



2012-2013

City of Portland

Employee Health

Benefit Handbook

Seasonal Maintenance Workers



Effective July 1, 2012

CITY OF PORTLAND EMPLOYEE BENEFITS

Welcome to the City of Portland employee benefits program. In the following pages, you will find a summary of the health plans offered by the City of Portland. 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 70 of this Handbook.

This Benefit Handbook is designed to provide a quick reference tool for information about the health 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.

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 an individual 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.

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.

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.

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

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.

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 under the SMW plan. 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 based on 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 will be processed as follows: the maximum amount allowed will be 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.

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 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 plan members for less than their usual fees. For the SMW plan, the network offered is the ODS Plus Network.

Orthotic device means 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.

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 co-insurance (City plans). You pay more when you use out-of-network providers.

Out-Of-Pocket Maximum: The amount of money that an individual 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 member in the SMW plan 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 pre-admission certification prior authorization is to ensure that individuals 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.

Prosthetic device as required by state law means an artificial limb device or appliance designed to replace in whole or in part an arm or a leg.

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.

Self-Insured Medical Plan: Claims are paid by the employer instead of by an insurance company in a self-insured plan. The SMW plan is self-insured. This means the City pays a third party administrator (ODS) to administer the plans and the City pays the costs (claims costs plus administration) directly out of the City's health fund.

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

TABLE OF CONTENTS

BENEFITS

Benefit Plan Year	1
What's New for 2012-13	2
Benefit Costs and Employee Premium Shares	2
Important Contacts	3

WHEN COVERAGE BEGINS

Employee Eligibility, Continuing Eligibility	4
Dependent Eligibility	4
Domestic Partners and State Income Tax	5

ENROLLMENT BASICS

What You Need to Do During Initial Enrollment	6
Default Benefits for Initial Enrollment (What happens if you do not complete your initial, new-hire enrollment)	6
What You Need to Do During Annual Enrollment	7
Default Benefits During Annual Enrollment (What happens if you do not complete your annual enrollment)	7
Enrolling Dependents After the Initial or Annual Enrollment Periods	7
Qualifying Family Status Changes—Employee/Family Member Notification Responsibilities	10
Other Status Changes	10
Enrollment/Changes Frequently Asked Questions	11
Medical, Dental & Vision Opt-Out	12

2012-13 MEDICAL PLAN

About the SMW Medical Plan	13
SMW Medical Plan Physicians & Hospitals	13
Frequently Asked Questions	14
Benefits for Special Medical Situations (SMW Plan)	16
Medical Plan Highlights Chart	17
SMW Prescription Drug Program	19

SMW PPO MEDICAL PLAN

Covered Services	21
SMW Plan Professional Providers	26
Tobacco Cessation Programs	27
Diabetes Education Programs	28

SMW Plan Limitations and Exclusions	29
SMW Prescription Drug Program Exclusions	33
SMW Coverage Frequently Asked Questions	34
Medical and Behavioral Management Services	35
Medical Review Services	35
Service Pre-Authorization Procedures	37
Care Coordination Services	37
Disease Management/Health Promotion	38
Filing A Claim for SMW Plan Benefits	38
Appeals and External Review	39
Coordination of Benefits -SMW Medical	41
SMW Vision Plan through VSP	
Vision Plan Benefits	46
Vision Plan Exclusions	47
SMW Dental Plan through ODS Dental	
ODS Dental Plan Benefits	48
ODS Dental Plan Exclusions	53
ODS Dental Plan Frequently Asked Questions	55
ODS Dental Plan Coordination of Benefits	56
ADDITIONAL TERMS OF COVERAGE – HEALTH PLANS	
Family/Medical Leave and Oregon Family Leave	61
Military Leave and Uniformed Services Employment & Reemployment Rights Act	61
Termination of Coverage	62
Certificate of Creditable Coverage	62
Reinstatement of Coverage	62
Continuation of Benefit Coverage	62
Continuation of Coverage – COBRA Provision	63
Oregon Medical Insurance Pool (OMIP) Portability Coverage	69
Washington State Health Insurance Pool (WSHIP)	69
Federal Newborns’ and Mothers’ Health Protection Act of 1996	70
Federal Women’s Health and Cancer Rights Act of 1998	70
Acts of Third Parties	70
HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA)	73
TECHNICAL PLAN INFORMATION	79

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. 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.

Health benefits include medical, dental and vision coverage for you and your eligible dependents. For eligible employees, the City will pay 90% of the cost and employees will contribute a 10% premium share.

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 participants or for charges in excess of what the applicable plan allows. The City is also not responsible for any claim or damages associated with injuries resulting from health 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 73.

Benefit Plan Year

The City of Portland offers you and your family benefit coverage that 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 changes 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 of the qualifying event.

What's New

The following changes will be effective beginning July 1, 2012.

SMW Medical Plan Benefit Changes

- Hospice lifetime maximum removed.
- Lifetime limit on claims related to intentional self-inflicted injury removed
- Limit removed on smoking cessation benefits.
- Medical services delivered through a 2 way video communication with a provider and member who is at an Originating Site (including a hospital, physicians office or skilled nursing facility.)
- Prescription Benefit Plan Changes
 - Statins (cholesterol lowering medications) – plan will pay only the cost of generic simvastatin. Those members who choose to purchase brand name drugs will pay the difference between the cost of the higher cost drug and simvastatin plus the 10% generic copay. Crestor 40mg will continue to be covered as it is now.
 - Proton-Pump Inhibitors (PPI) (eg. Nexium) -- plan will pay only the cost of generic omeprazole. Those members who choose to purchase brand name drugs will pay the difference between the cost of the higher cost drug and omeprazole plus the 10% generic copay.
 - Generic Minimum – The \$5.00 generic minimum payment has been reinstated for generic medications at most pharmacies. However, if you purchase your prescription at a \$4.00 pharmacy, the \$0 copay will still apply. \$4.00 prescription drug retailers include Target, Fred Meyer and WalMart.
 - Non-sedating antihistamines—all non-sedating antihistamines will be excluded from benefits under the plan as there are equivalent options available over the counter.

ODS Dental Plan

- Fluoride is covered once every 6 months for members 18 and under. Members age 19 and older could have fluoride covered at the above frequency if there is a recent history of periodontal surgery or high risk of decay due to medical disease, chemotherapy or similar not of treatment.

2012-13 Benefit Costs & Employee Premium Shares

Your cost for the medical plan with the new ODS Dental and VSP vision plan coverage is as follows:

Plan	Your Contribution Per Pay Period		
	Single	Two-Party	Family
SMW Medical, ODS Network with ODS dental and VSP vision plan	\$22.16	\$43.50	\$56.60

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 Benefits & Wellness Office to be available when you call. To help you get the answers you need you may 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 specific service provider directly at the customer service number(s) listed below:

For...	Contact the following...
City benefit plan information	Benefit Information Line: 503-823-6031 Email: HR, Benefits (internal) or mailto:benefits@portlandoregon.gov (external)
SMW Medical Plan Customer Service	503-243-3974 or 1-877-337-0649 For inquires, 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
SMW Healthcare Services (for prior authorization)	Medical Services Call 503-243-4496 or 1-800-258-2037 Behavioral Health (Inpatient or residential Mental Health or Chemical Dependency) Call 503-624-9382 or 1-800-799-9391
SMW Disease Management & Health Promotion	503-948-5548 or 1-877-277-7281 ext. 1390
SMW Mental Health or Chemical Dependency	503-624-9382 or 1-800-799-9391
ODS/PHCS network ODS Network provider directory PHCS Network Healthy Directions 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
Kroger Prescription Plans (KPP) - retail Postal Prescription Services (PPS) – mail order	1-800-482-1285; www.kpp-rx.com 1-800-552-8894 or 503-797-2100 in Portland www.ppsrx.com
ODS Dental Plan Customer Service	503-265-5680 or 1-877-337-0649 www.odskompanies.com Submit claims to: Oregon Dental Service 601 SW Second Avenue, Portland, OR 97204
VSP (Vision Service Plan)	1-800-877-7195 www.vsp.com Submit out-of-network claims to: VSP, PO Box 997105, Sacramento, CA 95899-7105

WHEN COVERAGE BEGINS

Seasonal Maintenance Worker Eligibility

Seasonal Maintenance Workers shall be eligible for the City of Portland's SMW Medical, Dental and Vision Benefit Plan if the employee worked as a Seasonal Maintenance Worker during the prior calendar year and is eligible for re-employment.

