers any such services, Kaiser may recover the charges for the services from the employer.
- b) Government agency responsibility: for any Services that the law requires be provided only by or received from a government agency, Kaiser will not pay the government agency and when Kaiser covers any such Services they may recover the Charges for the Services from the government agency. This exclusion does not apply to Medicaid.

Experimental or Investigational Services: Services are excluded if any of the following are true about the service:

The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or is the subject of a current new drug or new device application on file with the FDA; or is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any

other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives; or is subject to the approval or review of an Institutional Review Board ("IRB") or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy; or the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that (1) use of the service should be substantially confined to research settings, or (2) further research is necessary to determine the safety, toxicity, or efficacy of the service.

In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively: the Member's medical records, the written protocol(s) or other document(s) pursuant to which the service has been or will be provided, any consent document(s) the Member or Member's representative has executed or will be asked to execute, to receive the service, the files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body, the published authoritative medical or scientific literature regarding the service, as applied to the Member's illness or injury, and regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

If two or more services are part of the same plan of treatment or diagnosis, all of the services are excluded if one of the services is experimental or investigational.

Kaiser Permanente consults Medical Group and then uses the criteria described above to decide if a particular service is experimental or investigational.

Certain Examinations and Related Services: Physical examinations and related services required for obtaining or maintaining employment or participation in employee programs; insurance or governmental licensing; or court order or required for parole or probation. This exclusion does not apply if a Plan Physician determines that the Services are Medically Necessary.

Eye Surgery: Radial keratotomy, photorefractive keratectomy, and refractive surgery, including evaluations for the procedures.

Genetic Testing: Genetic testing and related services are excluded except for genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease and/or predisposition of disease, and to develop treatment plans. Covered services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when medically necessary as determined by a Physician. Testing for family members who are not Members is also excluded.

Hearing Aids.

Hypnotherapy All services related to hypnotherapy.

Intermediate Care. Care in an intermediate care facility.

Massage therapy services received without a referral from Kaiser Permanente.

Naturopathy Services received without a referral from Kaiser Permanente.

Non-medically necessary services.

Services Related to a Non-covered Service. When a Service is not covered, all Services related to the non-covered Service are excluded, except that this exclusion does not apply to Services we would otherwise cover to treat complications arising after the non-covered Service.

Sexual Re-assignment Surgery

Travel and Lodging. Transportation or living expenses for any person, including the patient, except for Medically Necessary ambulance Service covered under “Ambulance Services” and certain expenses that Kaiser preauthorizes in accord with Kaiser’s travel and lodging guidelines under “Transplants.”

Workers’ Compensation or Employer’s Liability. Financial responsibility for Services is excluded for any illness, injury, or condition to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as “Financial Benefit”), is provided under any workers’ compensation or employer’s liability law. Kaiser will provide Services even if it is unclear whether you are entitled to a Financial Benefit, but Kaiser may recover Charges for any such Services from the following sources:

- a. Any source providing a Financial Benefit or from whom a Financial benefit is due
- b. You, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers’ compensation or employer’s liability law.

Prescriptions drugs used for the treatment and/or prevention of sexual dysfunction.

Travel related services, including travel-only immunizations (such as yellow fever, typhoid and Japanese encephalitis are excluded.

Limitations

Kaiser Permanente will do its best to provide or arrange for your health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this contract, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities and labor disputes. However, in these circumstances, neither Kaiser, Plan Hospitals, Medical Group, nor any Plan Physician shall have any liability or obligation because of a delay or failure to provide these Services. In the case of a labor dispute involving Health Plan, Plan Hospitals, or Medical Group, Kaiser may postpone non-emergency care until after resolution of the labor dispute.

Acupuncture treatment may be covered for certain medical conditions on a limited basis. A Kaiser plan physician must prescribe the treatment. Referrals, if needed, will be to the designated Complementary Healthcare Plan (CHP) network of providers specializing in this service.

There may be other services you receive from Kaiser Permanente which require additional copayments. The service agreement between the City of Portland and Kaiser Permanente is the binding document between Kaiser Permanente and City of Portland members. If you have questions about specific services, and the costs to you, please call Kaiser Permanente directly at 1-503-813-2000.

Injuries or Illnesses Alleged to be Caused by Third Parties

Members must pay the Health Plan for covered services they receive for an injury or illness that is alleged to be caused by a third party’s act or omission, except that you do not have to pay more than you receive from or on behalf of the third party. To the extent permitted by law, Kaiser has the option of becoming subrogated to all claims, causes of action, and other rights the Member may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. Health Plan will be so subrogated as of the time they mail or deliver a written notice of exercise of this option to you or your attorney, but Health Plan will be subrogated only to the extent of the total covered charges for the relevant services and supplies.

To secure Health Plan’s rights, Health Plan will have a lien on the proceeds of any judgment or settlement the Member obtains against a third party. The proceeds of any judgment or settlement that the Member

obtains shall first be applied to satisfy Health Plan's lien regardless of whether the total amount of the recovery is less than the actual losses and damages the Member incurred.

Members must make all reasonable efforts to pursue any claim they may have against a third party. Within 30 days after submitting or filing a claim or legal action against a third party, the Member must send written notice of the claim or legal action to Health Plan at: Claims Administration; Kaiser Foundation Health Plan of the Northwest, 500 NE Multnomah St. #100, Portland, OR 97232-2099.

In order for Kaiser to determine the existence of any rights they may have and to satisfy those rights, you must complete and send them all consents, releases, trust agreements, authorizations, assignments and other documents, including lien forms directing your attorney, the third party and the third party's liability insurer to pay Kaiser directly.

At Kaiser's request, you must sign an agreement to place and hold a portion of your recovery amount sufficient to satisfy claims Kaiser has paid under this provision, in trust pending final resolution of the claim(s). You must provide Kaiser written notice before you settle a claim, obtain a judgment or if it appears you will make a recovery of any kind. If you recover any amounts from any third party for relevant services already paid by Kaiser, you must repay Kaiser or place the funds in a specifically identifiable account and retain control over the recovered amounts to which Kaiser may assert a right.

If your estate, parent guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent guardian, or conservator and any settlement or judgment recovered from the estate, parent, guardian, or conservator shall be subject to Kaiser's liens and other rights to the same extent as if you had asserted the claim against the third party. Kaiser may assign their right to enforce their liens and other rights.

If you are entitled to Medicare, Medicare law may apply with respect to Services covered by Medicare.

DIABETES EDUCATION PROGRAMS				
	Legacy	Portland Adventist	Providence	Kaiser
<p><i>General Description of Program</i></p> <p>Note: For CityCore & CityNet participants, all programs listed in this chart are paid as in-network with no deductible, regardless of your medical network. To receive reimbursement for your expenses, you must submit your claim to ODS.</p> <p>Kaiser participants are only eligible for the Kaiser program and must pay the member fees as outlined in this chart.</p>	Classes and individual self-management training, nutrition counseling, special programs for Type I and pump patients, Combining diabetes education and exercise sessions.	Information sessions, hands-on activities, self-care techniques include eating in restaurants, blood glucose self-monitoring, coping with diabetes, exercise, oral and insulin administration review.	Classes & individual self-management training for adults and seniors. Nutrition management and gestational diabetes management classes. Individual consultations in insulin pump training, insulin administration, blood glucose monitoring, and other services can be offered for patients with barriers to class settings.	Offered by the Health Education Services Department, sponsored by the Regional Diabetes Steering Committee, which is lead by Primary Care Clinicians and Endocrinologists to support and coordinate the care of Kaiser members with diabetes.
Locations	Legacy hospitals (Good Samaritan, Emanuel, Mount Hood, Meridian Park and Legacy Clinic, St. Helens. and Woodburn)	Adventist Medical Center 10000 SE Main Professional Bldg. 1 Suite 214 Portland, OR 97216	Providence Portland Medical Center, Sunset Business Park, Providence Milwaukee Hospital, Providence Newberg Hospital, Gresham	10 Kaiser Permanente Medical Offices in the Portland/ Vancouver area and one in Longview.
Frequency	Varies from site to site. Typically, 2 group classes per month for Type II, more extensive available for Type I and individual sessions.	Day classes , 3 mornings per month, generally from 8:30 to 12:00 noon. Evening classes: either 3 classes 6 – 9:30pm or 4 classes 6-8:30 pm. Classes include a pre-class visit and follow-up visit.	Classes offered on an on-going basis: 9:30am –11:30 am or 1:30pm - 3:30pm or 6:30pm – 8:30pm Individual consults are scheduled daily Monday through Friday.	Rotate between morning, afternoon and evening classes at all locations.
Program fees are subject to change. Please contact the provider for current pricing information.	General Education is 10 hours of instruction Medical Nutrition Services are charged in 15 minute incrementsCall 503-413-7227	Call 503-261-6003 for current pricing information.	Self Mgmt class (9 hrs) includes a one-hour individual appt with an RN or RD and four 2-hour classes Call 503-215-6265	Basic Series and follow-up Partners come for no extra fee. Call your local Kaiser Permanente Medical Office for further information.

Tobacco Cessation Programs

General Description of Program

Note: For **CityNet** participants, qualified tobacco cessation programs (including those listed in this chart) are paid as in-network with no deductible, regardless of your medical network. To receive reimbursement for your expenses, you must submit your claim to ODS.

Kaiser participants are only eligible for the Kaiser programs.

SMOKING CESSATION PROGRAMS				
	Legacy	Adventist	Providence	Kaiser
Program	<p>Stop Smoking</p> <p>4-session class over four weeks.</p>	<p>Becoming Smoke-Free, Staying Smoke-Free</p> <p>2-session program and ongoing aftercare support group.</p>	<p>Smoking Cessation</p> <p>11 session smoking cessation class at either Providence Portland Medical Center or Providence St. Vincent Medical Center</p> <p>Quit for Life</p> <p>Telephone based program offers 12-months of stop-smoking support.</p>	<p>Freedom From Tobacco:</p> <p>Class: Six 1 ½-hour sessions focus on techniques and strategies to help participants end their dependence on tobacco, <i>second</i> class is the quit date.</p> <p>Seminar: 2-hour seminar</p> <p><i>Telephone Counseling Program</i></p> <p>Create a plan for quitting and get ongoing support with a tobacco-cessation counselor.</p>
Locations	Class rotates at Legacy Hospitals	Adventist Medical Center 10123 SE Market St Portland, OR	Providence Portland Medical Center and Providence St. Vincent Medical Center	At various Kaiser facilities in Portland metro area, Vancouver and Salem.
Frequency	Four 1-hour sessions over a four-week period.	Two 2-hour sessions over two weeks. Ongoing support group meets once a week.	Eleven 1½ hour sessions various evenings.	Usually day and evening option offered quarterly. Sessions scheduled between 9 a.m. - 8 p.m., Monday through Friday.
Contact <i>All fees are subject to change Contact the provider for current fees.</i>	503-335-3500	503-256-4000	Smoking Cessation: 503-574-6595 Quit for Life: 1-800-292-2336	All Kaiser programs: 503-286-6816 or 1-866-301-3866 toll free

DENTAL PLANS

The City offers you a choice of two dental plans, the ODS Dental Premier Plan and a Kaiser Dental Plan. Your dental plan election is not tied to your medical plan election. In other words, you do not have to enroll in the CityNet PPO Medical Plan to elect the ODS Dental Premier Plan).

ODS Dental Premier Plan Highlights

- The annual deductible is \$25 per member; \$75 for a family of three or more.
- Eligible diagnostic and preventive services are paid at 100%, with no deductible.
- The lifetime orthodontia benefit is \$2,500 per person.
- The annual benefit maximum is \$2,000 per person.

Kaiser Dental Plan Highlights

The Kaiser Dental Plan includes the following:

- For diagnostic and preventive care, the office visit copay is \$10. For routine services, the plan pays 100% after a \$10 copay per visit.
- Urgent dental care appointments require an additional \$25 copay.
- For major dental services, the plan pays 80% after a \$10 copay per visit.
- There is a \$25.00 charge to you for missed dental appointments.

The orthodontia benefit covers adults and children. The plan pays 50% of eligible charges up to a \$3,000 lifetime maximum benefit.

Dental Plan Comparison

Dental Plan Feature	ODS Dental Premier Plan	Kaiser Dental Plan
Network Required	No	Yes
Plan Year Deductible	\$25/member; \$75/family of three or more	None
Plan Year Maximum Benefit	\$2,000/person	None
Maximum Plan Allowance (MPA)	Plan pays benefits based on MPA for expenses; you pay coinsurance amount plus anything over the MPA	Not applicable
Diagnostic and Preventive	ODS Class I – 100% (no deductible) for eligible services	Plan pays 100%* after a \$10 copay/visit
Routine	ODS Class II - 80% after deductible	
Major (includes inlays, onlays, crowns, and permanent prosthetics.) In addition, Kaiser includes periodontics & endodontics in this category.	ODS Class III – 50% after deductible	Plan pays 80% after \$10 copay/visit For Root canal therapy when the pulp chamber of a tooth is opened before a member's coverage is effective, coverage will be at 50%.
Orthodontics	Covers children and adults; 50%, up to \$2,500 lifetime maximum	Covers children and adults; 50% of eligible charges, up to a \$3,000 lifetime maximum benefit

*Kaiser offers 100% coverage for routine fillings, plastic and stainless steel crowns, and simple tooth extractions.

ODS DENTAL PREMIER PLAN

Below is a general list of services your dental care program covers when performed by a licensed dentist, certified denturist or registered hygienist. These services are covered only when determined to be necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or for accidental injury (accidental injury coverage is secondary to medical). ODS' dental consultants and dental director shall determine these standards.

Covered dental services are outlined in 3 "classes" that start with preventive care and advance into specialized dental procedures. Plan pays benefits based on the maximum plan allowance (MPA) for expenses. MPA is the maximum amount that ODS will reimburse providers. For a participating Premier dentist, the maximum amount is the dentist's filed or contracted fee with ODS/Delta Dental. For non-participating dentists, the maximum amount is based on a per service average allowance of the participating Premier dentists' filed fees. *The non-participating dentist has the right to bill the difference between ODS' maximum plan allowance and the actual charge. This difference will be the member's responsibility.*

Limitations may apply to these services, please see below.

Deductible: \$25.00

Per member (not to exceed \$75.00 per family) per plan year or portion thereof
Deductible applies to covered Class II and Class III services

Maximum Payment limit: \$2,000.00 *Per member per plan year, or portion thereof*
All covered services (Class I, II, III) apply to Maximum Payment Limit

I. Class I: 100% is provided toward covered Class I services

A. Diagnostic

Examination

Intra-oral x-rays to assist in determining required dental treatment.

Diagnostic Limitations:

1. Periodic (routine) or comprehensive examinations or consultations are covered once in any 6-month period*.
2. Complete series x-rays or a panoramic film is covered once in any 5-year period*.
3. Supplementary bitewing x-rays are covered once in any 12-month period*.
4. Separate charges for review of a proposed treatment plan or for diagnostic aids such as study models and certain lab tests are not covered.
5. Only the following x-rays are covered by the Plan: complete series or panoramic, periapical, occlusal, and bitewing.
6. ViziLite Plus TBlue is covered once in any 6-month period.

B. Preventive

Prophylaxis (Cleanings)

Periodontal maintenance

Topical application of fluoride

Space maintainers

Sealants

Preventive Limitations:

1. Prophylaxis (cleaning) or periodontal maintenance is covered once in any 6-month period*. Additional cleaning benefit is available for enrollees with diabetes and female enrollees in their third trimester of pregnancy. To be eligible for this additional benefit, enrollees must be enrolled in the Oral Health, Total Health program.
2. Topical application of fluoride is covered once in any 6-month period* for members age 18 and under. For members age 19 and over, topical application of fluoride is covered

once in any 6-month period* if there is recent history of periodontal surgery or high risk of decay due to medical disease or chemotherapy or similar type of treatment (poor diet or oral hygiene does not constitute a medical disease).

3. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspids and molars. Benefits will be limited to one sealant per tooth, during any 5-year period.
4. Space maintainers are a benefit once per space. Space maintainers for primary anterior teeth, missing permanent teeth or for enrollees age 14 or over are not covered.

***Please Note: These time periods are calculated from the previous date of service.**

II. Class II: 80% is provided toward covered Class II services

A. Restorative

Provides amalgam fillings on posterior teeth and composite fillings on anterior teeth for the treatment of carious lesions (decay).

Restorative Limitations:

1. Composite, resin, or similar (tooth colored) restorations in posterior teeth are considered optional services. Coverage shall be made for a corresponding amalgam restoration. If a tooth colored filling is used to restore posterior teeth, benefits are limited to the amount paid for an amalgam filling. The member is responsible for paying the difference.
2. Inlays are considered an optional service; an alternate benefit of an amalgam will be provided.
3. Crown buildups are considered to be included in the crown restoration cost. A buildup will be a benefit only if necessary for tooth retention.
4. Refer to Class III Limitations for further limitations when teeth are restored with crowns or cast restorations.
5. A separate charge for general anesthesia and/or IV sedation when in conjunction with non-surgical procedures is not covered.

B. Oral Surgery

Extractions (including surgical), other minor surgical procedures, general anesthesia or IV sedation (when administered by a dentist in conjunction with a covered surgical procedure performed in a dental office).

Oral Surgery Limitations:

1. A separate, additional charge for alveoplasty done in conjunction with surgical removal of teeth is not covered.
2. General anesthesia and/or IV sedation is only a benefit when administered by a dentist in conjunction with covered surgery.
3. Surgery on larger lesions or malignant lesions is not considered minor surgery.
4. Brush biopsy is covered once in any 6-month period. The benefit for brush biopsy is limited to the sample collection and does not include coverage for pathology (lab) services.

C. Endodontic

Procedures for treatment of teeth with diseased or damaged nerves (for example, pulpal therapy and root canal filling).

Endodontic Limitations:

1. A separate charge for cultures is not covered.
2. Pulp capping is covered only when there is exposure of the pulp.
3. Cost of retreatment of the same tooth by the same dentist within 24 months of a root canal is not eligible for additional coverage. The retreatment is included in the charge for the original care.

D. Periodontic

Treatment of diseases of the gums and supporting structures of the teeth and/or implants.

Periodontic Limitations:

1. Periodontal scaling and root planing is limited to once per quadrant in any 24-month period.
2. Coverage for periodontal maintenance procedure under Class I, Preventive.
3. A separate charge for post-operative care done within 3 months following periodontal surgery is not covered.
4. Full mouth debridement is limited to once in a 3-year period and only if there has been no cleaning (prophylaxis, periodontal maintenance) within 24 months.

III. Class III: 50% is provided toward covered Class III services

A. Restorative

Cast restorations, such as crowns, onlays or lab veneers, necessary to restore decayed or broken teeth to a state of functional acceptability.

Restorative Limitations:

1. Cast restorations (including pontics) are covered once in a 7-year period on any tooth. See Class II for limitations on buildups.
2. Porcelain restorations are considered cosmetic dentistry if placed on the upper second or third molars or the lower first, second or third molars. Coverage is limited to gold without porcelain, and you are responsible for paying the difference.
3. If a tooth can be restored with a material such as amalgam, but another type of restoration is selected by the patient or dentist, covered expense will be limited to the cost of amalgam. Crowns are only a benefit if the tooth cannot be restored by a routine filling.

B. Prosthodontic

Implants, bridges, partial dentures, and complete dentures. Includes denture relines and repair of an existing prosthetic device.