Initial Eligibility

The Seasonal Maintenance Worker will be automatically enrolled in 1-party coverage with City paid benefits beginning the first of the month after the employee:

- Satisfies an eligibility waiting period consisting of eighty (80) paid hours in a month after re-employment (excluding hours paid in a third pay period in a month).

The following examples are provided:

Example A: Employee John Doe worked as a Seasonal Maintenance Worker in calendar year 2011 and received a re-employment letter. In August of 2012, John is re-employed by the City and is paid for at least 80 hours in the first and second pay periods of August. He becomes eligible for the SMW plan September 1, 2012.

Example B: Employee Jane Doe worked as a Seasonal Maintenance Worker in calendar year 2011 and received a re-employment letter. In August of 2012, Jane is re-employed by the City and she is paid for 20 hours in August. In September she is paid at least 80 hours of pay in the 1st and 2nd pay periods of the month. She becomes eligible for the SMW plan October 1, 2012.

Dependent Eligibility

Seasonal Maintenance Workers may enroll their eligible dependents in the SMW Medical, Vision and Dental 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 City paid coverage;
- **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.
- **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 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 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.

- **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.

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 qualify. You must complete yearly certification with the City to claim your domestic partner as a tax dependent.

Special Enrollment Rights

Health Insurance Portability and Accountability Act of 1996 (HIPAA)

If you are declining enrollment for yourself or your dependents (including your spouse) because you have other health insurance coverage, you may in the future be able to enroll yourself or your dependents in the health plans described herein, provided that you request enrollment within 60 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your newly acquired dependents, provided that you request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption or other qualifying event.

Enrollment Basics

What You Need to Do During Initial Enrollment

Complete, sign and return any enrollment material to the Benefit Office by the due date if you are adding dependents or qualify to opt-out of coverage.

Provide any documentation to the Benefits Office as required.

You are automatically enrolled under the SMW Medical, Vision and Dental Plans.

There are no forms for you to complete to enroll yourself in the plan. If you want to enroll eligible dependents or you qualify to opt-out of coverage, you must complete and return your enrollment form to the Benefits Office within 30 days from your date of initial eligibility or the date you were notified of your eligibility, whichever is later. You will be assigned benefits as follows:

- You will automatically be enrolled under the SMW Medical, Vision and Dental Plans. In addition, you will be enrolled in the ODS Network of providers and hospitals for the medical plan. Coverage will be **only for you, the employee**. Any applicable premium share will be deducted from your paycheck on a pre-tax basis.
- If you have dependents you want to add to your coverage and do not return your enrollment form timely, your dependents will not be eligible for coverage until the next annual open enrollment period, or mid-year with a qualified family status change.

If you add dependents, the required catch-up premium share deductions will be taken in the next available pay period after enrollment. [NOTE: If the City receives a National Medical Support Notice issued by the Department of justice ordering the health plan enrollment of an employee's dependent(s), they will be added to the health plan as required by law with the additional premium contributions withheld as necessary.]

These deductions will be taken on a pre-tax basis and will be automatic until:

- You no longer have sufficient paid hours to qualify for City paid coverage
- You submit documentation to make a change in family status or provide proof of other medical coverage in order to opt out of City benefits, or
- The annual July 1 rate changes are implemented and employee automatic deductions are adjusted.

Continued Eligibility

Once initial eligibility has been established and you are enrolled in the SMW Medical, Dental and Vision Plans, your eligibility based on the required paid hours will be monitored from month to month.

City paid benefits will continue each month in which you:

- Are actively employed in a qualifying seasonal maintenance worker position,
- Have received at least 80 hours of qualifying pay in the 1st and 2nd pay periods of the month. (Qualifying pay must consist of regular work hours, holiday pay, or comp time paid for absence from regular work hours. No other type of pay or benefit applies to make up the paid hours required.) and;
- Make the required premium contribution.

The Benefits & Wellness Office will make determinations on continued eligibility after the 2nd pay period of each month when the paid hours for both pay checks is reported to the Office.

City paid coverage will continue to the end of the month in which you terminate, provided you have enough hours to cover your premium share for the month.

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.

Annual Enrollment

If otherwise eligible, 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 at that time 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 below in "Mid-Year Changes in Eligible Dependents". 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 your enrollment instruction materials.
2. Review the family members you have covered under the Plan. During the annual enrollment period, you are verifying that your dependents meet the City's benefit eligibility requirements. (See page 4 to review eligibility requirements.)
3. Complete, sign and return any enrollment material and required documentation to the Benefit Office by the due date.

Default Benefits: If You Do Not Complete Your Annual Enrollment

If you do not complete your enrollment by the Annual Enrollment deadline, your City benefit enrollment for the plan year will be defaulted to the elections and dependents in effect as of June 30 of the prior plan year.

Premium Share

If you are enrolled in 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, contact the Benefits Office, 503-823-6031, within 60 days of a qualifying family status event and submit the required documentation.

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.

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 provide the completed enrollment form and documentation to the Benefits Office. You are required to provide a copy of the marriage certificate, and/or a copy of a birth certificate for each child added (as applicable.) **If the Benefits & Wellness Office does not receive the required documentation within 30 days of the receipt of your enrollment form, 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 Domestic Partner Affidavit. Coverage will become effective the first of the month following the date you provide the completed enrollment form and documentation to the Benefits Office. You are required to provide a completed and notarized Affidavit of Benefit Eligible Dependent Status form and/or Oregon state's Certificate of Registered Domestic Partnership for yourself and your partner and/or a copy of a birth certificate for each child added (as applicable.) **If the Benefits & Wellness Office does not receive the required documentation within 30 days of receipt of your enrollment form, coverage for your new partner/eligible domestic partner's children 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 submit an enrollment form within 60 days of the birth to add your 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 receipt of your enrollment form, coverage for your dependent may terminate retroactively back to the 30th day and you will be held financially responsible for any premiums and 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 submit a completed enrollment form to add the child and a copy of the adoption or placement papers must be sent to the Benefits & Wellness Office. **If the Benefits & Wellness Office does not receive the required documentation within 30 days of receipt of your enrollment form, coverage for your dependent may terminate retroactively back to the 30th day and you will be held financially responsible for any premiums and 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 submit a completed enrollment form 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 receipt of the enrollment form, coverage for your dependent's child may terminate retroactively back to the 30th day and you will be held financially responsible for any premiums and claims paid on the child's behalf.**
- **Any other eligible child** may be added within 60 days from the date custody and guardianship are granted. The employee must submit a completed enrollment form to add the child and provide the Benefits & Wellness Office a copy of the court order granting custody and appointing the guardian and a copy of the letters of guardianship. **If the Benefits & Wellness Office does not receive the required documentation within 30 days of the receipt of the enrollment form, coverage for your dependent may terminate retroactively back to the effective date of coverage and you will be held financially responsible for any premiums and/or claims paid on the child's behalf.**

- **Qualified Medical Child Support Order:** If a judgment, decree or order 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. **If an election is not made by the employee, the Benefits & Wellness Office will add the child to the employee's coverage and will change any required premium share contribution.**
- **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 or Medicaid. A change in status form must be returned within 60 days of entitlement or loss of entitlement. Documentation from Medicare or Medicaid 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 an Unmarried child reaches 26 years of age or enters the military**, including the participant's:
 - natural child,
 - stepchild,
 - child who is required to be covered by the subscriber or subscriber's spouse as a result of divorce decree or court order to provide coverage.
 - adopted child or child placed for adoption, or
 - eligible child of an enrolled domestic partner (as declared on the Domestic Partner Affidavit).
- **Incapacitated and dependent children** who no longer have a Determination of Disability under the Social Security Act and/or who no longer reside with the enrollee and the enrollee does not provide primary support for the individual.
- **Loss of legal custody/guardianship of child because** the employee and/or spouse or domestic partner no longer has legal custody or is no longer the child's legal guardian.
- **The child of your enrolled Dependent (if you are not the child's legal guardian) will lose coverage** if the child's parent is no longer your eligible and Enrolled Dependent and/or both grandchild and birth parent no longer reside in the Employee's home.