Prosthodontic Limitations:

1. A bridge or denture (full or partial denture) will be covered once in a 7-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the last 7 years.
2. Full, immediate and overdentures: If personalized or specialized techniques are used, the covered amount will be limited to the cost for a standard full denture. Temporary (interim or provisional) complete dentures are not covered.
3. Partial dentures: A temporary (interim) partial denture is only a benefit when placed within 2 months of the extraction of an anterior tooth or for missing anterior permanent teeth of enrollees age 16 or under. If a specialized or precision device is used, covered expense will be limited to the cost of a standard cast partial denture. No payment is provided for cast restorations for partial denture abutment teeth unless the tooth requires a cast restoration due to decayed or broken teeth.
4. Denture adjustments, repairs, and relines: A separate, additional charge for denture adjustments, repairs, and relines done within 6 months after the initial placement is not covered. Subsequent relines will be covered once per denture in a 12-month period. Subsequent adjustments are limited to 2 adjustments per denture in a 12-month period.
5. Tissue conditioning is covered no more than twice per denture in a 36-month period.
6. Surgical placement and removal of implants are covered. Implant placement and implant removal are limited to once per lifetime per tooth space. We will also benefit:
 1. The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space over the lifetime of the implant; or
 2. Provide an alternate benefit per arch of a full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is

- placed to support a prosthetic device. The frequency limitation for prosthetic devices will apply to this alternate benefit (only once in any 7-year period); or
3. The final implant-supported bridge abutment and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 7-year period;
 4. Implant-supported bridges are not covered if one or more of the abutments is supported by a natural tooth;
 5. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 7 years.
7. Fixed bridges or removable cast partial dentures are not covered for members under age 16.
 8. Porcelain restorations are considered cosmetic if placed on the upper second or third molars or the lower first, second, or third molars. Coverage is limited to a corresponding metallic prosthetic. You are responsible for paying the difference.

C. Other

1. Other Services:
 - i. Athletic mouthguard
2. Other Limitations:

An athletic mouthguard is covered once per year for members age 15 and under and once every 2 years age 16 and over.

IV. General Limitation – Optional Services

If a more expensive treatment than is functionally adequate is performed, ODS will pay the applicable percentage of the maximum plan allowance for the least costly treatment. The member will then be responsible for the remainder of the dental care provider's fee.

V. Non-Participating Dentists

The amounts payable for services of a Non-participating Dentists are limited to the applicable percentages specified in the Plan for corresponding services in the non-participating provider fee schedule. The allowable fee in states other than Oregon shall be that state's Delta Affiliate's Non-participating Dentist allowance.

Oral Health, Total Health Program

Visiting a dentist on a regular basis and keeping the mouth healthy is critical to keeping the rest of the body healthy?

Studies have indicated a relationship between periodontal disease, bacteria in the mouth, and various health problems including pre-term, low birth weight babies and diabetes.

ORAL HEALTH, TOTAL HEALTH BENEFITS

We care about your overall health and have developed a program that provides additional cleanings (prophylaxis or periodontal maintenance) for ODS members based on this new evidence. This benefit is for the cleaning only. Coverage for a routine exam and other services is subject to the frequency limitations outlined in this handbook.

A. Diabetes

For members with diabetes, elevated blood sugar levels can have a negative effect on your oral health. Diabetes increases your risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely,

poor oral health can make your diabetes more difficult to manage. Infections may cause your blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes.

Diabetic members are eligible for a total of 4 cleanings per policy year.

B. Pregnancy

Keeping your mouth healthy during your pregnancy is important for you and your baby. According to the American Dental Association, pregnant women who have periodontal (gum) disease are more likely to have a baby that is born too early and too small.

Research suggests that periodontal disease triggers increased levels of biological fluids that induce labor. Furthermore, data suggests that women whose periodontal condition worsens during pregnancy have an even higher risk of having a premature baby. Dental visits during a woman's third trimester of pregnancy may help prevent pre-term, low birth weight babies.

Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during your third trimester of pregnancy. Members should talk to their dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. Pregnant members are eligible for a cleaning in the third trimester of pregnancy regardless of normal plan frequency limits.

C. How to Enroll

Enrolling in the Oral Health, Total Health program is easy. To enroll, a member can contact ODS Dental Customer Service or complete and return the Oral Health, Total Health enrollment form found on my ODS. Members with diabetes must include proof of diagnosis.

Orthodontic Benefit

Orthodontic services are a benefit for members.

Orthodontic services are defined as the procedures of treatment for correcting maloccluded teeth.

ODS will pay **50%** of the maximum plan allowance toward covered orthodontic services, up to the orthodontic lifetime maximum of . \$2,500.00. This lifetime maximum is not included in the dental plan year maximum.

The lifetime maximum amount the Plan will pay for orthodontic services for a member is \$2,500.00. This lifetime maximum is not included in the dental plan maximum.

If the dental plan has a deductible, it does not apply to orthodontic services.

LIMITATIONS

1. ODS' obligation to make payments for treatment will cease upon termination of treatment for any reason prior to completion, or upon termination of eligibility under the Plan.
2. Repair or replacement of an appliance furnished under the Plan is not covered.
3. If treatment began before the member was eligible under this Policy, ODS will base its obligation on the balance of the dentist's normal payment pattern. The orthodontic maximum will apply to this amount.

Exclusions

1. Procedures, appliances, restorations or any services that are primarily for cosmetic purposes.
2. The Plan does not cover:
 - Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this Plan;
 - Services that are inappropriate with regard to standards of good dental practice;
 - Services with poor prognosis.

3. Services Otherwise Available, including:
 - Services compensable under workers' compensation or employer's liability laws;
 - Services provided by any city, county, state or federal law, except for Medicaid coverage;
 - Services provided, without cost to the enrollee, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Plan;
 - Any condition, disease, ailment, injury or diagnostic service to the extent that benefits are provided or would have been provided had the patient enrolled, applied or maintained eligibility for such benefits under Title XVIII of the Social Security Act, as amended.
4. A separate charge for periodontal charting.
5. Services or supplies caused by or provided to correct congenital or developmental malformations; including, but not limited to treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth).
6. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth are excluded. This includes services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, periodontal splinting, and nightguards (occlusal guard).
7. Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ).
8. Gnathologic recordings or similar procedures.
9. Dental services started prior to the date the member became eligible for such services under the plan.
10. Hypnosis, premedications, analgesics (e.g. nitrous oxide), local anesthetics or any other prescribed drugs.
11. Hospital or facility charges for services or supplies, or additional fees charged by the dental provider for hospital, extended care facility or home care treatment.
12. Charges for missed or broken appointments.
13. Experimental procedures or supplies.
14. This plan does not cover services provided or supplies furnished after the date coverage ends, except for Class III services which were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after individual eligibility ends. This provision is not applicable if the Group transfers the plan to another carrier.
15. General anesthesia and/or IV sedation except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions.
16. Plaque control and oral hygiene or dietary instruction.
17. Claims submitted more than 12 months after the date of service are not covered, except as stated in the Claim Submission section.
18. Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue.
19. Services performed on the tongue, lip or cheeks.
20. Precision attachments.
21. Taxes.
22. Treatment of any condition caused by or arising out of service in the armed forces of any country or the active participation in a war or insurrection, or the voluntary participation in a riot or rebellion or arising directly from an illegal act.
23. Exclusions include all other services or supplies not specifically included in this Policy as covered dental services.

24. Services provided by a relative. Relatives, for the purpose of this exclusion, include a spouse, domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.
25. Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth.

ODS Dental Plan Frequently Asked Questions

1. Does ODS have a network of Dental Providers?

ODS does not print a dental network directory. You may review the ODS dental network online at www.odscompanies.com under "Find Care" or by calling ODS at 503-265-5680 or 1-877-277-7280. When online, choose the Premier (Traditional) dental network. Dentists posted as network dentists are those who have agreed that their charges will not exceed the plan allowance. Network dentists have also agreed to submit any necessary claims to ODS.

2. What dentist can I see?

The City of Portland's policy with ODS gives a member the option of seeing any licensed dentist. However, a nonparticipating dentist may charge more than the plan allowances, and the member will be responsible for any charge above that amount.

3. Can I see a dental specialist, such as an orthodontist or endodontist?

Specialist services are a covered benefit under the policy between the City of Portland and ODS. Members are encouraged to have the specialist submit a request for predetermination of benefits to determine how much benefit the Plan will pay.

4. How can I find out what my remaining benefits are for this current benefit year?

Contact ODS Dental Customer Service by calling 503-265-5680 or 1-888-277-7280 and ODS will review claims history to determine how much in benefits the member has remaining. Or visit ODS' website at www.odscompanies.com under my ODS.

5. What do I do if I have a dental emergency and I'm out of town?

Members may seek services through any licensed dentist. Payment may be required at the time of service. For determination of allowable reimbursement of expenses, a member must submit a paper claim to ODS with the itemized receipts from the dentist's office. A nonparticipating dentist may charge more than the plan allowances, and the member will be responsible for any charge above that amount.

6. How long are my children covered under my dental plan?

Eligible children are covered until age 26

7. What does the term "least costly" mean?

If a tooth can be restored with a procedure that is less expensive than the procedure rendered, benefits paid will be based on the procedure that costs less.

ODS Dental Plan Coordination of Benefits

Coordination of Benefits (COB) occurs when you have dental coverage under more than one Plan.

DEFINITIONS

For purposes of this section on Coordination of Benefits, the following definitions apply:

Plan means any of the following that provides benefits or services for dental care or treatment. If separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

Plan includes:

- Group insurance contracts and group-type contracts;
- HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group or group-type coverage.

Plan does not include:

- Fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Medicare supplement policies;
- Medicaid policies, or;
- Coverage under other federal governmental plans, unless permitted by law.

Each contract or other arrangement for coverage described above is a separate Plan. If a Plan has two parts and COB rules apply to only one of the two, each of the parts is treated as a separate Plan.

Complying Plan is a plan that complies with these COB rules.

Non-complying Plan is a plan that does not comply with these COB rules.

Claim means a request that benefits of a plan be provided or paid.

An **Allowable Expense** means a dental expense, including deductibles, coinsurance, and copayments, which is covered at least in part by any Plan covering the member. When a Plan provides benefits in the form of a service rather than cash payments, the reasonable cash value of the service will also be considered an Allowable Expense and a benefit paid. An expense that is not covered by any Plan covering the member is not an Allowable Expense. In addition, any expense that a provider by law or in accordance with a contractual agreement is prohibited from charging a member is not an Allowable Expense.

The following are examples of expenses that are **not** Allowable Expenses:

- The amount of the reduction by the primary Plan because a member has failed to comply with the Plan provisions concerning second opinions or prior authorization of services, or because the member has a lower benefit due to not using an in-network provider;

- Any amount in excess of the highest reimbursement amount for a specific benefit, if a member is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology;
- Any amount in excess of the highest of the negotiated fees, if a member is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a member is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another Plan that provides its benefits or services on the basis of negotiated fees, the primary Plan's arrangement shall be the Allowable Expense for all Plans. However, if the provider has contracted with the secondary Plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary Plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the Allowable Expense used by the secondary Plan to determine its benefits.

This Plan is the part of this group policy that provides benefits for dental expenses to which the COB provision applies and which may be reduced because of the benefits of other plans. Any other part of the policy providing dental benefits is separate from this Plan. A policy may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

A **Closed Panel Plan** is a Plan that provides dental benefits to covered persons primarily in the form of services through a network of providers that have contracted with or are employed by the Plan, and that excludes coverage for services provided by other providers, except in cases of emergency or referral by an in-network provider.

Custodial Parent is the parent awarded custody by a court decree or, in the absence of a court decree, is the parent with whom the child resides more than one half of the calendar year excluding any temporary visitation.

HOW COB WORKS

If the member is covered by another Plan or Plans, the benefits under this Plan and the other Plan(s) will be coordinated. This means one Plan pays its full benefits first, then any other plans pay. The order of benefit determination rules govern the order in which each Plan will pay a claim for benefits.

The Primary Plan (the Plan that pays benefits first) pays the benefits that would be payable under its terms in the absence of this provision.

The Secondary Plan (the Plan(s) that pay(s) benefits after the Primary Plan) will reduce the benefits it pays so that payments from all Plans do not exceed 100% of the total Allowable Expense.

This Plan will coordinate with a plan that is "excess" or "always secondary" or that uses order of benefit determination rules that are inconsistent with those contained in OAR 836-020-0770 to 836-020-0805 (non-complying plan) on the following basis:

- If this Plan is primary, it will provide its benefits first.
- If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan's benefits. This plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
- If the non-complying plan reduces its benefits so that the covered person receives less in benefits than s/he would have received had this Plan provided its benefits as the secondary plan and the non-complying plan provided its benefits as the primary plan, then this Plan shall advance additional benefits equal to the difference between the amount that was actually paid and the

amount that should have been paid if the non-complying plan had not improperly reduced its benefits. Additional payment will be limited so that ODS will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the covered person against the non-complying plan.

ORDER OF BENEFIT DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a Plan covers the member as other than a dependent, for example, an employee, member, subscriber, or retiree, then that Plan will determine its benefits before a Plan which covers the member as a dependent.
2. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the member is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the Plan of the parent whose birthday falls earlier in the calendar year is the primary Plan. If both parents' birthdays are on the same day, the Plan that has covered the parent the longest is the primary Plan. (This is called the 'Birthday Rule'.)
3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the member is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:
 - If a court decree states that one of the parents is responsible for the healthcare expenses of the child, and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to plan years commencing after the Plan is given notice of the court decree.
 - If a court decree states that both parents are responsible for the healthcare expenses of the child, or that the parents have joint custody without specifying that one parent is responsible, the 'birthday rule' described above applies.
 - If there is not a court decree allocating responsibility for the child's healthcare expenses, the order of benefits is as follows:
 - The Plan covering the custodial parent;
 - The Plan covering the spouse or domestic partner of the custodial parent;
 - The Plan covering the non-custodial parent; and then
 - The Plan covering the spouse or domestic partner of the non-custodial parent.
4. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one Plan of persons who are not the parents of the child, the first applicable provision (# 2 or #3) above shall determine the order of benefits as if those persons were the parents of the child.
5. **Active/Retired or Laid Off Employee.** The Plan that covers a member as an active employee, that is, one who is neither laid off nor retired (or as that employee's dependent) determines its benefits before those of a Plan that covers the member as a laid off or retired employee (or as that employee's dependent). If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule is ignored.
6. **COBRA or State Continuation Coverage.** If a member whose coverage is provided pursuant to COBRA or under a right of continuation provided by state or other federal law is covered under another Plan, the Plan covering the member as an employee, member of an organization, primary insured, or retiree or covering the person as a dependent of an employee, member or an organization, primary insured, or retiree, is the primary Plan and the COBRA or other continuation coverage is the secondary Plan. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of the benefits, this rule is ignored.

7. **Longer/Shorter Length of Coverage.** The plan that covered a member longer is the primary Plan and the Plan that covered the member for the shorter period of time is the secondary Plan.
8. **None of the Above.** If the preceding rules do not determine the order of benefits, the Allowable Expenses shall be shared equally between the Plans. In addition, this Plan will not pay more than it would have paid had it been the primary Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other dental coverage and apply that calculated amount to any Allowable Expense under its Plan that is unpaid by the primary Plan. The secondary Plan shall credit to its plan deductible any amounts it would have credited to its deductible in the absence of other dental coverage.

If the primary plan is a closed panel plan and the member uses an out-of-network provider, the secondary plan shall provide benefits as if it were the primary plan, except for emergency services or authorized referrals that are paid or provided by the primary plan.

ODS' RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

In order to receive benefits, the member must give ODS any information needed to pay benefits. ODS may release to or collect from any person or organization any needed information about the member.

CORRECTION OF PAYMENTS

If benefits that this Plan should have paid are instead paid by another plan, this Plan may reimburse the other plan. Amounts reimbursed are plan benefits and are treated like other plan benefits in satisfying the Plan's liability.

RIGHT OF RECOVERY

If the Plan pays more for a covered expense that is required by the Plan the excess payment may be recovered from:

1. The subscriber;
2. Any person to whom the payment was made; or
3. Any insurance company, service plan or any other organization which should have made payment.

Kaiser Dental Plan

Kaiser Permanente Dental Plan is a prepaid group practice offering comprehensive dental care. Dental services are covered only when provided in Kaiser Permanente facilities. This summary gives you general information and the copayments you pay for services. For more specific information about your coverage, contact Kaiser Permanente's Membership Services at 503-813-2000 or 800-813-2000.

The Plan's coverage is outlined in the Dental Coverage comparison chart on page 59. Allowable expenses include:

- **PREVENTIVE AND DIAGNOSTIC SERVICES:** Oral examinations and x-rays, teeth cleaning (prophylaxis), fluoride treatments, instruction in the care of your teeth and gums, and prescribed space maintainers.
- **BASIC RESTORATIVE SERVICES AND PROSTHETIC SERVICES:** Routine fillings, plastic and stainless steel crowns, and simple tooth extractions
- **MAJOR RESTORATIVE AND PROSTHETIC SERVICES:** Full and partial dentures, relines and rebases, gold and porcelain crowns, inlays, band bridge pontics, prescribed by a Kaiser Permanente dentist.
- **PERIODONTICS:** Treatment of disease of the gums, including scaling and root planning.
- **ENDODONTICS:** Root canal and related therapy. When the pulp chamber of a tooth is opened before a member's coverage is effective with Kaiser, root canal therapy will be covered at 50%.
- **ORAL SURGERY:** Surgical tooth extractions
- **EMERGENCY TREATMENT *Within the service area:*** You must use Kaiser Permanente facilities. You must pay a \$25.00 urgent care copay, in addition to the regular \$10.00 copay and any other copays that would apply.
- **EMERGENCY TREATMENT *Outside the service area:*** The plan will pay up to \$100.00 only for the relief of pain, acute infection, hemorrhage or injury.
- **ORTHODONTICS:** Orthodontic services and braces for children and adults.

24-HOUR SERVICE LINE

Kaiser Permanente participants can call the 24-hour service line to:

- Make return cleaning appointments, anytime day or night;
- Receive advice or help in a dental emergency;
- Verify or cancel appointments;
- Change and reschedule appointments;
(6:30 am – 7:00 pm weekdays; 7:30 am – 4:00 pm Saturdays)
- Get directions to Kaiser Permanente dental offices; and/or
- Talk to a dental member assistant
(6:30 am – 7:00 pm weekdays; 7:30 am – 4:00 pm Saturdays).

From Portland 503-286-6868

From Vancouver 360-254-9158

From Salem 503-370-4311

From Longview 360-575-4800

Kaiser NW Dental Plan Exclusions and Limitations

The general exclusions set forth in this Section apply to services and benefits otherwise covered under this Agreement and are in addition to any exclusions specific to a particular benefit that are stated in the relevant section of the Benefit Schedule. As used in all exclusions in this Section and in the Benefit Schedule, "service" means any treatment, therapeutic or diagnostic procedure, drug, facility, equipment, device or supply. When a particular service is excluded, all services that are necessary or related to the excluded service are also excluded.

Exclusions and Limitations

Exclusions from Coverage

- Care for conditions that are covered by workers' compensation or that are the employer's responsibility.
- Conditions for which care or reimbursement is required by law to be provided at or by a government agency.
- Cosmetic services.
- Dental implants, including bone augmentation and fixed or removable prosthetic devices attached to or covering the implants; all related services, including diagnostic consultations, impressions, oral surgery, placement, removal, and cleaning; and services associated with postoperative conditions and complications arising from implants.
- Experimental or investigational treatments, procedures and other services that are not commonly considered standard dental practice or that require governmental approval.
- Full mouth reconstruction and occlusal rehabilitation, including appliances, restorations and procedures needed to alter vertical dimension or occlusion or to splint or correct attrition or abrasion.
- General anesthesia.
- Genetic testing.
- Intravenous sedation.
- Medical, hospital and certain dental services.
- More than two visits for routine teeth cleaning (oral prophylaxis) treatments in any 12 consecutive month period.
- Prescription drugs.
- Prosthetic devices when necessary or desired following your decision to have a tooth (or teeth) extracted for nonclinical reasons or when a tooth is restorable.
- Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason except the pathological condition of the tooth or teeth.
- Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years old.
- Replacement of prefabricated, noncast crowns, including noncast stainless steel crowns that were not placed by a Kaiser Permanente dentist.
- Replacement of temporary removable appliances within five years of the date you received the appliance.
- Restorative or reconstructive treatment for specific congenital or developmental malformations.

- Services not approved by a Kaiser Permanente dentist. Kaiser Permanente does not pay for unauthorized services from dentists or facilities not affiliated with Kaiser Permanente, except as described under “Emergency Benefits.”
- Surgery to correct malocclusion or temporomandibular joint disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves and other tissues related to that joint.
- Work-in-progress for the following services and related materials: a) a prosthetic or other appliance, or modification of one, where an impression was made before your coverage became effective; b) a crown, bridge or gold restoration for which a tooth was prepared before your coverage became effective; c) root canal therapy, if the pulp chamber was opened before your coverage became effective, is covered at 50% of charges.
- Speech-aid prosthetic devices and follow-up modifications.
- Treatment to restore tooth structure lost due to attrition, erosion or abrasion.

Limitations in Service

Kaiser Permanente is not responsible for delay or failure to render service because of unusual circumstances, such as wars; riots; labor disputes not involving Kaiser Permanente, or major disasters or epidemics affecting Kaiser Permanente facilities or personnel. Non-emergency care may be postponed in the event of labor disputes involving Kaiser Permanente organizations.

In the event of a strike, lockout or labor dispute affecting the City of Portland, you may continue your group coverage for the term of the disruption or six months, whichever is less. You are responsible for payment of premiums during this period of time.

To submit an appeal, follow the instructions in the denial letter you receive, or call or send your appeal to Member Relations. You have the right to include with your appeal any written comments, documents, records and other information relating to the claim.

Appeals will be decided within 30 days after Kaiser receives your appeal. A decision will be expedited to meet the clinical urgency of the situation, not to exceed 72 hours if it involves a denial of urgently needed future care. Member Relations will conduct an independent review of your appeal and provide a written response. If your appeal is denied, the written notice you receive will explain the basis for the decision, along with other important disclosures as required under state and federal laws.

Injuries or Illnesses Alleged to be Caused by Third Parties

You must pay Kaiser Permanente for covered services that you receive for an injury or illness that is alleged to be caused by a third party’s act or omission or on the premise of a third party or when a no-fault insurance provision applies, except that you do not have to pay Kaiser for more than you receive from or on behalf of the third party. The covered services include amounts paid for claims and all Non-Member Charges for services provided by Kaiser Permanente.

As a condition of receiving benefits, Members must reimburse Kaiser Permanente for any eligible expenses paid by the Plan for which payment is received from any third party. If there is no recovery, Members are only responsible for the applicable cost-sharing under their Health Plan benefits.

To the extent permitted by law, Kaiser Permanente has the option of becoming subrogated to all claims, causes of action, and other rights the Member may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. Kaiser Permanente will be subrogated only to the extent of the total covered charges for the relevant services and supplies.

To secure their rights, Kaiser Permanente will have a lien on the proceeds of any judgment or settlement the Member obtains against a third party. The proceeds of any judgment or settlement that the Member obtains shall only be applied to satisfy Kaiser's lien after you are reimbursed the total amount of the actual losses and damages the Member incurred.

Members must make all reasonable efforts to pursue any claim they may have against a third party. Within 30 days after submitting or filing a claim or legal action against a third party, the Member must send written notice of the claim or legal action to Kaiser Permanente. In order for Kaiser to determine the existence of any rights they may have and to satisfy those rights, the Member must complete and send Kaiser all consents, releases, trust agreements, authorizations, assignments and other documents, including lien forms directing the Member's attorney, the third party and the third party's liability insurer to pay Kaiser Permanente directly. Members must not take any action prejudicial to Kaiser Permanente's rights.

Members must provide Kaiser Permanente written notice before they settle a claim, obtain a judgment or if it appears the Member will make a recovery of any kind. If the Member recovers any amounts from any third party for relevant services already paid by Kaiser Permanente, the Member must repay Kaiser after s/he is reimbursed the total amount of the actual losses and damages incurred or place the funds in a specifically identifiable account and retain control over the recovered amounts to which Kaiser Permanente may assert a right.

If the Member's estate, parent, guardian, or conservator asserts a claim against a third party based on the Member's injury or illness, any settlement or judgment recovered shall be subject to Kaiser Permanente's liens and other rights to the same extent as if the Member had asserted the claim against the third party. Kaiser Permanente may assign their rights to enforce their liens and other rights.

Deferral of Care. If a Member has a bad debt of greater than \$250.00 for Dental Services, further treatment may be deferred until the debt is paid. Dental Services will be provided to stabilize an urgent or emergent dental condition regardless of financial status.

Non-Duplication of Coverage. Benefits provided under this Agreement do not duplicate other coverage for dental care or treatment. If the Member is entitled to receive benefits or services for dental care or treatment under another individual, group or governmental plan or coverage, Health Plan may recover the reasonable cash value of services provided under this Agreement so that benefits and services under all plans or coverage do not exceed one hundred percent (100%) of allowable expenses (except copayments and coinsurance) as set forth in this Section.

Kaiser Dental Plan Frequently Asked Questions

1. What is the office visit copay for dental services through Kaiser?

The office visit copay is \$10 plus any additional percentage determined under the service agreement between Kaiser Permanente and the City of Portland.

2. What other dental co-pays may I be responsible to pay under Kaiser?

Emergency and urgent care visits with Kaiser plan providers require a \$25 copay plus any other copayments that normally apply.

Emergency treatment benefit from non-plan providers is the balance after you are reimbursed up to \$100 for qualifying claims outside the service area.

Participants will be charged a \$25 fee when a dental appointment is missed without calling in advance to cancel the appointment.

Participants will be charged \$15 for nitrous oxide for adults and children 13 and older.

Participants will pay 10% of charges for nightguards.

There may be other services you receive from Kaiser Permanente which require additional copayment from you, the participant. The copays identified within this question do not fully describe your benefit coverage. The service agreement between the City of Portland and Kaiser Permanente is the binding document between Kaiser Permanente and its City of Portland members.

Vision Plans

Vision coverage is provided through VSP if you elect the CityNet plan, and through Kaiser Vision if you elect the Kaiser medical plan. The following outlines the benefits under each of the plans.

Vision Plan Feature	Vision Service Plan (VSP)		Kaiser Vision
	VSP Provider	Non-VSP Provider	
Enrollment	Automatic enrollment with election of CityNet Medical Plan		Automatic enrollment with election of Kaiser HMO Medical Plan
Exams – adults: 1 visit/ 24 months – children: 1 visit/ 12 months	100% after \$15 copay	Plan pays up to \$50 Claims must be filed within 6 months of the date of service.	100% after \$10 office visit copay. No visit limit.
Eyeglass frames (1 pair/24 months)	Plan allows up to \$120 towards the cost of frames and provides a 20% discount for costs in excess of the \$120 allowance.	Plan pays up to \$70 per frame Claims must be filed within 6 months of the date of service.	\$150 allowance towards the purchase of covered lenses, frames and/or contact lenses every 24 months.
Eyeglass lenses (1 pair/24 months)	100% of prescribed lenses (See Special notes).	Plan pays up to the following: – single lenses (pair) \$ 50 – bifocal lenses (pair) \$ 75 – trifocal lenses (pair) \$100 Claims must be filed within 6 months of the date of service.	
Cosmetic contacts	Plan pays up to \$120 every 24 months in lieu of glasses plus 15% discount on the contact lens exam (fitting and evaluation)	Plan pays up to \$105 Claims must be filed within 6 months of the date of service.	
Medical necessary contacts*	100%	Plan pays up to \$210 Claims must be filed within 6 months of the date of service.	100%
Special notes:	Special cosmetic items, such as tinted or coated lenses, UV protected lenses, blended lenses, color contacts, etc., are not covered by VSP.		Lens options are not covered.

* One pair every 24 months.

VISION SERVICE PLAN (VSP) for CityNet Plan Participants

You must see a VSP provider for the in-network level of benefits. To find a VSP provider, go to www.vsp.com.

VSP also includes Costco as an affiliate provider. Costco will bill VSP like a VSP doctor, but the benefits are slightly different—lens options are at Costco pricing and the frame benefit is lower than in-network. If you go to Costco, you must advise them that you have VSP coverage before you receive any services. Costco will need to get an authorization from VSP prior to providing services. If the authorization is not received prior to the services, then you will receive out of network plan benefits for the services.

CityNet plan participants with the VSP plan may also select the Buy-up Option for richer benefits, including:

- Exam and lenses (either contacts or in glasses) every 12 months
- Increased retail frame allowance through VSP provider of \$170 every 24 months
- Polycarbonate lenses covered in full through VSP provider
- \$50 allowance toward progressive lenses through VSP provider;
- \$30 allowance toward anti-reflective lenses through VSP provider.

The additional monthly cost to you for the VSP Buy-Up option is:

Single coverage: \$4.60; One dependent: \$8.34; Family coverage: \$11.11.

The tier (one-party, two-party, family) you select for the VSP Buy-up option must match your medical plan election.

Vision Service Plan Exclusions and Limitations of Benefits (for coverage under the CityNet Plan)

This Plan is designed to cover visual needs rather than cosmetic materials. When the Covered Person selects any of the following extras, the Plan will pay the basic cost of the allowed lenses, and the Covered Person will pay the additional costs for the options.

Blended lenses
Oversize lenses
Cosmetic lenses
Optional cosmetic processes
Progressive multifocal lenses
UV (ultraviolet) protected lenses
The coating of the lens or lenses
The laminating of the lens or lenses
Certain limitations on low vision care
A frame that costs more than the Plan allowance
Contact lenses (except as noted elsewhere herein)
Photochromic lenses; tinted lenses except Pink #1 and Pink #2

VSP Exclusions

There is no benefit for professional services or material connected with:

Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +/- .38 diopter power); or two pair of glasses in lieu of bifocals;

Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available;

Medical or surgical treatment of the eyes;

Any eye examination, or any corrective eyewear, required by an employer as a condition of employment;

Corrective vision treatment and/or surgeries;

Any treatments considered to be of an experimental nature

Vision Service Plan, at its discretion, may waive any of the plan limitations if, in the opinion of VSP's Optometric Consultants, it is necessary for the visual welfare of the covered person.

Out of network claims submitted more than six months from the date of service.

Filing a Claim for Vision Plan Benefits

Vision claims covered by VSP must be submitted within six months of the date the charges were incurred.

Vision claims covered by VSP should be submitted to VSP at PO Box 997105, Sacramento, CA

95899-7105. Reimbursement forms are available at:

<http://www.portlandonline.com/omf/index.cfm?c=27553&a=314063>

KAISER PERMANENTE EYE CARE SERVICES

Eye Examinations are covered to determine the need for vision correction.

Eyeglasses and Contact Lenses.

Kaiser Permanente provides lenses, frames, industrial safety glasses and/or contact lenses up to a maximum of a prescription of a Plan Physician or Optometrist under contract with Health Plan after lenses, frames, industrial safety glasses, and/or contact lens(es) were last covered under this benefit. Any part of the allowance that is not exhausted at the initial point of sale may not be used at a later time.

If a change of .50 diopters or greater in prescription as determined by a Physician or Health Plan optometrist in either lens occurs within 12 months of the initial exam, lenses industrial safety lenses, or contact lens(es) with the new correction are covered at the following maximum values:

- a) \$60.00 for single vision and cosmetic contact lenses;
- b) \$90.00 for multifocal lenses.

Replacement coverage is for the original product type (contacts or eyeglasses) only.

Medically necessary contact lens(es) will be covered as described above if any of the following conditions are met. Covered services include fitting of contact lens(es) without charge.

- (a) Refractive error of twelve diopters or greater in any meridian;
- (b) Keratoconus which corrects to 20/30 or worse with best eyeglasses;
- (c) Anisometropia where the difference in refractive status between the two eyes is greater than five diopters and binocular vision can be significantly improved;
- (d) When vision with contact lens(es) as compared with glasses is improved by greater than two lines; i.e., 20/70 to 20/40; or
- (e) Aniridia.

Eyeglasses and Contact Lens(es) After Cataract Surgery.

(a) Cataract Surgery Involving an Intra-Ocular Lens Implant. After each cataract surgery involving an intra-ocular lens implant, the Member receives one pair of regular eyeglass lenses and frames from a specified selection of frames or contact lens(es) without charge.

(b) Cataract Surgery Not Involving an Intra-Ocular Lens Implant. After each cataract surgery not involving an intra-ocular lens implant, the Member receives one pair of regular lenses and frames from a specified selection and/or contact lens(es). Both eyeglass lenses and frames from a specified selection of frames and contact lens(es) are covered without charge if, in the judgment of a Physician or Health Plan optometrist, the Member must wear eyeglass lenses and contact lens(es) at the same time to provide a significant improvement in visual acuity or binocular vision not obtainable with regular lenses or contact lens(es) alone.

(c) When the benefits following cataract surgery have been exhausted, the Member may be entitled to receive benefits in accordance with the Optical Services benefits as described in the Kaiser packet.

Exclusions:

- a) Vision therapy (orthoptics or eye exercises).
- b) Low vision aids.
- c) Professional services for fitting and follow-up care for cosmetic contact lens(es).
- d) Replacement of eyewear and accessories due to loss, damage or carelessness. Exceptions may apply under optional warranty plans.

Flexible Spending Accounts (FSAs) Can Save You Money (Remember elections for MERP & DCAP must be made annually)

These Accounts allow you to set aside pre-tax dollars to reimburse yourself for qualifying expenses not covered by any insurance plan. Your Flexible Spending Account (FSA) options include the Medical Expense Reimbursement Plan (MERP) and Dependent Care Assistance Plan (DCAP.) When you use the City's pretax FSAs to reimburse yourself for out-of-pocket healthcare and dependent care expenses, it's as if you are paying for them at a discount because for every dollar you set aside in these accounts, you save federal, state, and FICA tax (if applicable).

Keep in mind, you cannot be reimbursed for expenses under the flexible spending account plans in addition to claiming a tax credit on your annual tax return. Reimbursable expenses under the Medical Expense Reimbursement Plan includes only those amounts not paid by insurance coverage provided for you and your eligible dependents through the City of Portland's Plan, or any other insurance plans.

Flexible Spending Accounts Are Governed by the IRS

Flexible spending accounts are made possible under the Internal Revenue Code Section 125, which allows you to reduce your federal income, state income and FICA tax liabilities (if applicable) by participating in these special accounts.

Domestic Partner Coverage Under Flexible Spending Accounts

According to the IRS, only eligible expenses incurred by employees, legal spouses, or tax dependents may be reimbursed tax-free through these accounts. As a result, expenses for domestic partners and children of domestic partners may be considered for tax-free reimbursement **only** if they meet the spouse or dependent eligibility requirements set out in IRS Code section 152(a) and 152(a)9. You must provide proof of dependency when filing a claim for reimbursement.

How Flexible Spending Accounts Work

When you participate in the City's flexible spending accounts, you contribute part of your pay into your account(s) through pre-tax payroll deduction. As you incur eligible out-of-pocket healthcare and dependent care expenses, you reimburse yourself throughout the plan year. As a result, you reduce your taxable income because your flexible spending account contributions come out of your paycheck before taxes are deducted. When you are reimbursed, the money remains tax-free.

"USE IT OR LOSE IT" – FORFEITURE OF UNUSED FUNDS

To get the most out of your flexible spending accounts, you need to carefully estimate your expenses for the upcoming plan year. Be sure to contribute only those amounts you know will be incurred because you will forfeit any money left over in your accounts at the end of the plan year. In other words, you must "use it or lose it." For example, if you contribute \$2,000 to a flexible spending account in plan year 2012-13 but incur only \$1,500 in eligible expenses during the year, you'll lose \$500. You are not allowed to receive unused funds, transfer dollars from one account to another, or carry over dollars to the following plan year.

Another reason to estimate carefully is you cannot make changes to your elections during the plan year, unless the change is on account of and is consistent with a qualifying family status change. Qualifying family status changes are described on page 11.

AFFECT ON SOCIAL SECURITY

Paying for benefits with pre-tax dollars results in your having lower annual pay on your W-2 form for federal income tax purposes. Any benefits based on your pay will be based on your total annual pay before your FSA contributions. If you contribute over a long period of time, your contributions to the FSAs will reduce your Social Security benefit by a minimal amount.

Enrolling in the Flexible Spending Accounts

If you decide to participate in a flexible spending account, you must authorize the City to make pre-tax payroll deductions for a specific amount for the plan year July 1, 2012, through June 30, 2013. To participate during Plan Year 2012/2013, enroll through BenefitsOnline during Annual Enrollment or within 30 days of your date of hire.

Your annual election will be divided and spread over 24 pay periods, beginning with your first paycheck in the plan year.

For the MERP account, the maximum contribution for the plan year is \$104.16 per pay period, for 24 pay periods, totaling \$2,499.84 per year. The minimum MERP contribution is \$5.00 per pay period.

For the DCAP account, the maximum contribution is \$208.33 per pay period, for 24 pay periods, totaling \$4,999.92 per year. The minimum DCAP contribution is \$5.00 per pay period.

Mid-Year Enrollment

Employees hired after the beginning of the plan year (July 1) may enroll on a prorated basis (i.e., prorated to reduce the total maximum plan allowance) for the pay periods remaining in the plan year.

Filing a Reimbursement Claim

Eligible expenses must be **incurred** during the period of enrollment. You will have until September 30 to submit a claim for reimbursement for the prior plan year. If you do not use your Benefits MasterCard, remember to submit your claim with the appropriate documentation as listed on the claim forms. Cancelled checks are not acceptable verification of expenses.

Flexible spending account claim forms are available from the Benefits & Wellness Office or at <http://www.benefithelpsolutions.com>.

For the MERP Account – Benefits MasterCard

When you sign up for the MERP, you will automatically receive a Benefits MasterCard unless you elect "AutoPay." The Benefits Card is a debit card that is used to access the money you set aside in your MERP for pre-tax healthcare-related purchases. But it's important to note that when you use your card, choose "Credit" when given the option at the check-out terminal because store registers read it as a credit card. You can use your card to pay for prescription and health plan copays without having to submit a claim or documentation. However, for hospital, medical, dental and vision care provider services which are billed to you, use your card to pay your bill; then BenefitHelp solutions will send a letter asking for documentation. Send the letter back to BHS with a copy of the provider bill or the health plan's Explanation of Benefits to complete the transaction. For eligible healthcare expenses such as deductibles, copays and coinsurance, you must first seek reimbursement from **all** healthcare insurance available to you and your eligible family members. This includes the City of Portland's plan, in addition to coverage provided by any other family member.