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 Benefits and Wellness 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 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. 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 opt-out of the 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 the Benefits and Wellness Office receives all required documentation.

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 63 for further information.)**

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

Qualifying Family Status Changes as described above

- Marriage;
- Criteria of Domestic Partner Affidavit is met;
- Addition of eligible dependent e.g., birth, adoption or placement for adoption, custody and legal guardianship or return to student status;
- Divorce or Legal Separation, including separation from domestic partner (see the COBRA section beginning on page 63 for further information);
- Death of spouse or domestic partner or dependent;
- Loss of dependent’s eligibility for coverage e.g., dependent enters the military or exceeds the plan age limit (see the COBRA section beginning on page 63 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;

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:

- 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..
- 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--Judgments, Decrees or Orders: If a judgment, decree or order 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.

- 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) 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.
- Loss of Medicaid or coverage under a state children's health insurance program (SCHIP).
- You or a dependent becomes newly eligible for a state premium assistance subsidy under the plan through Medicaid or SCHIP.

Frequently Asked Questions:

How do I report a family status change to the Benefits & Wellness Office?

Notify the Benefits & Wellness Office by calling 503-823-2869 to receive information and the required forms.

What happens if I don't report a family status change to the Benefits & Wellness Office within 60 days of the event?

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

Divorce/Legal Separation/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 Benefits & Wellness 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 and/or any premium differential will become your responsibility. In addition, your ex-spouse will not be eligible for COBRA continuation if the divorce/legal separation is not reported within 60 days of the event. (NOTE: Your former spouse may contact the Benefits & Wellness Office within 60 days of the event to elect COBRA.) ***Finally, if you have not notified the Benefits & Wellness 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 Benefits & Wellness Office receives the completed change form and required documentation.

Dependents who no longer qualify as eligible - 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, either by age, military service or legal guardianship. The cost of claims incurred by your dependents after the date benefits should have ended and/or any premium differential 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 & Wellness Office to elect COBRA.)

Medical, Dental and Vision Opt Out

If you have proof of enrollment in a group medical plan or individual policy, you may opt out of the SMW plan. You must complete the form and return it to the Benefits office with documentation of your enrollment in another health plan. If you opt out of the medical plan, you must also opt out of the SMW dental and vision plans. You may not elect either the dental or vision plan independent of the medical plan.

A Seasonal Maintenance Worker eligible for the benefit plan who provides proof of alternative medical coverage may choose to opt out of the City provided Plan unless otherwise prohibited by law. Proof of other coverage may include a certificate of coverage from another group plan or proof of other individual health plan coverage. In all cases, documentation will be required.

Once proof of other coverage is received and confirmed, a retroactive adjustment to reimburse the employee premium share deductions previously taken will be made on the next available pay check. You must notify the Benefits Office within 60 days of loss of other coverage at which time you will be enrolled in the SMW Plan. Proof of other coverage may be required at any time.

2012-13 SMW Medical Plan

Benefit-eligible employees are offered the following medical plan.

SMW Medical Plan with Preferred Provider (PPO)

The City offers a “self-insured” PPO medical plan for benefit-eligible employees. This means the plan is not insured by an insurance company; rather, the City pays the claim costs over and above what you pay. This plan is named the SMW Medical Plan. An administrator (ODS) pays claims and provides customer service for the SMW plan. The SMW medical plan offers a broad range of medical coverage as well as a choice of preferred provider networks.

About the SMW 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 copays 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 the ODS Plus network, the SMW PPO Medical Plan will pay 70% of your network’s discounted rate after you have satisfied the annual in-network deductible (\$200 per person; \$600 per family). When you don’t use a network provider, for most medically necessary covered services, the plan will pay 50% of the “maximum plan allowance” (MPA) after you have satisfied the annual out-of-network deductible (\$750 per person and \$2,250 per family of three or more.)

MPA is the maximum amount on which ODS will base its reimbursement to physicians and providers. For a ODS Plus network participating physician/provider, the MPA is the contracted reimbursement fee. For an explanation of MPA for non-participating physicians/providers, see the Common Health Plan Terms and Definitions in the beginning of this handbook.

Preventive Care Benefits are Important

The plan covers certain preventive care services. See the chart on page 17 for scheduled well child and adult physical exams, mammograms, PSA and gynecological exams and colorectal screenings. **The deductible will be waived for these services and coverage will be 100% when you use in-network providers.**

SMW Medical Plan Physicians and Hospitals

Under the SMW PPO Medical Plan you must choose ODS Plus network providers to receive the in-network level of coverage.

Participants of the SMW Medical Plan must use the ODS Plus Network: The ODS Plus Network includes physicians, hospitals and other providers associated with the Providence Health System, Legacy Health Systems, Portland Adventist, OHSU Hospital and OHSU physicians.

You may go online at: http://www.odscompanies.com/provider_search.shtml to search for providers in the ODS Plus Network. If your doctor or hospital of choice is not listed in the ODS Plus Network, services provided would be out-of-network and your out-of-pocket costs will be greater.

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.

When traveling outside of the ODS Plus Network area, you may use the PHCS Healthy Directions network for necessary care at discounted costs.

Alternative Care Providers

Only the ODS Plus Alternative care network providers are considered in-network for reimbursement of alternative care claims. 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. Chiropractic treatment must be prior authorized through ODS if treatment will extend for more than twenty (20) visits for CityCore plan members. Only medically necessary care anticipated to improve one’s medical condition is eligible for reimbursement. Maintenance care does not qualify for reimbursement. There is a 35 visit annual maximum for chiropractic care under the plans.

Choosing Providers and Hospitals

The SMW plan does not mandate the use of a primary care physician for referrals to in-network specialists but it is still important that you have a primary doctor to assist you in maintaining your health.

Family medicine doctors, internists and pediatricians are all considered primary care physicians. These doctors treat general medical conditions and may have additional training in specialized areas, such as diabetes, or digestive problems. Your primary doctor would be the provider you see for your wellness exams that are covered in full (no deductible) under this plan.

When seeking in-network services, consider the following information in your decision:

- Make sure the physician you are choosing can care for you at the hospital of your choice. If you are admitted to the hospital, does the doctor have the ability to care for you there? The doctor’s office can confirm what hospitals your doctor is associated with.
- If English is not your native language, check to see if the doctor you intend to see is bilingual.
- If you have a chronic health condition, such as diabetes or heart disease, you may want to consider a doctor that specializes in those areas.
- Is the doctor’s office easy to get to and at hours most convenient to you?

Frequently Asked Questions About the Plan Network

1. **How do I verify whether a medical provider I am interested in seeing is in the preferred provider network?** To confirm if a provider is in the ODS Plus network, http://www.odscompanies.com/provider_search.shtml to search for providers in the ODS Plus network.
2. **What is a Preferred Provider Network?** Preferred Provider Networks are groups of medical facilities and professionals who have contracted with the managing network group. These health care providers agree to negotiated fees charged to enrollees who belong to a plan that has a contract with the network. Under the SMW plan, participants receive a higher level of reimbursement if they seek services through the ODS Plus Preferred Provider Network.

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

3. **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.
4. **How will I be covered when I'm traveling outside of the country?** When you have an emergency outside of the country, then the SMW plan 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 when you return. 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 are enrolled in 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 SMW medical plan when certain medical situations occur.

Medical Situation **SMW Medical Plan pays the following:**

<p><i>Specialist or type of treatment is not provided in your network service area AND you live in the network service area</i></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. You are responsible for the in-network deductible, the in-network coinsurance, and any amounts over the 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. All determinations of when in-network benefits will apply to an out-of-network provider are made by the City's healthcare utilization and prior authorization program.</p>
<p><i>Your eligible dependent child, residing outside the elected network service area, needs health care and you live in the network service area</i></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 30% coinsurance amounts will accrue towards your in-network maximums.</p>
<p><i>Emergency care</i> <i>Note: Urgent care is not paid the same as emergency care. Regular plan benefits apply to urgent care.</i></p>	<p><i>Network providers:</i> In-network benefit level applies after \$50 emergency room copay for an emergency.</p> <p><i>Out-of-network providers:</i> In-network benefit level, up to MPA limits, after \$50 emergency room copay for an emergency.</p>
<p><i>Benefit level for employees residing outside the network service area</i></p>	<p>Although the City of Portland has worked to provide network access for all participants, there may be some people living outside the network service area. If these participants 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 SMW plan, the out-of-network benefit for most covered expenses is 50% of the MPA after the annual deductible.</p>
<p><i>Out of Network provider services ordered by in-network participating provider at an in-network hospital and/or urgent care center</i></p>	<p>After the in-network deductible is met, out-of-network services by an anesthesiologist, assistant surgeon, radiologist or pathologist, or supplies provided while a patient at an in-network hospital and/or urgent care center, 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.</p>

SMW PPO Medical Plan Highlights

SMW Medical Plan Features	PPO Medical Plan	
	In-Network Member pays	Out-of Network Member Pays
Network Required	All family members must use same network	
In-Network PPO Reimbursement Rates	After the deductible, plan pays benefits based on negotiated rates.	After the deductible, plan pays benefits based on Max plan allowance
Plan Year Deductible	\$200/person; \$600/ family maximum	\$750/person; \$2,250 family maximum Excludes in-network expenses. Charges over maximum plan allowance not applied to deductible.
Plan Year Out-of-Pocket Maximum (Excludes prescription drug, emergency room copays and charges over in-network PPO fees)	\$1,800 per person/ \$5,400 per family (excludes deductible & out-of-network expenses)	\$3,000/person/ \$9,000 per family (excludes deductible & in-network expenses)
Lifetime Maximum Benefits	No lifetime maximum benefit limit.	
Prior authorization	As required for specified procedures and all hospitalizations	
Wellness Routine Physical Exams & Cancer Screenings 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. Services as required under the Affordable Care Act.	100% - No deductible Your Responsibilities: o 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. o Seek services through an in-network provider. o 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. Routine physical exam maximum: Newborn 2 hospital exams Infant 6 exams in first 12 months Ages 1 to 4 7 exams Ages 5 and older 1 exam per 12 months Routine vision screening for age 3 to 5 Newborn hearing screening Mammogram maximum: Ages 35-39 1 Ages 40+ 1 per 12 months (365 days) At any age when high risk and deemed necessary by physician PSA maximum: 1 per 12 months (365 days) Pap smear maximum: 1 per 12 months (365 days) or at any time when high risk and deemed necessary by physician.	50% of out-of-network max plan allowance after deductible

SMW Medical Plan Features	PPO Medical Plan	
	In-Network Member pays	Out-of Network Member Pays
Office Visits <ul style="list-style-type: none"> • Primary care including , urgent care • Specialty care • Prenatal care • Allergy shots & other injections • Routine immunizations • Rehabilitative therapies (35 visits annual max) • Outpatient surgery 	\$15 per visit 30% after the deductible \$15 per visit \$10 per injection 100% - No deductible 30% after the deductible 30% after the deductible	50% of out-of-network maximum plan allowance after deductible for all listed services
X-Rays, imaging, laboratory & specialty diagnostic procedures	30% after the deductible	50% of out-of-network max plan allowance after deductible
Hospital inpatient Care	30% after the deductible	50% of out-of-network max plan allowance after deductible
Hospital maternity care for mother & newborn	Same as hospital inpatient	50% of out-of-network max plan allowance after deductible
Hospital Emergency Room	30% after \$50 copay	
Ambulance Services	30% (no deductible)	30% (no deductible)
Skilled Nursing Facility 30-day plan year maximum	30% after the deductible	50% of out-of-network max plan allowance after deductible
Durable Medical Equipment	30% after deductible	50% of out-of-network max plan allowance after deductible
Home Healthcare 60-visit plan year maximum	30% after deductible	50% of out-of-network max plan allowance after deductible
Hospice (\$25,000 lifetime max)	30% after deductible	50% of out-of-network max plan allowance after deductible
Mental Healthcare Inpatient Residential/ day treatment Prior authorization is required for all inpatient and residential treatment programs. Outpatient treatment	Same as hospital inpatient Residential treatment: Same as inpatient. Day treatment: Primary care office copay per day. Primary care office copay per day.	Same as hospital inpatient Residential treatment: Same as inpatient Day treatment: 50% of out-of-network max plan allowance after deductible 50% of out-of-network max plan allowance after deductible
Chemical Dependency Treatment Inpatient care Outpatient care	Same as mental healthcare Same as mental healthcare	Same as mental healthcare Same as mental healthcare
Alternative Care Providers (chiropractic, acupuncture and naturopathic providers)	30% after deductible	50% of out-of-network max plan allowance after deductible
	Chiropractic care has a 35 visit annual maximum. Services must be prior authorized by ODS for more than 20 visits.	

SMW Medical Plan Features	PPO Medical Plan	
	In-Network Member pays	Out-of Network Member Pays
Prescription Drugs	Deductible does not apply. In-Network Pharmacy (Up to a 30-day supply, or a 90-day supply of maintenance meds at a Kroger owned pharmacy such as Fred Meyer or QFC) – 90% of generic drug cost; \$5 minimum (\$0 minimum at \$4 pharmacies), \$25.00 maximum copay – 80% of preferred brand name drug cost; \$5 minimum, \$50.00 maximum copay For statins and proton pump inhibitors (PPI) member to pay difference between cost of brand name & generic in addition to the generic copay maximum of \$25) – 70% of non-preferred drug cost; \$5 minimum, \$75.00 maximum copay. Out-of Network pharmacy: (Up to 30-day supply): You pay the pharmacy; then submit claims to ODS for 60% reimbursement after out of network deductible is met. Mail order pharmacy (up to 90 day supply) Same as in-network pharmacy benefit levels shown above	

SMW Prescription Drug Program

The prescription drug benefit for the SMW Medical Plan is managed by Kroger Prescription Plans (KPP). KPP's retail pharmacy network is extensive and includes most major retail pharmacy chains in the Portland area, such as Costco, Fred Meyer, QFC, Rite Aid, Safeway, Walgreen's and many independent pharmacies.

The plan's pharmacy coverage pays benefits based on whether or not the prescription drug is on the formulary (i.e., a broad list of prescription drugs). KPP will pay prescription drug benefits on this basis. Because formularies vary by prescription drug program manager, be sure to verify whether the medications you are taking are on KPP's formulary. And remember, the formulary is not a static list. KPP will continually review and update the formulary 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 KPP to ensure the most appropriate medication is prescribed. Drugs which require prior authorization include but are not limited to the following drug classes: anabolic steroids, growth hormones and GH related, Gaucher Disease, select interferons and ribavirins, erectile dysfunction, multiple sclerosis, ADHD/narcolepsy, anemia, arthritis and topical acne.

With KPP, you will continue to be encouraged to use preferred and generic medications. For maintenance medications, you may choose to get a 90 day supply through a Fred Meyer or QFC pharmacy, or use the local mail order pharmacy services through Postal Prescription Services (PPS) Your share of the costs is based on a percentage of the actual costs with a flat dollar copayment maximum. For more information on the pharmacy benefit levels, see the Medical Plan Highlights chart on page 19.

Plan coverage for statin drugs (cholesterol-lowering medications) is limited to the cost of generic simvastatin. If you choose a higher-cost statin drug, you will pay the difference in cost

between the higher-cost drug and generic simvastatin in addition to the generic copay (with the exception of Crestor 40mg, which will be paid in accordance with the normal benefit schedule).

Plan coverage for Nexium will be limited to the cost of generic omeprazole. If you choose to purchase Nexium, you will pay the difference in cost between the higher cost Nexium and generic omeprazole in addition to the generic copay.

How to Use the Mail Order Service

With this service, you get a 90-day supply of your prescription mailed directly to your home from Postal Prescription Services (PPS). Your copay is based on the total cost of the medication for the 90-day supply at the copay levels shown on page 19. Mail order is ideal for long-term medications. Alternatively, you can get a 90-day supply at a Fred Meyer or QFC pharmacy at the same preferred pricing as you would get through PPS.