Only a few types of benefits card swipes can be automatically approved per the IRS rules. These include:

- Prescription medications purchased at a pharmacy with Inventory Information Approval System (IIAS) software
- Copayment matches
- Recurring expenses of the same amount to the same provider, established with documentation
- Eligible over-the-counter products purchased at a store with IIAS

The following types of benefits card swipes will not be automatically approved and will require documentation:

- Deductible payments
- Coinsurance payments
- Vision expenses (except copay)
- Dental expenses (except copay)
- Naturopath visits
- Chiropractor visits
- Acupuncture visits

What is “substantiated documentation”?

All substantiation documents must include the following details: who, what, when and by whom.

- Who was treated?
- What services were provided?
- When was the service provided?
- Who provided the service?

Substantiated documentation can include:

- An Explanation of Benefits (EOB) from your insurance carrier
- A Flexible Spending Account (FSA) itemization from the provider, if the services are not covered by your insurance carrier.

When do I need to get a letter of medical necessity?

A letter of medical necessity (LOMN) is required when expenses may or may not be eligible, depending on the condition being treated. Vitamins and other supplements fall into this category. Visit [BenefitHelp Solutions](#) online for a list of eligible and ineligible expenses and documentation requirements.

Do I need to get a prescription for OTC products?

A prescription is required for over-the-counter medications that you would like to be covered by the plan. You can use the card at the pharmacy counter if you have a prescription for an OTC medication.

Do I need a prescription as well as a letter of medical necessity?

You may. The letter of medical necessity includes specific information on the condition being treated and the expected benefits of the service or supply. This information is generally not included on a prescription.

What if I cannot substantiate a card swipe?

If a card swipe is not substantiated, it becomes an ineligible expense. You have a couple options in this situation:

- You can submit manual claims that can be used to offset the ineligible expenses.
- Offset claims must be submitted before the end of the plan run-out period.
- You can refund the plan.

What is a recurring expense?

A recurring expense is one that is paid to the same service provider for the same amount on a regular basis. One example of a recurring expense is orthodontic installment payments. Here's how it works:

- The first time you use the card to pay an orthodontic installment, for example, you will get a letter from BenefitHelp Solutions requesting documentation.
- Send BenefitHelp Solutions a copy of the contract between you and the provider showing the payment schedule and the amount, and request a recurring expense.
- BenefitHelp Solutions will substantiate the first card swipe. The provider and the amount will be set up as a recurring expense for future installments.
- Once the recurring expense is set up, every month when the installment payment is made with the card, it will be approved automatically.
- Other examples of recurring expenses include ongoing chiropractic manipulation visits, naturopathic office visits, etc.
- If the provider or the amount changes, it is no longer a recurring expense.
- Recurring expenses must be re-established each plan year.

AutoPay feature if you are enrolled in an ODS Health Plan (CityNet Medical, ODS dental)

If you do not want the Benefits MasterCard and you are enrolled on an ODS Health Plan, you can choose the AutoPay option. AutoPay will submit your ODS processed claims to BenefitHelp Solutions for you. The balance of the claim that you are responsible for will be reimbursed to you directly from your MERP account. There are some participants who will not qualify for AutoPay, (for example those who have dual coverage) so please read exclusions on the “AutoPay enrollment form”. Forms can be obtained at <http://www.benefithelpsolutions.com>.

For the DCAP Account

Once you incur an eligible dependent care expense, send a claim form to the plan administrator with a copy of your receipt. Remember to include the caregiver’s tax identification number, the dates of service and the name of the dependent for whom the care was provided.

Receiving Reimbursements

When you receive a reimbursement check from the plan, your pre-tax money comes back to you with no taxes withheld and you owe no additional taxes on the money. BenefitHelp Solutions processes and mails spending account payments on a daily basis.

Submit claims to:	BenefitHelp Solutions PO Box 67230 Portland, OR 97268 FAX: 1-888-249-5058
For inquiries call:	503-219-3679 or 1-888-398-8057
For forms:	Claim forms can be downloaded at: http://www.benefithelpsolutions.com/

Direct deposit of claims reimbursements

To make the reimbursement process even easier, you may want to set up direct deposit for your claims reimbursements. To do so, go to <http://www.benefithelpsolutions.com/> to print out a form. Complete the form, attach a copy of a voided check for automatic checking account deposit **or** savings account deposit slip for automatic savings account deposit and submit the form to BenefitHelp Solutions at the above address.

MEDICAL EXPENSE REIMBURSEMENT PLAN (MERP)

The Medical Expense Reimbursement Plan (MERP) allows you to contribute up to \$2,500 each plan year to pay for eligible out-of-pocket expenses not paid by any health plan under which you are covered.

ELIGIBLE DEPENDENTS

Expenses must be incurred by the employee, his or her spouse and/or eligible dependents. An eligible dependent for purposes of the MERP account is any person who qualifies as your dependent for federal income tax purposes.

ELIGIBLE EXPENSES

Eligible medical and dental expenses are those expenses for services incurred during the plan year for the diagnosis, treatment or prevention of disease, and for treatments affecting any part or function of the body. The expense must be to alleviate or prevent a physical defect or illness. Eligible expenses are those which could otherwise be allowed as tax deductions under federal income tax regulation and may include:

- Insurance deductibles and copayments;
- Alcohol, drug or chemical dependency treatment;
- Prescription drug copayments;
- Chiropractic, naturopathic, osteopathic and/or acupuncture treatment;
- Dental treatments (x-rays, fillings, crowns, etc.);
- Orthodontia, dental surgery, exams, cleanings;
- Eyeglasses, contacts, vision exams;
- Hearing aids, aids and assistance for the handicapped;
- Doctor and hospitalization expenses and services;
- Lab fees, physical exams, x-rays and vaccinations;
- Nursing homes and nursing services;
- Psychiatric, psychology and/or psychotherapy treatment;
- Surgery, sterilization, gynecology, obstetrics, anesthesia;
- Over the counter medication or drugs used to alleviate or cure a sickness; (effective January 1, 2011, over the counter medications will need to be prescribed by a doctor to be reimbursable.)
- Mileage to and from health provider visits;
- Weight loss services for morbid obesity (not including the cost of food and/or over the counter medications); or
- Speech or physical therapy, transplants and other medically necessary treatment.

INELIGIBLE EXPENSES

Expenses solely for cosmetic reasons, expenses that are merely beneficial to one's general health, or services and supplies ineligible under federal guidelines are not eligible under the Plan. These include (but are not limited to):

- Insurance premiums;
- Fitness programs;
- Health club dues;
- Expenses reimbursed by other sources of insurance; or

Nutritional supplements which are merely beneficial to general health and are not used in a course of treatment for a medical condition.

Massage therapy is generally not covered, but may be an eligible expense when for treatment related to an acute or chronic medical condition. You are required to provide a letter of medical necessity with the diagnosis from your physician OR the claim received from the massage therapist must include information indicating the condition being treated and that you were referred by your physician. You need to provide this information only once, per condition. Massage therapy is not covered for treatment for a non-medical reason or for depression.

REIMBURSED MERP EXPENSES NOT ELIGIBLE FOR HEALTH CARE TAX DEDUCTION

The Federal Government permits you to take a deduction on your income tax return for certain health care expenses. While most people do not incur enough expenses to qualify for this tax deduction, you should remember that you cannot claim the same expenses twice. If you use the Medical Expense Reimbursement Account, you cannot take a tax deduction for those expenses, and vice versa.

Period of Coverage

Reimbursement from your Medical Expense Reimbursement Account is limited to qualifying expenses incurred during the annual "period of coverage" (July 1 through June 30). Your "period of coverage" and eligible reimbursements will be affected if you start, change or cancel your medical election due to mid-year enrollment or a qualified status change. Eligible claims must be *incurred* during each "period of coverage".

Example, decreasing election mid-year: John elects \$2,400 of coverage at the beginning of the plan year, with a \$200 monthly premium. After three months, John changes his election. For the remaining nine months, he pays a monthly premium of \$100. Using the Blended Approach, John would have \$2,400 of coverage for the first three months and \$1,500 of coverage for the last nine months (\$1,500 = \$600 of premiums for the first three months + \$900 of premiums for the last nine months). No forfeitures would occur until the end of the 12-month plan year (or until the end of the grace period, if offered under the plan). So, for example, if John incurred claims of \$900 in July at the beginning of the plan year and \$800 in December, he would be reimbursed \$900 for the July claim but only \$600 for the December claim (\$600 = \$1,500 maximum, less \$900 already paid out).

Example, increasing election mid-year: Cory elects \$1,200 of health FSA coverage for the plan year under the MERP, with a \$100 monthly premium. After three months, Cory elects increased coverage with monthly premiums of \$200. Under the Blended Approach, Cory is viewed as having \$1,200 of coverage for the first three months of the year and \$2,100 of coverage for the last nine months of the year (\$2,100 = \$300 of premiums for the first three months + \$1,800 of premiums for the last nine months). Assume that Cory incurred \$1,800 of medical expenses in July (i.e., before electing increased coverage) and was reimbursed \$1,200. In October (after the increase in coverage), Cory cannot be reimbursed for the remaining \$600 of July expenses as he has already received full reimbursement for the first 3 months of coverage. Cory must use the remaining \$900 of health FSA coverage to reimburse medical expenses that are incurred during the last nine months of the year.

Any changes made to your medical election must be on account of and consistent with the specific family or work status change. If you terminate your employment with the City during the plan year, your coverage will cease on your termination date. Only expenses incurred while you were an active participant are eligible. You have the option to extend your coverage by making payments on an after-tax basis to the City, pursuant to the federal COBRA healthcare continuation.

TERMINATION OF EMPLOYMENT OR LOSS OF ELIGIBILITY

If you terminate employment or cease to be an eligible employee for any reason, your Medical Expense Reimbursement Plan terminates on your last day of employment. You will only be able to seek reimbursement for expenses you incurred from July 1 of the plan year through your termination date, unless you have elected to continue your coverage under COBRA on an after-tax basis. If you are subsequently re-employed during the same plan year and have not elected to continue your medical reimbursement plan under COBRA on a post-tax contribution, no new election may be made until the next plan year. If you are on an approved family leave, contact the Benefits Office at 503-823-6031 for information concerning your options for continuing or terminating your MERP participation.

CESSATION OF REQUIRED CONTRIBUTIONS

Your participation in the MERP will terminate immediately if you cease to make any required contributions during the plan year. You will only be able to seek reimbursement for plan year expenses you incurred prior to your termination date. In addition, no new election may be made until the next plan year. However, if you are in an unpaid status at the beginning of the next plan year, you may not participate in the MERP until you return to a paid status.

MERP ACCOUNT FREQUENTLY ASKED QUESTIONS

1. Who is eligible to participate in the Medical Expense Reimbursement Plan (MERP)?

Your eligible dependents must be eligible to participate in the City's medical/vision and dental plans to be eligible to have expenses reimbursed under a MERP with one exception. Domestic partners and their children are not eligible to have expenses reimbursed through a MERP unless they are considered to be a tax dependent under Code 152 of the Internal Revenue Code.

2. What expenses can I be reimbursed for under a MERP?

The general statutory principle is that medical care must be "for the diagnosis, cure, mitigation, treatment or prevention of disease." For a listing of covered expenses, go to http://www.benefithelpsolutions.com/pdfs/fsa_expenses.pdf

3. Are costs associated with Weight Loss Programs covered under a MERP?

The IRS ruled recently that expenses for weight-loss programs prescribed to treat obesity or hypertension are deductible expenses under an FSA. The IRS acknowledged that "obesity" is a disease in its own right." Consequently, the obese person's participation in a weight-loss program is deductible even in the absence of any other specific medical condition. However, the costs of special foods are not reimbursable. Also, costs of participating in a weight-loss program just to improve appearance, general health or well being are not reimbursable under an FSA.

4. How can I get my out-of-pocket costs for my child's orthodontia treatment reimbursed through MERP?

The following scenarios are how orthodontia expenses are reimbursed:

- a. Up-front payments for the entire orthodontia expense will be paid only from the plan year in which the payment was made. Example: You pay \$5,000 for the entire expense in January; BenefitHelp Solutions will reimburse the entire amount (up to your annual election) from the current plan year, only. If the annual election is not enough to pay the entire amount, BenefitHelp Solutions will not be able to carry over the remaining amount to the next plan year.
- b. If you want to be reimbursed for **installment "up-front" payments**, you can spread out the expense over the course of the treatment. Example: The over-all expense is \$3,000 for treatment over three years. You would need to obtain a signed yearly contract from the provider for \$1,000 each year, or a signed three-year contract that breaks out payments of \$1,000 for each year.
- c. If you want to make monthly installments, you will need to obtain a signed financial contract from the provider agreeing to monthly installments. You will need to file a copy of the agreement at BenefitHelp Solutions.

5. I have a semi-monthly premium share, can I use my MERP account to reimburse myself the insurance premiums that I must pay?

No, a MERP may not treat participant's premium payments for health coverage as reimbursable expenses. It may not reimburse participants for premium paid on individual policies, or premiums paid for health coverage under a plan maintained by the employer of the participant's spouse or dependent. This general rule would prohibit reimbursement of COBRA premiums as well.

6. Is Laser Eye Surgery covered under MERP?

Yes, amounts paid for radial keratotomy or other laser eye surgery is deductible if the procedures are done primarily to promote the correct function of the eye.

7. Are Infertility Treatments covered under MERP?

Yes, to the extent the treatment impacts the participant or a dependent of the participant. This includes shots, treatments, surgery, GIFT, etc. Procedures to overcome an inability to have children, such as in vitro fertilization (including temporary storage of eggs or sperm) and surgery, including an operation to reverse prior surgery preventing someone from having children are eligible for reimbursement under the MERP account.

ESTIMATION WORKSHEET

Estimate your healthcare expenses for FY 2012/2013

List the amount you expect to spend on...	FY 2011-12 Actual Expenses	FY 2012-13 Projected Expenses
Deductibles – medical and dental	\$	\$
Copayments/Coinsurance – medical and dental	\$	\$
Out-of-pocket medical expenses	\$	\$
Out-of-pocket dental expenses	\$	\$
Out-of-pocket orthodontia expenses	\$	\$
Out-of-pocket vision expenses	\$	\$
Prescription drug copayments and Over-the Counter (OTC) medications	\$	\$
Out-of-pocket hearing aid and hearing test expenses	\$	\$
Out-of-pocket physical therapy expenses	\$	\$
Out-of-pocket chiropractic services expenses	\$	\$
Other eligible expenses	\$	\$
Annual Total	\$	\$
Annual contribution to MERP (total from 3 rd column or what you have decided to contribute, up to \$2,500)		\$
Contribution per pay period (annual contribution divided by 24 paychecks)		\$

Note: The purpose of this worksheet is to assist you, not to provide tax advice. Consult your tax advisor if you have questions about the tax consequences of using flexible spending accounts.

DCAP Account (for Dependent Care Expenses)

The money you contribute to your DCAP can be used to reimburse you for care expenses for your children under age 13 or for disabled dependents who require care while you (or you and your spouse if you're married) go to work or attend school full-time. The annual maximum pretax contribution is \$5,000.

The IRS limits the maximum amount you can contribute to the DCAP account. If you're married and file a separate tax return, you can contribute up to \$2,500 a year into your DCAP account. If you're single/head of household or married/filing jointly, you can contribute up to \$5,000 a year.

However, your contribution cannot exceed your annual income or your spouse's annual income, whichever is less. If your spouse is a full-time student at least five months a year, or is incapable of self-care, the IRS considers your spouse's income to be \$3,000 a year if you have one dependent or \$6,000 a year if you have two or more dependents.

Eligible dependent care expenses include:

- Dependent care expenses for children under age 13 so that you and your spouse can work or go to school full-time
- Expenses for the care of a spouse, parent, or other eligible dependent who is incapable of self-care and qualifies as a dependent on your federal tax return

Some dependent care expenses are **not** eligible for reimbursement, such as:

- Babysitting during nonworking hours
- Transportation costs to and from a day care facility
- Education supplies and activities (such as field trips)

In addition, you cannot be reimbursed for dependent care expenses if the services are provided by:

- Anyone you claim as a dependent on your federal tax return
- Your child or stepchild under age 20

Your child under age 20 may qualify as a caregiver under IRS rules if you do not claim him or her as a dependent on your federal tax return.

See IRS Publication 503 at www.irs.gov for additional information about eligible dependent care expenses.

Dependent Care Tax Credit

Before you decide to contribute money in the Dependent Care Assistance Plan, keep in mind that you also may be eligible for a federal Dependent Care Tax Credit, and in some states, a state Dependent Tax Credit. It may be to your advantage to take that credit rather than participate in the Dependent Care Assistance Plan. Any amounts that are reimbursed under this account reduce the maximum you can use to calculate the tax credit. Keep in mind that you cannot claim the same expenses twice. If you use the Dependent Care Assistance Account, you cannot take the tax credit, and vice versa. You should check with your tax advisor to see what makes the most sense for you.

Termination of Employment or Loss of Eligibility

If you terminate employment or cease to be an eligible employee for any reason, your contributions to the Dependent Care Assistance Plan terminate on your last day of work. You may, however, be able to seek reimbursement for expenses you incurred through the end of the plan year (June 30th). If you are subsequently re-employed during the same plan year no new election may be made until the next plan year. If you are on an approved family leave, or unpaid leave of absence, contact the Benefits Office at 503-823-6031 for information concerning your options for continuing or terminating your DCAP participation.

Estimate your dependent care expenses FY 2012-13

List the amount you expect to spend on...	FY 2011-12 Actual Expenses	FY 2012-13 Projected Expenses
1. Day care center fees	\$	\$
2. Care in your home <ul style="list-style-type: none"> a. Wages/salary b. Social Security tax paid by you for your dependent care provider 	\$	\$
3. Total annual amount (line 1 + line 2)	\$	\$
Contribution per pay period (annual total up to \$5,000 divided by 24 paychecks)	\$	\$

Note: The purpose of this worksheet is to assist you, not to provide tax advice. Consult your tax advisor if you have questions about the tax consequences of using flexible spending accounts.

City of Portland Employee Assistance Program

The City of Portland's Employee Assistance Program (EAP) is a confidential, short-term counseling, assessment and referral service offered as a benefit to employees and their dependents eligible for the City's medical coverage. With today's to-do lists, it seems more difficult than ever to juggle the demands of work and family while managing a household, caring for loved ones and maintaining good health. The EAP is designed to help you deal with personal problems as they come up, in addition to providing information and resources to solve life's everyday challenges, big and small.

Employee Assistance Program (EAP)

Professional specialists are available to provide an objective viewpoint and expert guidance on all kinds of issues. You can have on-the-spot advice over the phone or a referral to work with a network clinician for up to eight face-to-face visits per plan year (July 1 through June 30) for a wide range of personal issues, including, but not limited to, substance abuse, relationship issues, mental and emotional problems and work-related issues. The EAP also provides services such as a Listening Library, tax resolution assistance, free online will preparation, career development services, life coaching and parent coaching.

Getting help is easy, convenient and confidential. Just call 1-800-433-2320. Trained specialists and professional counselors are available 24 hours a day, seven days a week via this number to confidentially discuss your concerns. The EAP is a prepaid benefit offered to you, and your eligible dependents by the City of Portland.