Generic medications will be substituted for brand-name medications when available and allowed by the prescribing physician. PPS utilizes only those generic medications rated highest by the FDA.

For mail order:

1. Ask your doctor to write a prescription for a 90-day supply (with up to 3 refills, as appropriate).
2. On the front of each new prescription, print clearly the member's name and relationship to the primary covered person (e.g. self, spouse, child) and the member's ID number:
 - Be sure the prescribing doctor's name is clearly indicated.
 - Complete the PPS order form including payment information
 - Provide a street address for delivery. Some medications, such as narcotics and drugs requiring refrigeration are restricted from delivery to a post office box.
3. Send your prescription(s), completed order form and copay in the envelope provided. A new order form and envelope will be returned with each Postal Prescription Service delivery.
4. You will need to call PPS to find out how much your prescription will cost. A PPS representative will ask you for the name of the medication, strength, quantity and dosage, then quote you a discounted price. You will use this price to calculate your copay.

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

You may order refills by calling 1-800-552-6694 or 503-797-2100 in Portland Oregon.

SMW MEDICAL PLAN

Covered Services

The following services, when medically necessary, are covered under this plan at the levels previously stated (see SMW PPO Medical Plan Highlights starting on page 17.) Prior authorization may be required (see "Medical Review Services" beginning on page 35 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 Plan Highlights chart on page 18.
- **Ambulance.** Up to 300 miles per 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 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 as determined by the Plan's third-party administrator. Appliances do not include dental appliances and braces, supporting devices such as corsets, eye glasses or contact lenses.
- **Artificial Limbs.** The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to the Plan that a new prosthetic device is medically necessary because of changing fit or poor function. Testicular prostheses 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 pre-certified (except for emergency hospital admissions, which must be certified within 48 hours of emergency admission).
- **Colorectal Screening**
- **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 symptoms of sufficient severity 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.
- **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.
- **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;
 - Other medically necessary out-patient hospital charges;
 - 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.
- **Infusion therapy benefits** require pre-authorization and include:
 - aerosolized pentamidine;
 - intravenous drug therapy;
 - total parenteral nutrition;
 - hydration therapy;
 - intravenous/subcutaneous pain management;
 - terbutaline infusion therapy;
 - SynchroMed pump management;
 - IV bolus/push drugs; and
 - Blood product administration.

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

In addition, covered expenses include only the following medically necessary services and supplies:

- solutions, medications, and pharmaceutical additives;
- pharmacy compounding and dispensing services;
- durable medical equipment for the infusion therapy;
- ancillary medical supplies;
- nursing services associated with:
 - patient and/or alternative care giver training;
 - visits necessary to monitor intravenous therapy regimen;
 - emergency services;
 - administration of therapy; and
 - collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy.
- **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.
- **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 and residential services** which have been prior authorized.
- **Nonprescription Enteral Formula For Home Use and Inborn Errors of Metabolism.** 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 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 30.)

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.
- Transplant does not include:
- The collection of and/or transfusion of blood or blood products.
- Corneal transplants.

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" mean 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 will be paid;
- Anti-rejection drugs following the covered transplant will be paid 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 authorized and be medically necessary and appropriate according to criteria established by ODS.

C. Prior Authorization Requirement

Prior Authorization Procedures. To request prior authorization, the member’s physician must contact the Medical Service Authorization Unit of ODS prior to the transplant admission. Prior authorization should be obtained as soon as possible after an enrollee has been identified as a possible transplant candidate. To be valid, prior authorization approval must be in writing from ODS.

- **Preventive Care and Well Child Care.** Coverage for preventive care and well child care according to the schedule listed in the Medical Plan Highlights chart on page 17.
- **Professional Services** – Medically necessary services of a professional provider (see page 26 for a list of eligible professional providers) are covered subject to plan limits.
- **Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis**--Covered expenses require pre-authorization and include:
 - Treatment planning and simulation;
 - Professional services for administration and supervision; and
 - Treatments, including therapist, facility and equipment charges.
- **Reconstructive surgery after breast cancer.** Includes 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.
- **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. The City of Portland Health Plan and/or ODS are 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.** Services consist of physical therapy, occupational therapy and/or speech therapy furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in continued improvement of the person's condition. Rehabilitation services include physical, occupational, speech or audiological therapy services necessary to restore or improve lost function caused by illness or injury. Recreational or educational therapy, non-medical self-help or training, services rendered for the treatment of delays in speech development, or treatment of psychotic or psychoneurotic conditions 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.
- **Surgical Benefits.** All inpatient elective procedures and some outpatient surgeries 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.
- **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.

- **Tobacco Cessation.** This benefit provides reimbursement to **certain providers** to assist enrollees to stop smoking. This coverage allows reimbursement for prescription drugs and for smoking cessation educational meetings and programs. These services are not subject to a deductible and are covered as in network regardless of authorized program used.
- **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.

SMW 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 the ODS/PHCS Network. 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
- An acupuncturist
- A Naturopath
- A dentist (doctor of medical dentistry or doctor of dental surgery), but only for treatment of accidental injury to natural teeth provided within 12 months after the injury, 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 clinical social worker (LCSW);
- A marriage & family therapist (LMFT);
- A professional counselor (LPC);
- 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, speech or audiological therapist
- A registered nurse or licensed practical nurse, but only for services provided upon the written referral of a doctor of medicine or osteopathy, or 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.

Tobacco Cessation Programs

General Description of Program

Note: For **SMW** 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.

TOBACCO CESSATION PROGRAMS				
	Legacy	Adventist	Providence	Kaiser
Program	<i>Stop Smoking</i> 4-session class over four weeks.	Becoming Smoke-Free, Staying Smoke-Free 2-session program and ongoing aftercare support group.	Smoking Cessation 11 session smoking cessation class at either Providence Portland Medical Center or Providence St. Vincent Medical Center Quit for Life Telephone based program offers 12-months of stop-smoking support.	<i>Freedom From Tobacco:</i> 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. Seminar: 2-hour seminar <i>Telephone Counseling Program</i> Create a plan for quitting and get ongoing support with a tobacco-cessation counselor.
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 Fees <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

DIABETES EDUCATION PROGRAMS				
	Legacy	Portland Adventist	Providence	Kaiser
<p><i>General Description of Program</i></p> <p>Note: For SMW participants, see page 21 for Plan benefit information. To receive reimbursement for your expenses, you must submit your claim to ODS.</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 increments Call 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.

SMW Medical Plan Limitations and Exclusions

The SMW Medical Plan will not cover any expense incurred for which the member is not legally liable or which is not medically necessary. Other expenses not covered are those in excess of the Maximum Plan Allowance (MPA), or in excess of what would have been charged in the absence of plan coverage. 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).
- 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
- Bodily injury or illness arising out of duty as a member of the armed forces of any state or country, or a war or any act of war (declared or undeclared).
- 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.
- Telemedical Health Services charges including telephone visits or consultations and telephone psychotherapy except as provided for in the paragraph titled "Telemedical Health Services."
- Services, prescription drugs, and supplies you or your dependent may 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 deemed by the plan administrator to be:
 - 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 only; 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.

Exclusions Related to Miscellaneous Services and Items:

- Support Education including Level 0.5I educational programs related to Driving Under the Influence (DUI), voluntary mutual support groups, such as Alcoholics Anonymous, or family education or support groups except for support groups rated A & B by the United States Preventive Services Taskforce.
- Behavior modification, psychological enrichment or self-help programs for mentally healthy individuals. These include assertiveness training, image therapy, sensory movement groups, 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.

- 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. Including radial keratotomy, corneal rings, LASIK, PRK, any procedure 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 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 participant's lifetime.
- Cosmetic/Reconstructive Surgery: Any procedure requested for the purpose of improving appearance without restoring bodily function or correcting physical impairment including breast augmentation, lipectomy, liposuction, 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.
- 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 are not covered.
- Charges incurred for telephone consultations with or between medical providers.
- 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 the plan will not cover services and supplies that do so by treating the obesity directly, even if morbid obesity is present. Services specifically excluded from this plan include, but are not limited to:
 - a. Surgical: Gastric restrictive procedures with or without gastric bypass, or the revision of the same.
 - 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 participant'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 the 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.
- Foot orthoses (orthotics) made of high impact plastics or other materials, designed to be inserted into shoes;
- Temporomandibular joint (TMJ) treatment and surgery.
- 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 are not covered.
- Counseling related to family, marriage, sex and career, 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.
- Routine foot care services that are not medically necessary including the following services unless required by the member's medical condition (e.g. diabetes):
 - Paring or cutting of benign hyperkeratotic lesion (e.g. corn or callus);
 - Trimming of dystrophic and non-dystrophic nails; and
 - Debridement of nail by any method.
- Routine physical exams for employment, licensing, insurance coverage 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

SMW 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 diabetes supplies).
3. Nose drops or nasal preparations that do not require a physician's written prescription.
4. Immunization agent.;
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. Non-sedating antihistamines
13. Prescriptions which are covered by workers' compensation laws, the Fire & Police Disability Retirement Fund, or other county, state or federal programs.
14. Compounds unless the prescription includes at least one legend drug that is an essential ingredient.
15. Naturopathic supplements, including when prescribed as a compound drug;
16. Drugs that are determined by the Plan Administrator to be experimental or investigational or that are labeled: "Caution-Limited by federal law to investigational use"

SMW 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 SMW 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. **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.
3. **What is an Emergency Medical Condition?** This means that you or a covered eligible dependent has a medical condition that manifests itself by symptoms of sufficient severity 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.
4. **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.
5. **Are Full Body Scans covered under the SMW plan?** Full Body Scans are not covered under the SMW 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 the SMW Medical Plan 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, or the first working day following a weekend or holiday admission;
- 3) If your physician recommends any of the health care services that require preauthorization. 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). For assistance with hearing and speech impaired, call the Telecommunications relay Service at 711.

Behavioral health management (mental health and chemical dependency) 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) or 711 for relay services.

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 reimbursement for the 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, copayments and charges in excess of what would have been certified by the Plan*

-  Behavioral Health Services, including:
 - Chemical dependency treatments, inpatient, partial hospitalization and residential services
 - Mental health services (inpatient, partial hospitalization and residential services)

- ☎ Durable medical equipment rental and purchases. (Rental exceeds 30 days or cost is over \$500)
- ☎ Home health care (includes palliative care)
- ☎ Hospice care
- ☎ Inpatient Services, Partial Hospitalization and Residential Programs
 - All non-emergency hospital confinements that are scheduled in advance and admission to any residential treatment program, must be authorized in order for maximum plan benefits to be payable. If the hospitalization, partial hospitalization or residential stay is not medically necessary, claims will be denied. ODS will authorize medically necessary lengths of stay, based upon the medical condition. Additional hospital or residential days are covered only upon medical evidence of need.
- ☎ Transportation in lieu of ambulance
- ☎ Organ transplants
- ☎ Skilled nursing facility care
- ☎ Special duty nursing
- ☎ Surgical procedures (all inpatient elective surgeries and procedures)
- ☎ Surgery/treatment (outpatient)—all outpatient surgeries/treatment on the following list:
 - Cartilage transplants of the knee
 - Capsule Endoscopy
 - Hyperbaric oxygen therapy
 - Nucleoplasty/IDET
 - Neck/back/spine surgeries
 - Prophylactic surgery (e.g. mastectomy)
 - Thoracic Sympathectomy (for hyperhidrosis)
 - Kyphoplasty/vertebroplasty
 - Cryoablation of breast lesions
 - Stereotactic radiosurgery (ie Gamma Knife)
 - Arthroscopies
 - Hip, knee, shoulder surgeries
- ☎ Colonoscopy for patients under age 50. In these cases, only those with medical or family history diagnosis will be eligible for plan benefits. No prior authorization is required for colonoscopy if age 50+.
- ☎ Pet scans
- ☎ Spect scans, unless being done for a cardiac diagnosis;
- ☎ Genetic testing
- ☎ 2nd sleep studies and sleep apnea treatments
- ☎ Anesthesia/out patient hospital for dental procedures
- ☎ Speech therapy (after initial evaluation)
- ☎ Infusion services, dialysis, radiation and chemotherapy treatment
- ☎ Sleep studies and treatment for sleep apnea.

Prior authorization Procedures

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

Non-Emergency Prior Authorization Procedure

In the event a participant 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 a prior authorization prior to 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.

The City may require, at its own discretion, 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% and the deductible is 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 the surgery and is 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.

Chemical Dependency and Mental Health Services Review- Review of recommended treatment plans.

High Risk Pregnancy- Prenatal screening.

CARE COORDINATION SERVICES (Case Management)

Care Coordination (case management) is performed by registered 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 experiencing 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:

Explanation of Benefits (EOB)

Soon after receiving a claim, ODS will report its action on the claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through myODS. ODS may pay claims, deny them, or accumulate them toward satisfying the deductible. If all or part of a claim is denied, the reason will be stated in the EOB.

APPEALS AND EXTERNAL REVIEW

If you disagree with the decision to deny a claim, you may appeal the decision. The Plan has a two level formal appeal process. Your appeal must be made within 180 days of the date of the Plan's action on your claim. You may also call the Plan's Medical Customer Service at (503) 243-3974 or toll-free at (877) 337-0649 to discuss the issue, as it may be possible to resolve it without filing a formal appeal.

Definitions

For purposes of this section, the following definitions apply:

Adverse Benefit Determination means a written notice from ODS, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: rescission of coverage, or a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a member's eligibility to participate in the Plan and one resulting from the application of any pre-existing condition exclusion or utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury. A **Final Internal Adverse Benefit Determination** is an adverse benefit determination that has been upheld by ODS at the completion of the internal appeal process or with respect to which the internal appeal process has been exhausted.

Appeal is a written request by a member or his or her representative for ODS to review an adverse benefit determination.

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 a member's medical condition, would subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

Complaint means an expression of dissatisfaction about a specific problem a member has encountered or about a decision by ODS or an agent acting on behalf of ODS, and which includes a request for action to resolve the problem or change the decision. A complaint does not include a request for information or clarification about any subject related to the Plan.

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.

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.

Time Limit for Submitting Appeals

A member has **180 days** from the date of an adverse benefit determination to submit an initial written appeal. If an appeal is not submitted within the timeframes outlined in this section, the rights to the appeals process will be lost.

The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. If a member is not satisfied with the outcome of the second level appeal, and the dispute meets the specifications outlined in the External Review section, the member may request external review by an independent review organization. The first and second levels of appeal will need to be exhausted to proceed to external review, unless the Plan agrees otherwise.

Note:

The timelines addressed in the sections 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 Appeals

Before filing an appeal, it may be possible to resolve a dispute with a phone call to ODS' Customer Service. Otherwise, an appeal must be submitted in writing to ODS. If necessary, ODS' Customer Service can provide assistance filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her 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 the member fails to provide sufficient information for ODS to make a decision. In this case, ODS will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member 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 Appeals

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of ODS' action on the 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. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf. If new or additional evidence or rationale is used by ODS in connection with the claim, it will be provided to the member, in advance and free of charge, before any final internal adverse benefit determination. Members may respond to this information before ODS' determination is finalized. ODS will notify the member in writing of the decision, the basis for the decision, and if applicable, information on the right to request an external review.

External Review

After exhausting the appeal process described in the First Level Appeal and the Second Level Appeal sections, unless such requirement is waived by the Plan or waived because ODS fails to meet the internal timeline for review or to provide all of the information and notices required under federal law for appeals, members may request external review of an adverse benefit determination or final internal adverse benefit determination that involves rescission of coverage or medical judgment (including, but not limited to, those based on medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit; or a determination that a treatment is experimental or investigation). The request for external review must be in writing no more than four months after receipt of the adverse benefit determination or final internal adverse benefit determination.

Within 6 business days following receipt of a request, ODS will send a written notice to the member if the request is incomplete or ineligible for external review. Otherwise, the independent review organization will provide a written notice of the final external review decision within 45 days after its receipt of the request. For claims involving urgent care, the independent review organization will expedite the review and provide notice within 72 hours after its receipt of the request. 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.