Work/Life Benefits

The EAP's Work/Family/Life programs consist of childcare, eldercare, legal, financial, ID theft and concierge resource retrieval and reporting within 72 hours of your initial call. Access is free and confidential for all participants and information is available 24 hours a day, seven days a week. These services include:

- **Legal:** Each covered member is eligible for one initial thirty-minute office or telephone consultation per separate legal matter (limit three per year) at no cost with a network attorney. If you decide to retain the attorney after the initial consultation, you will be provided with a preferred rate reduction of 25% from the attorney's normal hourly rate.
- **Financial:** Each employee is eligible to receive 30 consecutive days of free, unlimited telephonic financial coaching. At the end of the initial 30 day free period, the member has two options:
 - In the event the employee continues beyond the initial 30 day free period, subsequent months are paid by the employee at a monthly fee. If the member cancels the paid monthly services, the member is ineligible for 30 consecutive days (waiting period) before they are able to receive another free 30 consecutive day benefit.
 - If an employee declines the self-pay option, the employee is ineligible for 30 consecutive days (waiting period) before the employee can access the 30 day free period again. The waiting period will begin at the conclusion of the initial free 30 day period. For example, if the initial period begins on March 1st, the employee would not be eligible for another free 30 day period until May 1st; the month of April would be the waiting period.
- **Identity Theft Services** - This service provides members with up to a 60-minute free consultation with a highly trained Fraud Resolution Specialist™ (FRS). The FRS will conduct emergency response activities and assist members with restoring their identity, good credit and with the costly steps to dispute fraudulent debts, etc. In addition, members also receive an Emergency Response Kit outlining actions and suggestions regarding Identity Theft Prevention and Restoration of the member's damaged identity.
- **Cascade Personal Advantage** (Interactive Website) Access to health assessments, financial calculators, informational videos/articles and monthly interactive electronic brochures.
- **Home Ownership Program:** Assistance and discounts on services associated with selling, buying and refinancing a home.

EAP Frequently Asked Questions

1. **Are these services confidential?** Yes. All records-including personal information, referrals and evaluations-are kept confidential in accordance with federal and state laws.
2. **How much does the program cost?** There is no charge to speak with an EAP Specialist, obtain a referral to a legal or financial expert, or to see a network EAP Clinician. Discounted services for legal and mediation are also available. Of course, you may access information and develop personal plans on www.cascadecenters.com as often as you want at no charge.
3. **Is the EAP just for workplace problems?** No. You and your eligible family members can use the EAP to help deal with any number of concerns, big or small, whether or not your issue will have a direct impact on your work environment.
4. **Can I call the EAP even if my concern is not a crisis?** Yes. The EAP is a life management tool, designed to help you sort through whatever is happening in your life. Call the EAP when you need a new perspective on things. Call when you need help identifying your options and making informed choices. EAP services have been provided to help you live healthy and work well.
5. **Who will provide service to me?** Services are provided by a large and diverse network of licensed and certified professionals who can help with any concerns you may have. With the EAP Program, you can get advice from experts such as attorneys, financial professionals, mediators and dependent care professionals. For more complicated issues, you can meet with a full range of certified Clinicians, including licensed masters-level psychologists and substance abuse professionals (SAPs).

ADDITIONAL TERMS OF COVERAGE – HEALTH PLANS

Family and Medical Leave, Oregon Family Leave, Military Leave and Uniformed Services Employment & Reemployment Rights Acts

The City's health plans comply with the health continuation provisions of the federal Family Medical Leave Act (FMLA), Oregon Family and Medical Leave Act (OFLA) and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

The following rules apply to FMLA leaves:

1. Affected members will remain eligible for coverage under the plan during an approved family and medical leave.
2. If the employee does not return to work after the approved family and medical leave, reimbursement of all the City benefit payments will be requested unless there is a continuation, recurrence or onset of a serious health condition.
3. If members elect not to remain covered during family and medical leave, they will be eligible to be reinstated in the plan on the date the employee returns from FMLA leave.
4. In all events, a member's rights under family and medical will be governed by applicable state or federal statute and regulations.

Payment of Premium While on Approved Family and Medical Leave

While on an approved family and medical leave, an Employee may elect to continue his or her group health coverage, provided the Employee continues to pay the required portion of the cost, if any, of the elected plans. The employee also may pay the unpaid portion of the premium share upon the return to work.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If an Employee leaves his or her job to perform military service, he or she has the right to elect to continue his or her existing health plan coverage and for enrolled members for up to 24 months while in the military. If the employee doesn't elect to continue coverage during military service, the Employee has the right to be reinstated in the City's health plan upon reemployment generally without any waiting periods or exclusions except for service-connected illnesses or injuries.

The following rules apply to military leaves:

1. Employees on unpaid military leave 31 days or more shall have the right but are not required to elect and purchase continuation of medical, dental and vision benefits under COBRA for themselves if they are already enrolled in City medical/vision and/or dental coverage. COBRA coverage would be in addition to military coverage. Upon reemployment, the City will reinstate the employee's coverage without imposing any exclusion or waiting periods that would not have been imposed had the coverage not been terminated. The City will pay the cost of continuing to provide health insurance coverage under COBRA for up to 24 months and will waive the 2% administrative fee for the dependents of City employees who are called to active duty for a minimum of 31 days (training periods do not qualify) at the same level and cost provided while the employee was at work. The dependents of employees who have dual coverage through the City or a spouse/domestic partner's employer are not eligible for this benefit.
2. For employees on military leave less than 31 days, their City paid coverage will continue.

Certificate of Creditable Coverage

When coverage ends, members will receive a certificate of creditable coverage that provides proof of prior medical coverage. A member may need to have this certificate to obtain medical coverage in the future. He or she will receive a written certificate when:

- A member ceases to be covered under the Plan;
- A member becomes eligible to elect COBRA coverage;
- A member ceases to be covered under COBRA continuation coverage;
- A member requests a Certificate of Creditable Coverage within 24 months of their termination of coverage.

Reinstatement of Coverage

If a PPA member's coverage has been terminated due to loss of eligibility, coverage can be resumed without meeting the eligibility waiting period, provided the employee returns to a benefits eligible status within 12 consecutive months after the date benefits ceased. If an employee is eligible for reinstatement, City contributions become effective the first of the month following 80 hours of paid time in a benefits eligible position.

Continuation of Benefit Coverage

Under certain conditions, members may continue medical and vision, dental insurance, the Employee Assistance Plan (EAP) and MERP when such coverage would otherwise terminate. There are four types of continuation: Worker's Compensation/Industrial Accident Leave, Continuation based on Oregon statute, Retiree/Disabled Self-Pays and COBRA. The four types of continuation coverage are described below:

1. Continuation of coverage during Worker's Compensation or Industrial Accident Leave

Benefits may continue during a Worker's Compensation or Industrial Accident Leave in accordance with Oregon statutes, the applicable Labor Agreement and/or Administrative Rule 6.13. Employees must continue to pay any applicable employee premium share contributions in order to continue coverage, even while in an unpaid status.

2. Continuation For Legally Separated, Divorced or Widowed Spouses or Registered Domestic Partners over age 55

A surviving spouse or registered domestic partner of a deceased employee or a legally separated or divorced spouse or registered domestic partner age 55 or over, and their eligible dependents, may continue coverage until 1) Medicare eligibility for the surviving divorced or legally separated spouse/domestic partner and 2) until the dependents reach the maximum eligibility age limits under the Plan. The surviving or legally separated/divorced spouse/domestic partner and any children whose coverage under the policy otherwise would terminate because of the death of, or legal separation/divorce from the covered employee, may continue coverage if the spouse/domestic partner is 55 years of age or older at the time of the death, legal separation or divorce. Coverage under this law will be subject to all other regulations governing COBRA administration (See "Continuation of Coverage—COBRA below), but is not considered a second qualifying event.

3. Retiree Continuation

City of Portland retirees and their eligible dependents may continue medical and vision, dental and the employee assistance program (EAP) coverage by self-paying the monthly premium costs. Where collective bargaining agreement language deviates from this document, the collective bargaining agreement language will be the governing language.

Eligibility

In order to be eligible for retiree continuation of coverage, the employee must meet all of the following conditions:

- Be eligible to receive retirement income from the Oregon Public Employees Retirement System (PERS), the Oregon Public Service Retirement Plan (OPSRP) or the Fire and Police Disability and Retirement Fund; and
- Must have been covered under the active employee health plans on a City paid basis in the month preceding retirement.

PERS Retirees Continuing Eligibility

Retirees not eligible for Medicare at retirement and their non-Medicare eligible, covered dependents are able to continue on the City's healthcare plans for active employees by timely self-paying the monthly premium. Once a retiree and/or dependent becomes eligible for Medicare and/or attains age 65, they are no longer eligible for the City active employee medical, vision, or dental plans. However, if the retired employee has a covered spouse or domestic partner under age 65 at the time the retiree becomes entitled to Medicare and/or attains age 65, the retiree may move to a Medicare Supplement plan and the spouse (or domestic partner) may continue on the "under 65" medical plan until they become entitled to Medicare and/or attain age 65 or they no longer meet the definition of a dependent as defined by the Plan. Retirees 65 and older at retirement that have eligible dependents under age 65 are eligible for coverage under the City's or Kaiser Medicare Supplement plans. When both the retiree and the spouse (or domestic partner) become entitled to Medicare and/or attain age 65, they are no longer eligible for any City benefit plan.

Fire and Police Disability and Retirement Fund Retirees Continuing Eligibility

Retirees not eligible for Medicare at retirement and their non-Medicare eligible covered dependents are able to continue on the City's active employee medical plans by self-paying the monthly premium. Once a retiree and/or dependent becomes entitled to Medicare and/or attains age 65, the enrollee is only eligible for the City's or Kaiser's Medicare Supplement plan. However, if the retiree has a covered spouse (or domestic partner) under age 65 at the time the retiree becomes entitled to Medicare and/or attains age 65, the spouse (or domestic partner) may continue on the active employee medical plan until becoming entitled to Medicare and/or attain age 65, or no longer meets the definition of a dependent as defined by the Plan. Dependent children covered at the time the retiree becomes entitled to Medicare and/or attains age 65 are eligible to continue on the active employee plan until no longer meeting the definition of a dependent as defined by the Plan.

***Note:** Fire fighters and police officers who reach age 65 and establish through formal documentation that they are not entitled to Medicare through any means are eligible to continue on the active employee plans by self-paying the monthly premiums. If participants becomes entitled to Medicare at a later date based on their spouses' or ex-spouse's Social Security eligibility, they will no longer be able to continue medical coverage on the active employee plan.*

Retirees age 65 or older at retirement and their eligible dependents that are age 65 or older are eligible for the City's or Kaiser's Medicare Supplement Plan. The Medicare Supplement Plans are the only plans available to retirees and dependents age 65 or older. However, if the retiree has a covered spouse (or domestic partner) under age 65, the spouse (or domestic partner) may continue on the "under 65" medical plan until becoming entitled to Medicare and/or attaining age 65 or no longer meeting the definition of a dependent as defined by the plan.

Termination of Coverage

If retirees elect to terminate coverage under City plans prior to age 65, they can only return to the City's medical and dental plans in which they were previously enrolled if they are not Medicare eligible and they maintain continuous medical and dental group (employer sponsored) coverage

between the time they leave the City plans to the date they want to return. An independent election to dental coverage is not allowed if the participant continues to maintain other group medical coverage. Written verification from the other employer-sponsored plan will be required.

4. Disabled Employee Continuation

City of Portland disabled employees and their eligible dependents may continue medical and vision, dental and EAP coverage by self-paying the monthly premium costs. Where collective bargaining agreement language deviates from this document, the collective bargaining agreement language will be the governing language.

Eligibility

In order to be eligible for disabled employee continuation of coverage, the employee must meet all of the following conditions:

- Be eligible to receive disability benefits from the Oregon Public Employees Retirement System (PERS), the Oregon Public Service Retirement Plan (OPSRP) or the Fire and Police Disability and Retirement Fund; and
- Must have been covered under the active employee health plans on a City paid basis in the month preceding disability.

PERS Disabled Employee Continuing Eligibility

Disabled participants not eligible for Medicare and their non-Medicare eligible, covered dependents are able to continue on the City's healthcare plans for active employees by timely self-paying the monthly premium. Once a disabled employee and/or dependent become eligible for Medicare and/or attains age 65, they are no longer eligible for the City active employee medical, vision, or dental plans. However, if the disabled employee has a covered spouse or domestic partner under age 65 at the time the disabled employee becomes entitled to Medicare and/or attains age 65, the disabled employee may move to a Medicare Supplement plan and the spouse (or domestic partner) may continue on the "under 65" medical plan until they become entitled to Medicare and/or attain age 65 or they no longer meet the definition of a dependent as defined by the Plan. Disabled employees age 65 who have eligible dependents under age 65, are eligible for coverage under the City's or Kaiser Medicare Supplement plans, but are no longer eligible for dental or vision coverage. When both the disabled employee and the spouse (or domestic partner) become entitled to Medicare and/or attain age 65, they are no longer eligible for any City benefit plan.

Fire and Police Disability and Retirement Fund Disabled Continuing Eligibility

Disabled employees not eligible for Medicare and their non-Medicare eligible covered dependents are able to continue on the City's active employee medical plans by self-paying the monthly premium. Once a disabled employee and/or dependent become entitled to Medicare and/or attains age 65, they are only eligible for the City's or Kaiser's Medicare Supplement plan and are not eligible for dental or vision coverage. However, if the disabled employee has a covered spouse (or domestic partner) under age 65 at the time the disabled employee becomes entitled to Medicare and/or attains age 65, the spouse (or domestic partner) may continue on the active employee medical plan until they become entitled to Medicare and/or attain age 65, or they no longer meet the definition of a dependent as defined by the Plan. Dependent children covered at the time the disabled employee becomes entitled to Medicare and/or attains age 65 are eligible to continue on the active employee plan until they no longer meet the definition of a dependent as defined by the Plan.

Note: *Fire fighters and police officers who reach age 65 and establish through formal documentation that they are not entitled to Medicare through any means, are eligible to continue on the active employee medical plans by self-paying the monthly premiums. They are not eligible for dental coverage. If a participant becomes entitled to Medicare at a later date based on their*

spouses' or ex-spouse's Social Security eligibility, they will no longer be able to continue medical coverage on the active employee plan.

Disabled employees age 65 or older and their eligible dependents that are age 65 or older are eligible for the City's or Kaiser's Medicare Supplement Plan and are not eligible for vision or dental coverage. The Medicare Supplement Plans are the only plans available to disabled employees and dependents age 65 or older. However, if the disabled employee has a covered spouse (or domestic partner) under age 65, the spouse (or domestic partner) may continue on the "under 65" medical plan until they become entitled to Medicare and/or attain age 65 or no longer meet the definition of a dependent as defined by the plan.

Termination of Coverage

If disabled participants elect to terminate coverage under City plans prior to age 65, they can only return to the City's medical and dental plans in which they were previously enrolled, if they are not Medicare eligible and they maintain continuous medical and dental group (employer sponsored) coverage between the time they leave the City plans to the date they want to return. An independent election to dental coverage is not allowed if the participant continues to maintain other group medical coverage. Written verification from the other employer-sponsored plan will be required.

5. Continuation of Coverage "COBRA Provision"

Federal law requires that most group health plans (including this Plan) give employees and their families the opportunity to continue their health care coverage when there is a "qualifying event" that would result in a loss of coverage under an employer's plan. Depending on the type of qualifying event, "qualified beneficiaries" can include the employee (or retired employee) covered under the group health plan, the covered employee's spouse, and children of the covered employee. The following outlines COBRA coverage, when it may become available to you and your family and what you need to do to protect the right to receive it.

There are four group health components to the City's COBRA continuation coverage: 1. Medical/Vision, 2) Dental, 3) Employee Assistance Program (EAP) and 4) the Medical Expense Reimbursement Plan (MERP.) COBRA applies only to these components and not to any other benefits offered by the City of Portland. The City provides no greater COBRA rights than what COBRA requires—nothing in this Benefit Handbook is intended to expand your rights beyond COBRA's requirements.

What is continuation coverage?

Continuation coverage is the same coverage that the Plan gives to other members or beneficiaries under the Plan who are not receiving continuation coverage. In general, you and your covered dependents (if any) will only be given an opportunity to continue the coverage you each were receiving immediately before the qualifying event. In a few circumstances, however, you may elect alternative coverage that the City makes available to active employees, such as:

- If you participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage available to active employees.
- You and your covered dependents (if any) will have the same opportunity as an active employee to change your coverage at annual enrollment, add new family members, or drop dependents.
- A qualified beneficiary who has elected COBRA continuation coverage may elect to cover certain family members under special enrollment rights if certain requirements are satisfied.

COBRA Coverage under the MERP Component

COBRA coverage under the MERP component is only available to qualified beneficiaries who have remaining MERP account balances at the time of COBRA eligibility. A qualified beneficiary has an under spent account if the annual limit elected by the covered employee, reduced by reimbursements up to the time of the qualifying event, is equal to or more than the amount of the premiums for MERP COBRA coverage that will be charged for the remainder of the plan year.

COBRA coverage will consist of the MERP coverage in force at the time of the qualifying event (i.e., the elected annual limit reduced by expenses reimbursed up to the time of the qualifying event.) The "use it or

lose it” rule will continue to apply, so any unused amounts will be forfeited at the end of the plan year. *COBRA coverage will terminate at the end of the plan year and qualified beneficiaries may not enroll in the MERP in subsequent years.*

Unless otherwise elected, all qualified beneficiaries who were covered under the MERP will be covered together for MERP COBRA coverage. However, each qualified beneficiary could alternatively elect separate COBRA coverage to cover that beneficiary only, with a separate MERP annual limit and a separate premium. If you are interested in this alternative, contact the City Benefits & Wellness Office for more information.

How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued only for up to a total of 18 months. In the case of losses of coverage due to an employee’s death, divorce or legal separation, the employee’s becoming entitled to Medicare benefits or a child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When coverage is lost due to the employee’s termination of employment, appointment to a non-benefits eligible position, leave of absence or a reduction in hours and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA coverage under the Plan’s Medical/Vision, Dental and EAP components for qualified beneficiaries (other than the employee) who lose coverage as a result of the qualifying event can continue until up to 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare eight months before the date on which his employment terminates, COBRA coverage for his spouse and children who lost coverage as a result of his termination can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months.) This COBRA coverage period is available only if the covered employee becomes entitled to Medicare within 18 months BEFORE the termination or reduction of hours.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary first becomes covered under another group health plan that does not impose any preexisting condition exclusion for a preexisting condition of the qualified beneficiary. ***In this case, the qualified beneficiary must notify the Benefits & Wellness Office within 30 days of eligibility for such other coverage.***
- a qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage. The qualified beneficiary must notify the Benefits & Wellness Office within 30 days of entitlement to Medicare.
- during a disability extension period, the Social Security Administration makes a final determination that the disabled qualified beneficiary is no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate.) In this case, the qualified beneficiary must notify the Benefits & Wellness Office within 30 days after the date of the Social Security final determination.
- the City ceases to provide any group health plan for its employees; or
- Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

How can you extend the length of COBRA continuation coverage?

If you elect continuation coverage, an extension of the maximum period of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the City of Portland Benefits Office of a disability or a second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is determined under the Social Security Act (SSA) to be disabled. The disability must have started at some time on or before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. Notice to the Benefits & Wellness Office must be provided with a copy of the Social Security determination letter within 60 days after it is made and before the 18-month COBRA period expires. ***If notice to the Benefits & Wellness Office is not received within this timeframe, there will be no disability extension of COBRA coverage.*** This extension is available only for qualified beneficiaries who are receiving COBRA coverage because a covered employee terminated employment or lost Plan coverage because his or her hours were reduced, leave of absence, or change to a non-benefit eligible position.