Additional Member Rights

Members may contact the Employee Benefits Security Administration at 866-444-3272 or the Oregon Insurance Division for questions about their appeal rights or for assistance:

By mail: Oregon Insurance Division
P.O. Box 14480
Salem, Oregon 97309-0405

By phone: 503-947-7984

By internet: www.cbs.state.or.us//ins/index.html

By e-mail: cp.ins@state.or.us

Coordination of Benefits-Medical Plan

Coordination of Benefits (COB) occurs when you have healthcare 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 medical or 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;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- 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:

- Hospital indemnity coverage or other fixed indemnity coverage;

- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident coverage;
- Benefits for non-medical components of group long-term care policies;
- 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.

Claimant means the enrollee for whom the claim is made.

An **Allowable Expense** means a healthcare expense, including deductibles, coinsurance, and copayments, which is covered at least in part by any plan covering the claimant. 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 claimant 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 claimant is not an allowable expense.

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

- 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;
- The amount of the reduction by the primary plan because a claimant has failed to comply with the plan provisions concerning second surgical opinions or prior authorization of admissions or services, or because the claimant has a lower benefit because that claimant did not use an in-network provider;
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant 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 person is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person 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.
- If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person 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).

This Plan is the part of this group contract 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 contract providing healthcare benefits is separate from this Plan. A contract 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 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.

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 claimant 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.

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.

If the primary plan is a closed panel plan and the secondary plan is not a closed panel plan, the secondary plan shall provide benefits as if it were the primary plan when an enrollee uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary plan.

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 enrollee 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 enrollee against the non-complying plan.

WHICH PLAN PAYS FIRST?

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a plan covers the claimant 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 person as a dependent. However, if the claimant 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 so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

- 2. Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant 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'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
- 3. Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant 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 has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
 - If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
 - The plan covering the custodial parent;
 - The plan covering the spouse or Partner of the custodial parent;
 - The plan covering the non-custodial parent; and then
 - The plan covering the spouse or Partner of the non-custodial parent.This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
- 4. Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one plan of individuals 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 individuals were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
- 5. Active/Retired or Laid Off Employee.** The plan that covers a claimant 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 claimant 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. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
- 6. COBRA or State Continuation Coverage.** If a claimant 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 that claimant as an employee, member, 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. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

7. Longer/Shorter Length of Coverage. The plan that covered an employee, member, subscriber, or retiree (non-dependent) longer is the primary plan and the plan that covered the claimant for the shorter period of time is the secondary plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

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.

Where part of a plan coordinates benefits and a part does not, each part will be treated as a separate plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. 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 may then reduce its payment by the amount so that, when combined with the amount paid by the primary plan, the total benefits paid or provided by all plans for the claim do not exceed the total allowable expense for that claim. In addition, 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 a claimant is enrolled in two or more closed panel plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one closed panel plan, COB shall not apply between that plan and other closed panel plans.

ODS' RIGHT TO COLLECT AND RELEASE NEEDED INFORMATION

Certain facts about healthcare coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. ODS may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other plans covering the claimant. ODS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give ODS any facts it needs to apply those rules and determine benefits payable.

FACILITY OF PAYMENT

If another plan makes payments we should have made under this coordination provision, we can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

RIGHT OF RECOVERY

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment from one or more of the persons it has paid or for whom it has paid; or any other person or organization that may be responsible for the benefits or services provided for the claimant. The "amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

VISION PLAN

Vision coverage is provided through Vision Service Plan (VSP). The following outlines the benefits under the plan.

Vision Plan Feature	Vision Service Plan (VSP) Basic Plan	
	VSP Provider	Non-VSP Provider
Enrollment	Automatic enrollment with election of SMW 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.
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.
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.
Medically necessary contacts*	100%	Plan pays up to \$210 Claims must be filed within 6 months of the date of service.
Special notes:	Special cosmetic items, such as tinted or coated lenses, UV protected lenses, blended lenses, color contacts, etc., are not covered by VSP.	

* One pair every 24 months.

VISION SERVICE PLAN (VSP) for CityCore 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.

Vision Service Plan Exclusions and Limitations of Benefits (for coverage under the SMW 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>

2012-13 DENTAL PLAN

ODS Dental Premier Plan Highlights

- The annual deductible is \$25 per person; \$75 for a family of three or more.
- Eligible diagnostic and preventive services are paid at 100%, with no deductible.
- Eligible routine services (Class II) are covered at 80% after the deductible
- The annual benefit maximum is \$1,000 per person.

Dental Plan Feature	ODS Dental Plan
Network Required	ODS Premier (Traditional)
Plan Year Deductible	\$25/person; \$75/family of three or more
Plan Year Maximum Benefit	\$1,000/person
Maximum Plan Allowance (MPA)	Plan pays benefits based on MPA for expenses; you pay coinsurance amount plus anything over the MPA
Diagnostic and Preventive	ODS Class I – 100% (no deductible) for eligible services
Routine	ODS Class II - 80% after deductible
Major (includes inlays, onlays, crowns, and permanent prosthetics.)	ODS Class III – 50% after deductible

ODS DENTAL PREMIER PLAN

Below is a general list of services your dental care program covers when performed by a dental provider (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.

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: \$1,000.00 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. Members age 19 and older could have fluoride covered at the above frequency if there is a recent history of periodontal surgery, or high risk of decay due to medical disease, chemotherapy or similar type of treatment (not due to poor diet or oral hygiene).
3. Sealant benefits are limited to the unrestored, occlusal surfaces of permanent bicuspid 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 (back) teeth and composite (tooth colored) fillings on anterior (front) teeth for the treatment of carious lesions (decay).

Restorative Limitations:

1. Composite, resin, or similar (tooth colored) restorations in posterior (back) teeth are considered optional services. Coverage shall be made for a corresponding amalgam (silver) restoration. If a tooth colored filling is used to restore posterior (back) teeth, benefits are limited to the amount paid for a silver 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 5-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 5-year period and only if the tooth, tooth site, or teeth involved have not received a cast restoration benefit in the past 5 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:
 - The final crown and implant abutment over a single implant. This benefit is limited to once per tooth or tooth space in any 5-year period;
 - 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 5-year period); or
 - The final implant-supported bridge abutment and implant abutment, or pontic. The benefit is limited to once per tooth or tooth space in any 5-year period;
 - Implant-supported bridges are not covered if one or more of the abutments is supported by a natural tooth;
 - 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 5 years.
7. Fixed bridges or removable cast partial dentures are not covered for enrollees 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. Athletic Mouthguards

Covered at 50% once per year for members ages 15 and under and once every 2 years for ages 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 provider's fee.

V. Non-Participating Dental Providers

The amounts payable for services of a Non-participating Dentist 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 your mouth healthy is critical to keeping the rest of your 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 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 calendar 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 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 the myODS website. Members with diabetes must include proof of diagnosis.

ODS Dental Plan 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 cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth), are excluded.
6. Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. 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 individual became eligible for such services under the Policy.
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. Orthodontic treatment.

23. Exclusions include all other services or supplies not specifically included in this Policy as covered dental services.
24. 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.
25. 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.
26. 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.odshealthplans.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 Health Plans.

2. What dentist can I see?

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

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

Specialist services are a covered benefit under the service agreement between the City of Portland and ODS. You are encouraged to have the specialist submit a request for preauthorization and predetermination of benefits to determine how much benefit you can expect to receive.

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

Contact ODS Dental Customer Service by dialing (503) 243-4494 (local) or 1-800-452-1058 (toll free) and ODS will review your claims history to determine how much in benefits you have remaining. Or visit ODS' website at www.odshealthplans.com under myODS

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 your expenses, you 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 you 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.

Claimant means the insured person for whom the claim is made.

An **Allowable Expense** means a dental expense, including deductibles, coinsurance, and co-payments, which is covered at least in part by any Plan covering the claimant 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 claimant 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 claimant 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 claimant member has failed to comply with the Plan provisions concerning second opinions or prior authorization of services, or because the claimant member has a lower benefit because that claimant did not use due to not using an in-network provider;
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant 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 person member is covered by two or more plans that provide benefits or services on the basis of negotiated fees;
- If a person 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 contract 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 contract policy providing dental benefits is separate from this Plan. A contract 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 claimant 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 the any other Plan(s) pay(s) 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.

If the primary Plan is a Closed Panel Plan and the secondary Plan is not a Closed Panel Plan, the secondary Plan shall provide benefits as if it were the primary Plan when a covered person uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the primary Plan.

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 DETERMINATION (WHICH PLAN PAYS FIRST?)

The first of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a Plan covers the claimant 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 person member as a dependent.
2. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant 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'.) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant 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:
 - a. 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.

- b. 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 has responsibility for the healthcare expenses of the child, the 'birthday rule' described above applies.
 - c. If there is not a court decree allocating responsibility for the dependent child's healthcare expenses, the order of benefits is as follows:
 - d. The Plan covering the custodial parent;
 - e. The Plan covering the spouse or Partner of the custodial parent;
 - f. The Plan covering the non-custodial parent; and then
 - g. The Plan covering the spouse or Partner of the non-custodial parent.
 - h. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
4. **Dependent Child Covered by Individual Other than Parent.** For a dependent child covered under more than one Plan of individuals 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 individuals persons were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
 5. **Active/Retired or Laid Off Employee.** The Plan that covers a claimant 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 claimant 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. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
 6. **COBRA or State Continuation Coverage.** If a claimant 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 that claimant the member as an employee, member of an organization, subscriberprimary insured, or retiree or covering the person as a dependent of an employee, member or an organization, subscriberprimary 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. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
 7. **Longer/Shorter Length of Coverage.** The plan that covered a member an enrollee as an employee, member, subscriber, or retiree (non-dependent) longer is the primary Plan and the Plan that covered the claimant member for the shorter period of time is the secondary Plan. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
 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.

Where part of a Plan coordinates benefits and a part does not, each part will be treated as a separate Plan.

EFFECT ON THE BENEFITS OF THIS PLAN

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all Plans during a plan year are not more than the total Allowable Expenses. 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 may then reduce its payment by the amount so that, when combined with the amount paid by the primary Plan, the total benefits paid or provided by all Plans for the claim do not exceed the total Allowable Expense for that claim. In addition, 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.

If a claimant is enrolled in two or more Closed Panel Plans and if, for any reason, including the provision of service by an out-of-network provider, benefits are not payable by one Closed Panel Plan, COB shall not apply between that Plan and other Closed Panel Plans.

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.

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. ODS may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the claimant. ODS need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give ODS any facts it needs to apply those rules and determine benefits payable.

FACILITY 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.

If another Plan makes payments we should have made under this coordination provision, we can reimburse the other Plan directly. Any such reimbursement payments will count as benefits paid under this Plan and we will be released from liability to you regarding them. The term 'payments' includes providing benefits in the form of services, in which case 'payments' means the reasonable cash value of the benefits provided in the form of services.

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.

ADDITIONAL TERMS OF COVERAGE FOR MEDICAL, DENTAL & VISION COVERAGE

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. The employee and his/her enrolled dependents will remain eligible to be covered under the plan during an approved FMLA leave.
2. If the employee does not return to work after the approved FMLA period of 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 the employee and/or his/her enrolled dependents elect not to remain covered during FMLA leave, the employee and/or enrolled dependents will be eligible to be reinstated in the plan on the date the employee returns from FMLA leave.
4. In all events, the employee's and/or his/her enrolled dependents' rights under this provision are determined by the Family and Medical Leave Act of 1993 and its regulations, as amended.

Payment of Premium While on Approved FMLA Leave

While on an approved FMLA 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 dependents 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.

Termination of Coverage

Termination of City paid coverage will occur if you do not meet the eligibility criteria or if you have received notification of termination or lay-off. Employees who become ineligible for participation in the SMW City medical plan will have the right to continue coverage on a self-pay basis in accordance with state and federal law (COBRA). Coverage will end for yourself or eligible dependent on:

- The last day of the month for which you make a premium contribution as determined by the eligibility rules of the plan;
- The date the group policy terminates;
- The date you or a dependent cease to qualify for coverage.

Certificate of Creditable Coverage

When your coverage ends, you and/or your dependents will receive a certificate of creditable coverage that provides proof of prior medical coverage. You may need to have this certificate to obtain medical coverage in the future. You will receive a written certificate when:

- You cease to be covered under the Plan;
- You become eligible to elect COBRA coverage;
- You cease to be covered under COBRA continuation coverage;
- You request a Certificate of Creditable Coverage within 24 months of your termination of coverage.

Reinstatement of Coverage

If an employee's coverage has been terminated due to loss of eligibility, coverage can be reinstated the first of the month following 80 hours of pay without meeting the initial eligibility waiting period so long as the Seasonal Maintenance Worker is not returning from a lay-off status.

Continuation of Benefit Coverage – COBRA and Other Programs

Under certain conditions, employees and/or their eligible dependents may continue medical insurance when such coverage would otherwise terminate. There are various types of continuation programs. Review the following to determine which may apply to you. COBRA continuation is the most common (see #3 below). Other programs include: Worker's Compensation/Industrial Accident Leave, Legally Separated, Divorces or Widowed Spouses Over 55. These all 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, 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 over age 55

A surviving spouse of a deceased employee or a legally separated or divorced spouse age 55 or over, and their eligible dependents, may continue coverage until 1) Medicare eligibility for the surviving divorced or legally separated spouse and 2) until the dependents reach the maximum eligibility age limits under the Plan. The surviving or legally separated/divorced spouse and any dependent 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 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. 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 the eligible 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.

For SMW employees, COBRA applies only to the SMW Medical Plan 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:

- You and your covered dependents (if any) will have the same opportunity as an active employee to 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.

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 medical plan 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 dependent 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 member 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. 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 dependent children. 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 member 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.

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 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 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.

Oregon Medical Insurance Pool (OMIP) Portability Coverage

The Oregon Medical Insurance Pool (OMIP) provides health benefit portability coverage to Oregonians who have exhausted COBRA benefits and have no other portability options available to them. OMIP has different plans from which enrollees may choose.

The OMIP program is under Oregon's Department of Consumer & Business Services. A citizen board of directors guides policy for the program. Regence BlueCross BlueShield of Oregon is OMIP's administering insurer and handles eligibility, enrollment, member services and claims processing.

The premiums OMIP enrollees pay cover about 65% of the medical and drug claims costs in the program. The balance of the costs are paid by assessments on insurers and self-insured public employers.

Individuals who enroll themselves or family members in an OMIP Plan must have the financial resources to pay the premiums. OMIP does not subsidize premiums or reduce them according to an individual's ability to pay.

For information about OMIP plans and costs or other healthcare options, call 1-800-848-7280 or visit their website at <http://www.oregon.gov/DCBS/OMIP/faqs.shtml>.

Washington State Health Insurance Pool (WSHIP)

The Washington state Health Insurance Pool (WSHIP), offers individual health insurance coverage to Washington residents who have exhausted COBRA benefits and have been rejected for individual coverage based on medical reasons. WSHIP offers four preferred provider plans and one standard plan for qualified individuals who are not eligible for Medicare. Medicare supplement plans are also available.

For more information, contact WSHIP Customer Service at 1-800-877-5187 or go to <https://www.wship.org/> .

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 your Plan Administrator 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 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 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. 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 the member's 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 the member's 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.

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 a self-insured (SMW) medical plan. The City hires a third party administrator, currently ODS (Administrator), to administer the Plan and to process medical claims and appeals made by participants in the Plan. It also hires various other agencies to assist in administering the cafeteria plan components, utilization review, pharmaceutical benefits, and other benefit consulting needs. These Agents are currently Aliquant, AON Consulting, Managed Healthcare Northwest, ODS and Kroger Prescription Plans.

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 Benefits & Wellness 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 your self 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 or other 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 disclose 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 this 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) 823.3506
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

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 administered by the Human Resources/Benefits & Wellness Office of the City of Portland.

Plan Administrator: Benefit Program Manager
City of Portland Bureau of Human Resources
1120 SW 5th Avenue, Room 404
Portland, Oregon 97204

IMPORTANT NOTICE

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 that 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 Benefits & Wellness Office at 503-823-2869.