Each covered employee or covered family member who is determined to be disabled (under Title II or XVI of the Social Security Act) at any time during the first 60 days of COBRA continuation coverage has the responsibility to: (1) inform the Benefits & Wellness Office within 60 days after the date of that determination, and (2) if applicable, inform the Benefits & Wellness Office within thirty (30) days after the date of any final determination that the covered employee or covered family member is **not** disabled.

Second Qualifying Event

An 18-month extension of coverage will be available to spouses and children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation from the covered employee, the covered employee's becoming entitled to Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the Plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the Plan if the first qualifying event had not occurred. **The covered employee or a covered family member must notify the Benefits & Wellness Office of the employee's divorce or legal separation, or a child losing dependent status under the Plan within 60 days after the occurrence of such event.** *Failure to notify the Benefits & Wellness Office of a second qualifying event within the 60 day timeframe will eliminate the right to extend the period of COBRA coverage.*

There are special enrollment rights for certain family members upon the loss of other group health plan coverage or upon the acquisition by the employee or participant of a new spouse or of a new dependent through birth, adoption, or placement for adoption. Please note that a family member whom you first enroll during an open enrollment period or special enrollment period while you are receiving COBRA continuation coverage and who was not covered by the Plan on the day before the initial COBRA qualifying event occurred is not eligible to extend the initial COBRA continuation period as described in this notice, unless that family member is a child born to the covered employee or placed with the covered employee for adoption during the initial 18-month period of COBRA continuation coverage and enrolled in the Plan while the covered employee was receiving COBRA continuation coverage.

Who is Entitled to Elect COBRA? (Qualifying Events)

- A. A City employee may have the right to elect continuation coverage if he or she loses coverage under the Plan because of any one of the following "qualifying events":
1. Termination of employment (for reasons other than gross misconduct) or reduction in hours of employment;
 2. Appointment to a non-benefit eligible position;
 3. Leave of Absence in excess of, or outside the parameters of the maximum leave covered under the Family and Medical Leave Act (FMLA);

4. Absence upon denial of a workers' compensation claim.
- B. A spouse of an employee covered by the Plan has the right to elect continuation coverage if he or she loses coverage under the Plan because of any of the following "qualifying events":
1. The death of the employee;
 2. The termination of the employee's employment (for reasons other than gross misconduct);
 3. The reduction in the employee's hours of employment.
 4. Divorce or legal separation from the employee.

If an employee eliminates coverage for his or her spouse in anticipation of a divorce or legal separation, and a divorce or legal separation later occurs, then the later divorce or legal separation will be considered a qualifying event even though the ex-spouse lost coverage earlier. If the ex-spouse notifies the administrator within 60 days of the later divorce or legal separation and can establish that the coverage was eliminated earlier in anticipation of the divorce or legal separation, then COBRA coverage may be available for the period after the divorce or legal separation.

- C. A child of an employee covered by the Plan has the right to elect COBRA continuation coverage if the child's group health coverage under the Plan is lost for any of the following qualifying events:
1. The death of the employee-parent;
 2. The termination of the employee-parent's employment (for reasons other than gross misconduct);
 3. Reduction in the employee-parent's hours of employment;
 4. The parents' divorce or legal separation;
 5. The employee-parent becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or
 6. The child ceases to be a "child" under the Plan.
- D. **Newborn or Newly Adopted Child:** If a child is born or adopted by the covered employee during the period of COBRA continuation coverage, and the covered employee has elected COBRA continuation coverage, then the employee (or other guardian) may elect COBRA continuation coverage for the child.
- E. **Domestic Partners.** An enrolled employee who, at the time of the qualifying event was covering his or her domestic partner under the Plan, can elect COBRA continuation coverage that includes continuing coverage for the domestic partner. A domestic partner who is covered under the Plan by the enrolled employee is not a "Qualified Beneficiary" and, therefore, does not have an independent election right under COBRA. This also means that the domestic partner's coverage ceases immediately when the enrolled employee's COBRA coverage terminates (for example, due to death or coverage under another plan).
- F. Under special rules that apply if an employee does not return to work at the end of an FMLA leave, some members may be entitled to elect COBRA even if they were not covered under the Plan during the leave. Contact the City Benefits & Wellness Office for more information about these special rules.

How can you elect COBRA continuation coverage?

Following a qualifying event, you will be sent a COBRA package. To elect continuation coverage, you must complete the Election Form and furnish it according to the directions on the form. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any child. The employee or the employee's spouse can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having preexisting condition exclusions applied to you by other group health plans if you have a 63-day gap in health coverage, and election of continuation coverage may help prevent such a gap. Second, you will lose the guaranteed right to purchase individual health coverage that does not

impose a preexisting condition exclusion if you do not elect continuation coverage for the maximum time available to you. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of the qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Independent Election Rights

While an election by a covered employee or covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may elect COBRA continuation coverage even if the employee does not make that election. If a child is born to, or placed for adoption with, a covered former employee during the COBRA continuation coverage period and the covered employee has elected COBRA continuation coverage, then the employee may elect COBRA continuation coverage for that child provided that the covered former employee notifies the plan administrator within the Plan's normal enrollment window for newborn children, adopted children, or children placed for adoption. You (or your covered spouse or dependents) may elect COBRA continuation coverage even if you (or your covered spouse or dependents) are covered under another group health plan or are entitled to Medicare prior to electing COBRA continuation coverage. Any qualified beneficiary for whom COBRA is not elected within the 60-day election period specified in the Plan's COBRA election notice **WILL LOSE HIS OR HER RIGHT TO ELECT COBRA COVERAGE.**

How much does COBRA continuation coverage cost?

Generally, each qualified beneficiary may be required to pay the entire cost of continuation coverage. The amount a qualified beneficiary may be required to pay may not exceed 102 percent (or, in the case of an extension of continuation coverage due to a disability, 150 percent) of the cost to the group health plan (including both employer and employee contributions) for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage.

The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

- Where coverage extends beyond 18 months for a disabled individual, the cost of COBRA continuation coverage will be 150% of the applicable premium,
- Where the qualified beneficiary changes to more expensive coverage, or
- Where the Plan was previously requiring payment of less than the maximum permissible amount.

A member seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 18-, 29-, or 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required 60 day COBRA election period, it is likely that a member will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty-five (45) days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. An individual need not show proof of insurability to elect COBRA continuation coverage.

The amount of your COBRA premiums may change from time to time during your period of COBRA coverage and will most likely increase over time. You will be notified of COBRA premium changes.

When and how must payment for COBRA continuation coverage be made?

First payment for continuation coverage

If you elect continuation coverage, you do not have to send any payment with the Election Form. However, you must make your first payment for continuation coverage not later than 45 days after the date of your election. (This is the date the Election Notice is post-marked, if mailed.) ***If you do not make***

your first payment for continuation coverage in full not later than 45 days after the date of your election, you will lose all continuation coverage rights under the Plan. Your first payment must cover the cost of COBRA coverage from the time your coverage under the Plan would have otherwise terminated up through the end of the month before the month in which you make your first payment. (For example, your employment terminates on September 26, and you lose coverage on September 30. You elect COBRA on November 10. Your initial premium payment equals the premiums for October and November and is due on or before December 25, the 45th day after the date of your COBRA election.)

Claims for reimbursement will not be processed and paid until you have elected COBRA and made the first payment for it. You are responsible for making sure that the amount of your first payment is correct. You may contact the Benefits Office to confirm the correct amount of your first payment or to discuss payment issues.

Periodic payments for continuation coverage

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage period. The amount due for each month for each qualified beneficiary will be disclosed in the election notice provided to you at the time of your qualifying event. Under the Plan, each of these periodic payments for continuation coverage is due on the first day of the month for that coverage period. If you make a periodic payment on or before the first day of the coverage period to which it applies, your coverage under the Plan will continue for that coverage period without any break. The Benefits & Wellness Office will not send a bill to you for your COBRA coverage—it is your responsibility to pay your COBRA premiums on time.

Grace periods for periodic payments

Although periodic payments are due on the first day of each month of COBRA coverage, you will be given a grace period of 30 days after the first day of the month to make each monthly payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment. However, if you pay a periodic payment later than the first day of the month to which it applies, but before the end of the grace period for the month, your coverage under the Plan will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the periodic payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that coverage period, you will lose all rights to continuation coverage under the Plan.

All COBRA premiums must be paid by check or money order or other available approved electronic method. Your first payment and all monthly payments for COBRA coverage must be mailed or hand delivered to the individual at the payment address specified in the election notice provided to you at the time of your qualifying event. However, if the Benefits & Wellness Office notifies you of a new address for payment, you must mail or hand deliver all payments for COBRA coverage to the individual at the address specified in that notice of a new address.

If mailed, your payment is considered to have been made on the date that it is postmarked. If hand-delivered, your payment is considered to have been made when it is received by the individual at the address specified above. You will not be considered to have made any payment by mailing or hand delivering a check if your check is returned due to insufficient funds or otherwise.

Member Obligations under COBRA

When the qualifying event is the end of employment, reduction of hours, or death of the employee, the City will offer COBRA coverage to qualified beneficiaries. **Under COBRA, the covered employee or a covered family member has the responsibility to inform the City Benefits & Wellness Office of the employee's divorce or legal separation, or a child losing dependent status under the Plan.** COBRA continuation will only be available to those qualified beneficiaries who notify the City Benefits & Wellness Office in writing, with the appropriate documentation within 60 days after the later of (1) the date of such an event, or (2) the date on which the affected employee or family member would otherwise lose coverage because of such event. Notice to the Benefits & Wellness Office must be made either through the City's BenefitsOnline program or by completion and submission of a Family Status Change Form. The

Family Status Change Form may be requested from the Benefits & Wellness Office at 503-823-6031. If this notice is not provided to the Benefits & Wellness Office within the required 60-day period, the affected employee or family member will not be entitled to elect COBRA continuation coverage.

When the Benefits & Wellness Office is notified that one of these qualifying events has occurred, they will in turn notify the qualified beneficiaries that they have the right to elect COBRA continuation coverage. To elect COBRA continuation coverage the qualified beneficiaries must complete and submit the Election Form provided within the COBRA notice packet within 60 days after the later of (1) the date that coverage under the Plan would otherwise terminate due to the qualifying event, or (2) the date that the qualified beneficiaries are provided with written notification of their right to elect COBRA continuation coverage. **IF THE BENEFITS & WELLNESS OFFICE DOES NOT RECEIVE A COMPLETED ELECTION FORM BY THE DUE DATE, YOU WILL LOSE YOUR RIGHT TO ELECT COBRA.**

COBRA Notice Procedures

If you do not follow these notice procedures, you and all related qualified beneficiaries will lose the right to elect COBRA (or will lose the right to an extension of COBRA coverage, as applicable.)

Any notice you provide concerning changes in family status must be made through the BenefitsOnline system or in writing to the Benefits Office on the City's Change in Family Status form. The change in Family Status form is available at <http://www.portlandonline.com/shared/cfm/image.cfm?id=28504>.

Written notices must be mailed or hand delivered to:

COBRA Administrator
City of Portland
BHR/Benefits & Wellness Office
1120 SW Fifth Avenue, Room 404
Portland, OR 97204

If mailed, your notice must be postmarked no later than the last day of the applicable notice period. If hand-delivered, your notice must be received by the COBRA Administrator at the address specified above no later than the last day of the applicable notice period. (The applicable notice periods are described in the above COBRA sections.)

Any notice you provide must include:

1. The name and address of the employee who is (or was) covered under the Plan;
2. The names and addresses of all qualified beneficiaries who lost coverage as a result of the qualifying event;
3. The qualifying event and the date it happened; and
4. The certification, signature, name, address and telephone number of the person providing the notice.

If the qualifying event is a divorce or legal separation, your notice must include a copy of the decree of divorce or legal separation. If your coverage is reduced or eliminated and later a divorce or legal separation occurs, and if you are notifying the Benefits & Wellness Office that your Plan coverage was reduced or eliminated in anticipation of the divorce or legal separation, your notice must include evidence satisfactory to the Benefits & Wellness Office that your coverage was reduced or eliminated in anticipation of the divorce or legal separation.

Any notice of disability that you provide must include:

1. The name and address of the disabled qualified beneficiary;
2. The date the qualified beneficiary became disabled;
3. The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
4. The date the Social Security Administration made its determination;
5. A copy of the Social Security Administration's determination; and
6. A statement whether the Social Security Administration has subsequently determined the disabled qualified beneficiary is no longer disabled.

Any notice of a second qualifying event you provide must include:

1. The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
2. The second qualifying event and the date it happened;
3. If the second qualifying event is a divorce or legal separation, a copy of the decree of divorce or legal separation.

The covered employee (i.e., the employee or former employee who is or was covered under the Plan,) a qualified beneficiary who lost coverage due to the qualifying event described in the notice or a representative acting on behalf of either may provide the required notices. A properly submitted notice provided by any of these individuals will satisfy any responsibility to provide notice on behalf of all qualified beneficiaries who lost coverage due to the qualifying event described in the notice.

PORTABILITY COVERAGE

A member who loses coverage under this Plan, may be entitled to convert to one of ODS' Portability Plans. The purpose of Portability Coverage is to make health coverage portable, or in other words, to improve the availability and affordability of health benefit plans for persons leaving group coverage. The benefits contained in the Portability Plan will be different than the benefits under this Plan.

ELIGIBILITY FOR PORTABILITY COVERAGE

A member covered under the insured CityNet Plan has the right to convert to an ODS' Portability Plan if he/she is an Eligible Individual. An Eligible Individual is one who has left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans, or meets the eligibility requirements of the Health Insurance Portability and Accountability Act of 1998. In either case, the member must apply for Portability coverage not later than the 63rd day after termination of group coverage issued by an Oregon carrier and be an Oregon resident at the time of such application.

A person who remains eligible for his/her prior group coverage or would remain eligible for prior group coverage in a plan under the Federal Employee Retirement Income Security Act of 1974, as amended (ERISA), were it not for action by the plan sponsor relating to the actual or expected health condition of the person, or who is covered under another health benefit plan or is eligible for the Federal Medicare program is not an Eligible Individual. However, a person who is eligible to obtain a Portability plan may obtain such a plan regardless of whether he or she has continued coverage under COBRA or General Oregon Continuation or whether the person, having exercised such rights, has received any benefits thereunder, unless he/she is an Eligible Individual who is leaving or has left an employee welfare benefit plan or multiple employer welfare arrangement that is exempt from state regulation under ERISA.

If an eligible dependent is not enrolled when Portability coverage begins, that dependent is not eligible for enrollment as a dependent in the plan at any later date. For the purposes of this rule, an eligible dependent is one who was covered by the prior group health benefit plan, provided that such dependent meets the eligibility requirements of the Portability plan. After Portability coverage begins, ODS shall accept for enrollment any new dependent, provided that such dependent meets the eligibility requirement of the Portability plan.

Domestic partners are not eligible dependents under a portability health plan. Domestic partners who otherwise meet the eligibility criteria above will need to enroll in a Portability plan as a subscriber. A domestic partner will not be able to enroll in a Portability plan as the former employee's dependent.

The Portability Plans are not available if the Group terminates the Plan and replaces it with a similar group plan within 31 days, and the coverage takes effect immediately following the date of termination.

ISSUANCE AND RENEWABILITY

Portability Plans "are guaranteed issue", guaranteed renewable and may be retained indefinitely subject to certain exceptions as stated below. Additionally, Portability Plans cannot contain pre-existing condition, exclusion, waiting periods or other similar limitations on coverage.

Portability plans shall be renewable with respect to all Portability plan members, except:

- For nonpayment of the required premiums by the subscriber;
- For fraud or intentional misrepresentation by the subscriber;
- If ODS elects to discontinue offering all of its group health benefit plans in accordance with ORS 743.737 and 743.754; or
- If the director orders ODS to discontinue coverage.

ENROLLMENT AND EFFECTIVE DATE OF COVERAGE

A member losing group coverage, for any reason other than group replacement of coverage will receive an explanation of Portability coverage within 10 days after ODS takes action to initiate or document the loss of coverage.

Eligible individuals must submit a written application and pay the first premium no later than the 63rd day after the date your coverage terminated under this plan. Coverage becomes effective on the day following termination of coverage under this plan. Eligible Individuals may enroll in Portability coverage before, during, or at the end of their COBRA or state continuation coverage. Portability coverage is guaranteed renewable and may be retained indefinitely.

A member may elect COBRA or State Continuation or Portability.

Please Note: When Portability coverage is chosen instead of COBRA or State Continuation, members will not be eligible to elect COBRA or State Continuation at a later date.

PORTABILITY OPTIONS

Portability coverage via the Oregon Medical Insurance Pool (OMIP) is available to Eligible Individuals who were covered by a non-Oregon group plan while a resident of Oregon. Portability coverage via OMIP is also available to Eligible Individuals who were covered by a self-funded multiple employer welfare arrangement or a self-funded group plan operated by a public entity in Oregon. However, these individuals must first complete continuation coverage offered through federal or state law, if they are eligible for such coverage.

ODS offers two options for Portability coverage:

- The Prevailing Plan reflects benefit coverages that are prevalent in the group health insurance market; and
- The Low Cost Plan emphasizes affordability for Eligible Individuals.

For more information regarding the Prevailing and Low Cost Plans, members may contact ODS Customer Service.

The Federal Newborns' and Mothers' Health Protection Act of 1996

The Federal Newborns' and Mothers' Health Protection Act of 1996 (NMHPA) relates to the amount of time a mother and newborn child can spend in the hospital in connection with the birth of a child. Under NMHPA, if a group health plan provides health coverage for hospital stays in connection with the birth of a child, this coverage must be provided for a minimum period of time. For example, NMHPA provides that coverage for a hospital stay following a normal vaginal delivery may generally not be limited to less than 48 hours for both the mother and newborn child. Health coverage for a hospital stay in connection with childbirth following a cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child. The City of Portland's health plans are in compliance with NMHPA.

Federal Women's Health and Cancer Rights Act of 1998

The City of Portland's plans, as required by the Federal Women's Health and Cancer Rights Act of 1998 (Women's Health Act) provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema.) Call ODS at 503-243-3974 for more information.

Women's Health Act Frequently Asked Questions

1. **I've been diagnosed with breast cancer and plan to have a mastectomy. How will the Women's Health Act affect my benefits?** Under the Women's Health Act, group health plans offering mastectomy coverage must also provide coverage for reconstructive surgery in a manner determined in consultation with the attending physician and patient. Coverage includes all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas.
2. **Under the Women's Health Act, may group health plans impose deductibles or coinsurance requirements for reconstructive surgery in connection with a mastectomy?** Yes, but only if the deductibles and coinsurance are consistent with those established for other benefits under the plan or coverage.

ACTS OF THIRD PARTIES

Third-Party Liability:

There may be situations in which a third party, including a member's or another liability insurer, is responsible for the charges for health care services. For example, if a member is injured in a store, the owner or the owner's insurance carrier may be responsible for payment of the charges for the member's health care services arising out of the injury. The following rules will apply in such situations. (For situations involving motor vehicle injuries, see the Motor Vehicle section.)

1. Assumption or Adjudication of Responsibility:

- a. If a third party has accepted financial responsibility or been adjudicated (determined) to be liable for all or a portion of the charges for the member's health care services, the Plan shall not be responsible for the amount for which the third party has accepted responsibility or been adjudicated liable, and the provisions of the Plan shall not apply to the services for which responsibility has been accepted or liability has been adjudicated. The rules set forth in the following Subrogation section apply to any other services and charges.

2. Subrogation to Member's Rights:

- a. For services and charges for which a third party may be responsible, other than those described above, the Plan will provide benefits for covered services but will be entitled to recover the charges for those services in the name of the member or the Plan, or to be reimbursed from the third party or from the member's or another liability insurer. The Plan will not provide services unless the member complies with the provisions of this paragraph. The Plan shall be entitled to recover or be reimbursed for the charges for all past and future health care services for which the Plan provides benefits, which are required on account of the condition from which recovery is sought. The Plan's recovery for health care charges is measured by the Plan's actual paid expenses. The Plan will provide the member with information regarding the amount of these charges. If the member continues to receive medical treatment for an illness or injury after obtaining a settlement or recovery from a Third Party, the Plan will continue to provide Benefits for the continuing treatment of that illness or injury only to the extent that the member can establish that any sums that may have been recovered from the Third Party for the continuing medical treatment have been exhausted for that purpose.
- b. The member agrees to cooperate in protecting the interest of the Plan under this provision. The Plan can require the member to testify for the Plan and to sign and deliver all legal papers necessary to secure the member's and the Plan's rights. If the Plan asks the member to sign an agreement to reimburse the Plan and to hold the proceeds of any recovery in trust for the Plan, he or she must do so. The member must agree to sign a subrogation agreement that allows the Plan to bring an action in the member's name. The Plan has the right to deny coverage for claims related to the accident or incident pending receipt of the required legal papers and/or subrogation agreement. If a Plan member fails to complete required paperwork after the payment of claims, the Plan will issue a retroactive denial of claims and the member will be responsible for all claims associated with the accident or incident. The Plan will pay its share of the attorney fees and expenses of obtaining a recovery out of the proceeds of that recovery. The Plan will determine what share of attorney's fees and expenses are appropriate to be paid by the Plan. If any action or proceeding against the member is necessary to enforce the rights of the Plan under this paragraph, the prevailing party shall be entitled to such reasonable attorney fees and costs as the court shall find reasonable at trial or on appeal.

3. Motor Vehicle Coverage:

- a. Oregon law requires motor vehicle liability policies to provide personal injury protection benefits which include benefits for health care expenses. This insurance is primary health care expense coverage of the insured and members of the insured's family who reside in the same household. To the extent coverage is available from the personal injury protection insurance, the Plan will be entitled to recover the cost of health care services that are required as a result of a motor vehicle injury for which the Plan provides benefits. A member must give the Plan information about any personal injury protection insurance available to the member or covered dependents.

- b. The Plan will provide benefits for the charges for health care services which exceed the motor vehicle personal injury protection insurance. However, when the Plan provides benefits, it is entitled to recover the charges for health care services which exceed the motor vehicle personal injury protection insurance payment, and to recover the charges for health care services when it does not receive payment from personal injury protection insurance, from any recovery the member makes from a claim or legal action related to the motor vehicle injury. This includes claims the member makes against his or her own uninsured or under-insured motorist coverage. The member must promptly notify the Plan of any such claim or legal action. The Plan's recovery for health care charges is measured by the Plan's actual claims expenses. The Plan may recover the charges for health care services in one of the following ways:
- 1) The Plan may use an inter-insurer reimbursement proceeding to obtain direct reimbursement from the motor vehicle liability insurer.
 - 2) The Plan may elect to file a lien against the recovery of the claim or legal action. If it elects to file a lien, the Plan will notify the member in writing within 30 days of when it receives notice of the claim or legal action. The Plan will also notify the person against whom the claim is made or the legal action instituted, within 30 days of receiving notice of the claim or legal action. The Plan shall give this written notice by U.S. mail. If the member has begun a legal action, the Plan will file with the clerk of the court a return showing service of such notice of election to file a lien. The lien is created by the Plan's notification of the parties. The Plan is entitled to recover the charges for health care services for which we have furnished benefits, less our portion of expenses, costs, and attorney fees incurred by the member in connection with recovery of the amount of the lien. The member must include as damages in the claim or legal action the charges for services for which the Plan furnished benefits.
 - 3) If the Plan elects not to file a lien, it is entitled to the proceeds of any settlement or judgment the member receives as the result of filing a claim or instituting a legal action, to the extent that the Plan has furnished benefits for health care costs resulting from the accident or incident. The Plan's recovery of health care charges will be less the Plan's share of expenses, costs, and attorney fees incurred by the member in connection with their recovery. The member will hold all rights or recovery in a trust for the benefit of the Plan, up to the amount of the benefits provided by the Plan. The member agrees to cooperate in protecting the Plan's interest under this provision.

If the Plan requests in writing that the member take such action necessary or appropriate to recover benefits provided for the member, the member must agree to do so. The Plan can require the member to testify for the Plan and to sign and deliver all legal papers necessary to secure the member's and the Plan's rights. For example, the Plan can require a member to sign a subrogation agreement that allows the Plan to bring an action in the member's name. The Plan will also be reimbursed out of the recovery made from this action for the member's share of expenses, costs, and attorney fees incurred in connection with the recovery. The Plan has the right to deny coverage for claims related to the accident or incident pending receipt of the required legal papers and/or subrogation agreement.

Basic Group Term Life Insurance and Group Supplemental Life Insurance

Do I qualify for Basic Group Term Life Insurance (Basic Life) coverage?

You qualify if you are an active employee of the City of Portland, are in a benefits eligible position, and are one of the following:

- A full-time employee regularly working at least 72 hours each pay period.
- A permanent part-time employee regularly working at least 40 but less than 72 hours each pay period

You are not a member if you are a temporary or seasonal employee who is not in a benefits eligible position.

Do my spouse or domestic partner and children qualify for Basic Life insurance coverage?

No, they do not qualify for Basic Life insurance. However, they may qualify for Group Term Supplemental Life Insurance (Supplemental Life) coverage if you are enrolled in Supplemental Life coverage for yourself.

Your spouse or domestic partner may qualify for Group Term Supplemental Life Insurance if:

- Your spouse is a person to whom you are legally married and from whom you are not legally separated.
- Your domestic partner is an individual with whom you have completed the City of Portland's Domestic Partner Affidavit or who is a registered domestic partner as per the Oregon Family Fairness Act of 2007 and submitted those affidavits to the City Benefits & Wellness Office, and filed those affidavits for public record if required by law.

Your children qualify if:

- Your child is an unmarried child from live birth to age 26, and
 - A natural child.
 - An adopted child.
 - The child of your spouse or domestic partner, if your spouse or domestic partner is required by divorce decree or court order to provide health insurance for the child, or is primarily responsible for financial support of the child.
 - The child of your child, if your child is insured for Supplemental Life for Dependents, under the City of Portland's plan.
 - Any other child related to you or your spouse or domestic partner by blood or marriage, for whom you or your spouse or domestic partner has been awarded court appointed guardianship, and of whom you or your spouse or domestic partner has custody.

Note: To qualify for coverage as a child, one of the following additional dependency tests must be met with respect to a child under age 19:

- You or your spouse or domestic partner must be entitled to claim the child as an income tax exemption; or
- You or your spouse or domestic partner must be obligated to provide health insurance for the child by court decree or state order, and not be entitled to claim the child as an income tax exemption solely on the court decree.
- A disabled child may be covered beyond the limiting ages above if the child is continuously:
 - Incapable of self-sustaining employment because of mental retardation or physical handicap; and
 - Chiefly dependent upon you for support and maintenance, or institutionalized because of mental retardation or physical handicap.

You must give the City's Group Term Supplemental Life insurance carrier proof that the child is disabled within 31 days after the date on which insurance would otherwise end because of the child's age. At reasonable intervals thereafter, the insurance company may require further proof of disability.

What benefit amounts are available?

Basic Life Insurance

For PPA employees: \$50,000

Supplemental Life Insurance

You may apply for the following amounts for yourself and your spouse or domestic partner.

For you: Any multiple of \$10,000, from \$20,000 to a maximum of \$500,000

For your spouse or domestic partner: Any multiple of \$10,000, from \$20,000 to a maximum of \$300,000 (not to exceed the amount of Supplemental Life Insurance for which you are insured)

Note: You may not be insured simultaneously as both an employee and a spouse or domestic partner.

You may apply for the following amounts for your children.

For your children: Any multiple of \$5,000, to a maximum of \$25,000 (not to exceed the amount of Supplemental Life Insurance for which you are insured)

Note: You may not be insured simultaneously as both an employee and a child. Children may not be insured by more than one parent.

*Annual earnings are based on your annual rate of earnings from the City of Portland in effect on the May 1 coinciding with or preceding your last full day of active work. Annual earnings include your contributions to a salary reduction agreement under an IRC Section 125 Cafeteria Plan and to a deferred compensation plan. Annual earnings do not include bonuses, commissions, overtime pay, shift differential pay, your employer’s contributions on your behalf to any deferred compensation arrangement or pension plan, medical/vision plan opt out dollars or any other compensation. (Note: If your work status changes for more than six months, your annual earnings will be based on your rate of earnings in effect on the date six months following the date of change in work status.)

How much will the Supplemental Life Insurance annual premium cost per Family Member?

Your or your spouse's/domestic partner's age on May 1:	Your Annual Cost per \$10,000 of Supplemental Life (Active):
Under 30	\$ 3.00
30 through 34	\$ 4.56
35 through 39	\$ 4.80
40 through 44	\$ 6.00
45 through 49	\$ 9.00
50 through 54	\$13.80
55 through 59	\$25.80
60 through 64	\$37.20
65 through 69	\$60.00
70	\$80.40
71	\$82.20
72	\$90.00
73	\$97.80
74	\$105.60
*Eligible Dependent Children: \$5,000 to \$25,000 in increments of \$5,000	Monthly cost: \$0.65 per \$5,000 of dependent life, regardless of the number of dependents covered.

Who pays for Basic Life coverage?

The City pays the entire cost of \$50,000 of Basic Life coverage for full-time PPA employees.

Who pays for Supplemental Life coverage?

You pay for all Supplemental Life insurance and for Supplemental Life for Dependents amounts for which you, your spouse or domestic partner and children become insured.

When can I apply?

If you qualify for coverage (see above) and have completed the eligibility waiting period (as described below) you can apply for Basic Life insurance, Supplemental Life insurance and Supplemental Life for Dependents at any time. You must agree to make the required premium contributions for any Supplemental Life insurance and Supplemental Life for Dependents you elect, and for any Basic Life insurance amounts for which you are required to contribute premiums.

If you do not make an election for your Basic Life insurance amount, you will automatically become insured under Option 1 after completing the eligibility waiting period, provided you also meet the active work requirement.

For Basic Life insurance, your eligibility waiting period is determined as follows:

- If you are a permanent part-time or job-share employee, represented by PPA, you become eligible on the first day of the calendar month following 174 hours of continuous service with the City of Portland.
- If you are a full-time PPA employee, you become eligible on the first day of the calendar month following 30 consecutive days of service with the City of Portland.

For Supplemental Life insurance, your eligibility waiting period is as provided under the terms of the City of Portland Benefit Plan Document or under the terms of your bargaining unit's agreement with the City, as applicable.

When does my insurance coverage become effective?

Coverage becomes effective as follows, provided you meet the active work requirement on that date.

Basic Life insurance

- Basic Life insurance coverage paid for by the City becomes effective on the first day after the end of the eligibility waiting period (described above).
- Basic Life insurance amounts for which you are required to pay become effective on the date you apply, provided you apply within 60 days after the end of your eligibility waiting period. If you apply to increase the amount of your Basic Life Insurance more than 60 days after the end of your eligibility waiting period, you will be required to submit satisfactory evidence of insurability to become insured for the increased amount.

Supplemental Life Insurance

For you:

- If you apply for Supplemental Life insurance within 60 days of your initial eligibility period, or within 60 days of a marriage/domestic partner addition, birth or adoption of a child, coverage amounts up to \$300,000 become effective on the first day of the calendar month following the date you apply. If you apply for an amount between \$300,000 and \$500,000, you will have to submit evidence of insurability to the insurance company. The additional coverage will be effective on the first day of the calendar month following the date the insurance company approves your application.

- If you apply for Supplemental Life insurance after the end of your eligibility waiting period, coverage becomes effective on the first day of the calendar month following the date the insurance company approves your evidence of insurability.
- Evidence of insurability is also required for any increase in your Supplemental Life insurance.

For your spouse or domestic partner:

- If you apply for Supplemental Life insurance for your spouse or domestic partner within 60 days after becoming eligible to cover your spouse or domestic partner, coverage amounts up to \$30,000 become effective on the first day of the calendar month following the date you apply. Amounts in excess of \$30,000 become effective on the first day of the calendar month following the date the insurance company approves your spouse or domestic partner's evidence of insurability.
- If you apply for Supplemental Life insurance for your spouse or domestic partner more than 60 days after becoming eligible to cover your spouse or domestic partner, coverage becomes effective on the date the insurance company approves your spouse or domestic partner's evidence of insurability.
- Evidence of insurability is also required for any increase in Supplemental Life insurance for your spouse or domestic partner.

Supplemental Life for Dependents

- If you apply for Supplemental Life for Dependents within 60 days after becoming eligible to cover your children, coverage becomes effective on the first day of the calendar month following the date you apply.
- If you apply for Supplemental Life for Dependents more than 60 days after becoming eligible to cover your children, coverage becomes effective on the first day of the calendar month following the date you apply.
- Your newborn or newly adopted child will be automatically insured for \$25,000 for the first 31 days from birth or adoption.
- Evidence of insurability is not required for any newly insured or increase in Supplemental Life for Dependent children.

Active Work Requirement

To meet the active work requirement you must be performing the material duties of your own occupation at your employer's usual place of business. If you are incapable of meeting this requirement because of physical disease, injury, pregnancy or a mental disorder on the day before the scheduled effective date of insurance or an increase in insurance, coverage will not become effective until the day after you meet the active work requirement for one full day as a qualified employee.

Note

Approval of evidence of insurability is also required if (a) coverage terminates for any reason and you, your spouse or domestic partner or children desire to become insured again, and (b) if you, your spouse or domestic partner or children converted coverage to an individual life policy and wish to become insured again under the group policy.

How do you submit evidence of insurability to the City's Group Term Life insurance carrier?

- Complete and sign a Medical History Statement that includes an authorization for the insurance company to obtain information about the person's health.
- Undergo a physical examination, if required, which may include blood testing.
- Provide any additional information about the person's insurability that the insurance company may reasonably require.

Does Basic Life and Supplemental Life coverage terminate due to changes in age?

Basic Life insurance does not terminate due to changes in your age.

Supplemental Life insurance will terminate when you become 75 years of age.

Your spouse or domestic partner's Supplemental Life insurance will terminate when your spouse or domestic partner becomes 75 years of age (or when you become 75 years of age, if earlier).

Supplemental Life for Dependents terminates when the child reaches a limiting age (see "Do my spouse or domestic partner and children qualify for coverage?" above).

To whom are benefits paid?

The insurance company pays Supplemental Life benefits to you if your spouse or domestic partner or child dies.

The insurance company pays Basic Life insurance and your Supplemental Life insurance benefits of \$10,000 or more to your beneficiary(ies) by depositing funds into convenient, no fee, interest-bearing draft accounts. Each beneficiary receives a personalized checkbook and has complete control of the account. Beneficiaries can write checks as needed or for the full amount.

If you do not designate a beneficiary, benefits will be paid in equal shares to the first surviving class of the following classes: (a) your spouse, (b) your children, (c) your parents, (d) your brothers and sisters, or (e) your estate.

Are there any coverage exclusions?

The following suicide exclusion applies to increases in Basic Life insurance due to changes in Option selected, and to all Supplemental Life insurance amounts for you and your spouse or domestic partner.

If death results from suicide or other intentionally self-inflicted injury, while sane or insane, the following will apply:

- The amount payable will exclude amounts of Basic Life insurance subject to this suicide exclusion and Supplemental Life insurance for you and your spouse or domestic partner and which have not been continuously in effect for at least 2 years on the date of death.
- The insurance company will refund all premiums paid for that portion of Basic Life insurance and Supplemental Life insurance that is excluded from payment under this suicide exclusion.

What if I become disabled?

Waiver of Premium During Total Disability

If you are an active member and become totally disabled from any occupation while insured under the group policy and while under age 60, Basic Life insurance, Supplemental Life insurance and Supplemental Life for Dependents may be continued without premium payment under the plan's Waiver of Premium provision. Coverage will end if you are no longer Totally Disabled or if you become 65 years of age.

Accelerated Benefit

If you qualify for Waiver of Premium and you give the insurance company satisfactory proof that you are terminally ill with a life expectancy of less than 12 months, you may have the right to receive during your lifetime a portion of your Basic Life insurance and Supplemental Life insurance as an accelerated benefit. You may receive an accelerated benefit of up to 75% of your Basic Life insurance and Supplemental Life insurance, not to exceed \$300,000. The minimum accelerated benefit is \$5,000 or 10% of your Basic Life insurance and Supplemental Life insurance, whichever is greater.

When does my insurance coverage end?

Basic Life insurance and your Supplemental Life insurance end automatically on the earliest of the following:

- The last day of the last period for which you make a premium contribution, with respect to contributory coverage.
- The date you become 75 years of age, with respect to Supplemental Life insurance.
- The first day of the calendar month following the date you cease to be benefits-eligible (unless you elect to continue coverage under the Continuation Of Insurance Privilege or you qualify for Waiver of Premium).
- The date the group policy terminates.
- The date you cease to qualify for coverage (see "Do I qualify for life insurance coverage?").
- The first day of the calendar month following a calendar month in which you fail to work at least 80 hours for the City of Portland.

Supplemental Life insurance for your spouse or domestic partner and Supplemental Life for Dependents end automatically on the earliest of the following:

- The date your Supplemental Life insurance ends.
- The last day of the last period for which you make a premium contribution.
- For Supplemental Life insurance, the date your spouse or domestic partner becomes 75 years of age (or the date you become 75 years of age, if earlier).
- For Supplemental Life insurance, the date of your divorce or legal separation from your spouse, or the date of termination of your domestic partnership.
- For Supplemental Life for Dependents, the date your child ceases to qualify for coverage (see "Do my spouse or domestic partner and children qualify for coverage?").
- For Supplemental Life for Dependents, 90 days after the insurance company mails you a request for proof of a child's disabled status, if proof is not given.

Note: Insurance may be continued for a limited period under certain leave circumstances.

What happens when my insurance ends?

Continuation of Insurance Privilege

You may continue your Supplemental Life insurance and Supplemental Life for Dependents if your employment with the City terminates, provided you are not disabled. The maximum amount you may continue is the amount in effect prior to termination of your employment. If you wish to continue coverage for your spouse or domestic partner and children, you must continue coverage for yourself. You must apply and pay the first premium to the insurance company within 31 days after the date your employment terminates.

Right To Convert to an Individual Policy

If insurance ends or is reduced for any reason other than failure to pay your premium, you, your spouse or domestic partner or your children may have a right to buy an individual policy of permanent life insurance without submitting evidence of insurability during the 31 day conversion period. If you, your spouse or domestic partner or your children die during this 31-day conversion period, the insurance company will pay the benefit amount the insured person could have converted.

For questions about Life insurance coverage or assistance making a claim for benefits, call the City of Portland Benefit Office at (503) 823-6031

Important: This summary is designed to answer some common questions about your Group Term Life insurance and Group Term Supplemental Life Insurance. It is not intended to provide a detailed description of the coverage. You may request a Certificate of Insurance, which provides a more complete description of coverage, by contacting the City of Portland Benefit Office. The controlling provisions of coverage are in the group insurance policy. This summary and the Certificate of Insurance do not modify the group insurance policy or the insurance coverage in any way.

HIPAA NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

The Plan is in compliance with the Health Insurance Portability and Accountability Act (HIPAA) of August 1996. Certification of creditable coverage will be provided to plan participants pursuant to this act and to relevant administrative rules.

THIS NOTICE DESCRIBES HOW YOUR MEDICAL INFORMATION MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY

Effective May 1, 2005

INTRODUCTION

The Health Insurance Portability and Accountability Act (HIPAA) requires the City provide you with this notice. It describes how medical information about you may be obtained, used, and disclosed by the City of Portland (City), by the Administrator of the Health Plans (Administrator), and by the various providers, consultants, and agencies (Agents) hired by the City, and how you can get access to this information and your medical records. Please review it carefully.

The City will maintain a limited amount of protected health information (PHI), such as enrollment data, for the Plans, COBRA, and Cafeteria Plan components. All of the Administrators and Agents are required by HIPAA to obey its requirements. The City has entered into Business Associate Agreements with each of these entities that makes their compliance with HIPAA part of their contractual obligations with the City.

The City of Portland, its Administrators, and Agents respect the privacy and confidentiality of your protected health information. All are committed to ensuring the confidentiality of your information in a responsible and professional manner. All are required by law to maintain the privacy of your protected health information and abide by the terms of this notice.

The City offers an insured PPO (CityNet) and an insured HMO (Kaiser) health plan. The City also hires various other agencies to assist in administering the cafeteria plan components, Employee Assistance Program (EAP) and other benefit consulting needs. These Agents are currently BenefitHelp Solutions, Aliquant, AON Consulting, Kaiser Permanente, Cascade Centers, Inc., Managed Healthcare Northwest, ODS, and Vision Service Plan.

Should any of the City, Administrator, or Agency privacy practices change, the City reserves the right to change the terms of this notice and to make the new notice effective for all protected health information. Once revised, the City will notify you that a change has been made and post the notice on our Web site at www.portlandonline.com/omf/bhr. You may also request the new notice be mailed to you.

This notice explains how the City, Administrator, and Agents use information about you and when that information can be shared with others. It also informs you about your rights. Finally, this notice provides you with information about exercising these rights.

HOW THE CITY USES OR SHARES INFORMATION

The City acquires limited “Protected Health Information” (PHI) about you in order to enroll, maintain, change and terminate your participation in the Plans. Those in the City performing these functions include City payroll employees in your bureau, employees in the Bureau of Technology Services (BTS), and employees assigned to the Benefit Office in the Bureau of Human Resources. They will obtain the following information from you to perform these functions: The names, dates of birth, addresses, phone numbers, social security numbers, employment data with the City, enrollment in other medical benefit plans if any, of yourself and any dependents and/or domestic partners that participate in the Plans. Other authorized City employees may also use this information to conduct quality assessment and improvement activities, other activities relating to the creation, renewal or replacement of health benefits and budget creation and analysis.

The City may also acquire information from the Plans that has been de-identified – that is medical information that cannot be linked to any individual participant, for purposes of utilization review, cost studies, and review of appeals decisions made by the Administrator with respect to any Plan benefit.

HOW THE ADMINISTRATORS AND AGENTS USE AND SHARE INFORMATION

The City’s Agents and Administrators use protected health information and may share it with others as part of your treatment, payment for treatment, and Plan operations. The following are ways the Agents and Administrators may use or share information about you:

- The Agents and Administrator will use the information to administer your plan benefits and help pay your medical bills that have been submitted to the Agents and Administrator by doctors and hospitals for payment.
- The Agents and Administrator may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, the Agents and Administrator may provide access to any medical records sent to the Agents and Administrator by your doctor.
- The Agents and Administrator may use or share your information with others to help manage your health care. For example, the Agents and Administrator might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- The Agents and Administrator may share your information with individuals who perform business functions for the City. The City will only share your information if there is a business need to do so and if our business partner agrees to protect the information, in accordance with this privacy notice.

- The Agents and Administrator may give you information about treatments and programs or about health related products and services that may be to your benefit. For example, the Agents and Administrator sometimes send out letters to notify you about chronic conditions, smoking cessation or nutrition programs.

There are also state and federal laws that may require the City Agents and Administrator to release your health information to others. The Agents and Administrator may be required by law to provide information to others for the following reasons:

- The Agents and Administrator may have to give information to law enforcement agencies. For example, the Agents and Administrator are required to report when child abuse or neglect or domestic violence is reasonably believed to have occurred.
- The Agents and Administrator may be required by a court or administrative agency to provide information because of a search warrant or subpoena.
- The Agents and Administrator may report health information to public health agencies if the Agents and Administrator believe there is a serious health or safety threat.
- The Agents and Administrator may report health information on job-related injuries because of requirements of state workers' compensation laws.
- The Agents and Administrator may report information to the Food and Drug Administration. This agency is responsible for investigating or tracking prescription drug and medical device problems.
- The Agents and Administrator may have to report information to state and federal agencies that regulate the City, such as the U.S. Department of Health and Human Services.

If the City Agents and Administrator use or disclose your information for any reasons **other than the above**, your written authorization will be obtained first. If you give the Agents or Administrator written permission and change your mind, you may revoke your written authorization at any time. The Agents and Administrator will honor the revocation except to the extent that the Agents or Administrator have already relied on your authorization.

NOTE: If the City Agents or Administrator discloses information as a result of your written authorization, it may be re-disclosed by the receiving party and may no longer be protected by state and federal privacy rules. However, federal or state law may restrict re-disclosure of additional information such as HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment, or referral information.

What Are Your Rights

You have certain rights with respect to your protected health information. These include:

- ***You have the right to ask the City Agents and Administrator to restrict*** how your information is used or disclosed for treatment, payment, or health care operations. You also have the right to ask the Agents and Administrator to restrict information provided to persons involved in your care. While the Agents

and Administrator may honor your request for restrictions, *they are not required to agree* to these restrictions.

- ***You have the right to submit special instructions*** to the Agents and Administrator regarding how information is sent to you that contains protected health information. For example, you may request that your information be sent by a specific means (for example, U.S. mail only) or to a specific address. The Agents and Administrator will accommodate reasonable requests by you as explained above. The Agents and Administrator may require that you make your request in writing.
- ***You have the right to inspect and obtain a copy*** of information that the Agents and Administrator maintain about you in a designated record set. *However*, you may not be permitted to inspect or obtain a copy of information that is:
 - contained in psychotherapy notes;
 - compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
 - subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provisions of access to the individual would be prohibited by law or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2).

Additionally, in certain situations the Agents and Administrator may deny your request to inspect or obtain a copy of your information. If the Agents and Administrator deny your request, the Agents and Administrator will notify you in writing. Any denial will explain your right to have the denial reviewed.

The Agents and Administrator may require that your request be made in writing. The Agents and Administrator will respond to your request no later than 30 days after it is received. If the information you request is not maintained or accessible to the Agents and Administrator on-site, the Agents and Administrator will respond to your request no later than 60 days after it is received. If additional time is needed, the Agents and Administrator will inform you of the reasons for the delay and the date that the Agents and Administrator' action on your request will be completed.

If you request a copy, a reasonable fee based on copying and postage costs will be required. You may request a copy of the portion of your enrollment and claim record related to an appeal free of charge.

- ***You have the right to ask the Agents and Administrator to amend*** information maintained about you in a designated record set. The Agents and Administrator will require that your request be in writing and that you provide a reason for your request. The Agents and Administrator will respond to your request no later than 60 days after it is received. If a response cannot be made within 60 days, the time may be extended by no more than an additional 30 days. If additional time is needed you will be notified of the delay and the date by which action on your request will be completed.

If an amendment is made you will be notified that it was made, and the Agents and Administrator will obtain your authorization to notify the relevant persons you have identified

with whom the amendment needs to be shared. The Agents and Administrator will notify these persons, including their business associates, if any, of the amendment.

If your request to amend is denied, you will be notified in writing of the reasons for the denial. The denial will explain your right to file a written statement of disagreement. The Agents and Administrator have a right to rebut your statement. However, you have the right to request that your written request, the Agents and Administrator written denial, and your statement of disagreement be included with your information for any future disclosures.

- ***You have the right to receive an accounting*** of certain disclosures of your information made by the Agents and Administrator during the six years prior to your request, but does not include disclosures made prior to April 14, 2003. The accounting may not include disclosures:
 - for treatment, payment, and health care operations purposes;
 - made for you;
 - made in connection with a use or disclosure otherwise permitted;
 - made pursuant to your authorization;
 - for a facility's directory or to persons involved in your care or other notification purposes;
 - for national security or intelligence purposes;
 - to correctional institutions, law enforcement officials; or
 - made as part of a limited data set for research, public health, or health care operations purposes.

Additionally, if the City Agents and Administrator disclose your information for research purposes pursuant to an authorization, the Agents and Administrator may not account for each disclosure of your information. Instead, the Agents and Administrator will provide for you: (1) the name of the research protocol or activity; (2) a description of the research protocol or activity including the purpose for the research and the criteria for selecting particular records; (3) a description of the type of protected health information that was disclosed; (4) the date or period of time when such disclosure occurred; and (5) the name, address, and telephone number of the entity that sponsored the research and researcher to whom the information was disclosed.

The Agents and Administrator will act on your request for an accounting within 60 days. Additional time may be needed to act on your request, and may therefore take up to an additional 30 days. Your first accounting will be free, and you will be entitled to one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving a free accounting, you will be charged a fee. You will be informed of the fee in advance and you will be provided with an opportunity to withdraw or modify your request.

Exercising Your Rights

You have a right to receive a paper copy of this notice upon request at any time. You can also view a copy of the notice on our Web site at www.portlandonline.com/omf/bhr

If you have any questions about this notice or privacy practices of the City, its Agents or Administrator, please contact the HIPAA Program Coordinator at 503.823.5219. Our office is open Monday through Friday from 8 a.m. to 5 p.m.

If you believe your privacy rights have been violated by an Agent or Administrator you may file a complaint with the City by writing the City at the address as follows:

Anna Kanwit
City of Portland Privacy Officer

Bureau of Human Resources
City of Portland, Oregon
1120 SW 5th Avenue, Room 404
Portland, Oregon 97204
Phone: (503) 823.5219
Fax: (503) 823.3522

E-Mail: Anna.Kanwit@portlandoregon.gov

You may also notify the Office of Civil Rights, U.S. Department of Health and Human Services of your complaint. The City cannot and will not take any action against you for filing a complaint. You may contact the Office of Civil Rights at

Office for Civil Rights

U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue, S.W.
Washington, DC 20201

OCR Hotlines-Voice: 1-800-368-1019

Ocrmail@hhs.gov

Drug Coverage and Medicare

Important Notice from the City of Portland About Your Prescription Drug Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription drug coverage with the City of Portland and about your options under Medicare's prescription drug coverage. This information can help you decide whether or not you want to join a Medicare drug plan. If you are considering joining, you should compare your current coverage, including which drugs are covered at what cost, with the coverage and costs of the plans offering Medicare prescription drug coverage in your area. Information about where you can get help to make decisions about your prescription drug coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription drug coverage:

1. Medicare prescription drug coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Drug Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription drug coverage. All Medicare drug plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Portland has determined that the prescription drug coverage offered by the CityNet and Kaiser Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription drug coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

When Can You Join A Medicare Drug Plan?

You can join a Medicare drug plan when you first become eligible for Medicare and each year from November 15th through December 31st.

However, if you lose your current creditable prescription drug coverage, through no fault of your own, you will also be eligible for a two (2) month Special Enrollment Period (SEP) to join a Medicare drug plan.

What Happens To Your Current Coverage If You Decide to Join A Medicare Drug Plan?

If you decide to join a Medicare drug plan, your current City of Portland coverage will not be affected. The City of Portland plan's coverage will be primary and pay before Medicare.

If you do decide to join a Medicare drug plan and drop your current City of Portland coverage, be aware that you and your dependents will not be able to get this coverage back.

When Will You Pay A Higher Premium (Penalty) To Join A Medicare Drug Plan?

You should also know that if you drop or lose your current coverage with the City of Portland and don't join a Medicare drug plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare drug plan later.

If you go 63 continuous days or longer without creditable prescription drug coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go nineteen months without creditable coverage, your premium may consistently be at least 19% higher than

the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following November to join.

For More Information About This Notice Or Your Current Prescription Drug Coverage...

Contact the person listed below for further information.

NOTE: You'll get this notice each year. You will also get it before the next period you can join a Medicare drug plan, and if this coverage through the City of Portland changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Drug Coverage...

More detailed information about Medicare plans that offer prescription drug coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare drug plans.

For more information about Medicare prescription drug coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

If you have limited income and resources, extra help paying for Medicare prescription drug coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare drug plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2012
Name of Entity/Sender:	City of Portland
Contact--Position/Office:	Benefits & Wellness Office
Address:	1120 SW Fifth Ave., Room 404 Portland, Oregon 97201
Phone Number:	503-823-6031

TECHNICAL PLAN INFORMATION

Employer Tax ID No.: 93-6002236

Agent for Legal Process: City Attorney

1221 SW 4th Avenue, Room 430

Portland, OR 97204

Funding Process: Funded through a combination of employee payroll deductions and employer benefit dollar allocations.

Type of Administration: The Plan is insured and administered by the ODS Health Plan, Inc.

IMPORTANT NOTICE

REQUEST FOR INFORMATION

When necessary to process claims, ODS may require that you submit information concerning benefits to which you or your dependent are entitled. It may also require that you authorize any physician or healthcare provider to provide ODS with information about a condition for which you claim benefits.

CONFIDENTIALITY OF MEMBER INFORMATION

Keeping a member's protected health information confidential is of very importance to ODS. Protected health information includes enrollment, claims, and medical and dental information. ODS uses such information internally for claims payment, referrals and authorization of services, and business operations such as case management and quality management programs. ODS does not sell your information. For more detail about how ODS uses your information, please refer to the Notice of Privacy Practices. A copy of the notice is available on the ODS website by following the HIPPA link or by calling ODS at 503-243-4492.

TRANSFER OF BENEFITS

Only you and your insured dependents are entitled to benefits under this Plan. These benefits are not assignable or transferable to anyone else. Any attempted assignment or transfer will not be binding on ODS.

RECOVERY OF BENEFITS PAID BY MISTAKE

If ODS mistakenly make a payment for you or an insured dependent to which you are not entitled, or if ODS pays a person who is not eligible for payments at all, it has the right to recover the payment from the person paid or anyone else who benefited from it, including a physician or provider of services. The right to recovery includes the right to deduct the amount paid by mistake from future benefits ODS would provide for you or any insured dependent even if the mistaken payment was not made on that person's behalf.

CONTRACT PROVISIONS

The policy with ODS Health Plan, Inc. and the Group and this handbook plus any endorsements or amendments are the entire contract between the parties. No promises, terms, conditions or obligations exist other than those contained in the contract. This handbook and the group policy plus such endorsements or amendments, if any, shall supersede all other communications, representations or agreements, either verbal or written between the parties.

REPLACING ANOTHER PLAN

If this Plan replaces an earlier ODS or other Group plan, OD benefits and deductibles will be applied as follows:

- ODS will apply the benefits under the Plan reduced by any benefits payable by the prior plan, subject to other provisions of this Plan relating to termination of coverage. This provision does not

apply to any person excluded under this Plan because the person is otherwise covered under another policy with similar benefits.

- The ODS Plan shall give credit for the satisfaction or partial satisfaction of any deductibles met under the prior plan for the same or overlapping benefit periods with this Plan, but the credit shall apply or be given only to the extent that the expenses are recognized under the terms of this Plan and are subject to a similar deductible provision.

RESPONSIBILITY FOR QUALITY OF MEDICAL CARE

In all cases, members have the exclusive right to choose their provider. Neither the City nor ODS is responsible for the quality of medical care a member receives, since all those who provide care do so as independent contractors. Neither can be held liable for any claim or damages connected with injuries a member suffers while receiving medical services or supplies.

WARRANTIES

All statements made by the Group or a member, unless fraudulent, are considered representations and not warranties. No statement made for the purpose of obtaining coverage will void the coverage or reduce benefits unless contained in a written form and signed by the Group or the member, a copy of which has been given to the Group or to the member or the member's beneficiary.

NO WAIVER

Any waiver of any provision of the Plan, or any performance under this contract, must be in writing and signed by the waiving party. Any such waiver shall not operate as, or be deemed to be, a waiver of any prior or future performance or enforcement of that provision or any other provision. If ODS delays or fails to exercise any right, power or remedy provided in the Plan, including a delay or failure to deny a claim, that shall not waive ODS' right to enforce the provisions of the Plan.

GROUP IS THE AGENT

The Group is the member's agent for all purposes under the Plan. The Group is not the agent of ODS Health Plan, Inc.

GOVERNING LAW

To the extent the Plan is governed by state law, it shall be governed by and construed in accordance with the laws of the State of Oregon.

WHERE ANY LEGAL ACTION MUST BE FILED

Any legal action arising out of the Plan must be filed in either a state or federal court in the State of Oregon.

TIME LIMITS FOR FILING A LAWSUIT

Any legal action arising out of, or related to, the Plan and filed against ODS by a member or any third party, must be filed in court within 3 years of the time the claim arose. All internal levels of appeal under the Plan must be exhausted before filing a claim in court.

EVALUATION OF NEW TECHNOLOGY

ODS develops medical necessity criteria for new technologies and new use of current technologies. The technology committee reviews information consisting of medical studies, national, regional or local clinical practice guidelines, and local and national carrier benefits to develop the criteria. The reviews are performed once a year or more often if needed.

Any falsification, misrepresentation, misleading statements or omission of the employee when enrolling in these plans may be cause for immediate termination from the City benefit plans and may subject the employee to discipline, including discharge, from City employment, regardless of when or how discovered. If an employee fails to report family status change events within 60 days of the date eligibility would cease, such as divorce or cessation of dependent eligibility requirements, it will be the employee's obligation to reimburse the City of Portland any monies which are paid by a City of Portland Health Plan for claims incurred. If an employee or the employee's dependent fraudulently obtains any healthcare

benefits under the City of Portland Health Plan, the employee and/or dependent will be prosecuted to the full extent of the law.

The terms within this Benefit Handbook are valid on a year-to-year basis. Therefore, the provisions within this document apply to FY 2012-13 only.

This summary is written to provide a reference to your employee benefits. Each component is created by a contract or a plan document, which governs the plan's provisions and administration. Except to the extent that this summary or any of its component plans are governed by federal law, this summary and all of its component plans shall be construed, administered, enforced and governed by and in accordance with the laws of the State of Oregon, where applicable, even if Oregon's choice of laws otherwise would require application of the law of a different jurisdiction. In the case of a dispute regarding your benefits, the contract or plan document will determine your actual benefit. If you would like to read a contract or plan document, please contact the Employee Benefit Office at 503-823-6031.