# CITY OF PORTLAND EMPLOYEE BENEFITS PROGRAM

**As Amended and Restated July 1, 2024**

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# Chapter 1.
# Introduction

## 1.01 Establishment

The City of Portland (the "City") established the City's Employee Benefits Program (the "Plan") to provide health and welfare benefits to eligible employees and their eligible dependents. The Plan is hereby amended and restated effective of July 1, 2024 (the "Effective Date"). The terms of this Plan supersede any prior oral or written versions of the Plan.

## 1.02 Purpose and Status of Plan

The Plan is designed to permit an Eligible Employee to elect various Benefits and to pay for those Benefits with a combination of Employer Contributions and Employee Contributions. Employee Contributions may be paid on a pre-tax salary reduction basis under the Cafeteria Plan or with after-tax deductions, as permitted under the Code and the applicable Component Plan.

The Plan shall be interpreted and administered in accordance with the following intent:

(a) The Cafeteria Plan is intended to be a cafeteria plan that qualifies under Code Section 125 and shall be interpreted to accomplish that objective.

(b) The Premium Payment Benefit is intended to qualify as a salary reduction plan under Code Section 125 to permit Participants to pay their share of the rates or premiums for their Health Plan Benefits on a pre-tax basis.

(c) The Healthcare Flexible Spending Account (HFSA) is intended to qualify as a "self-insured medical reimbursement plan" under the Code, and the Medical Expenses reimbursed thereunder are intended to be eligible for exclusion from Participants' gross income under Code Sections 105(b) and 106.

(d) The Dependent Care Flexible Spending Account (DFSA) is intended to qualify as a "dependent care assistance plan" under the Code, and the Dependent Care Expenses reimbursed thereunder are intended to be eligible for exclusion from Participants' gross income under Code Section 129(a).

(e) Although reprinted within this document, the Premium Payment Benefit, the HFSA, and the DFSA are separate plans for purposes of administration and all reporting and nondiscrimination requirements imposed by Code Sections 105(h), 125, and 129. The HFSA is also a separate plan for purposes of the provisions of COBRA, as applicable to government plans by the Public Health Services Act ("PHS Act").

(f) The Plan includes and encompasses each Component Plan, and the terms of each Component Plan and Related Documents are hereby incorporated into the Plan by reference. The Plan as set forth herein, together with all Component Plans and Related Documents, constitutes the written plan document for the Plan.

(g) The provisions of the Plan as restated herein shall amend and supersede in their entirety the prior provisions of the Plan. All Benefits payable before the Effective Date shall be made in accordance with the Plan provisions then in effect.

## 1.03 Plan Limitations

(a) Nothing contained in the Plan or any of its Component Plans shall be deemed to give any Employee the right to be retained in the service of the City or to interfere with the right of the City to

discharge any Employee at any time, regardless of the effect which such discharge shall have upon such Employee as a Participant under the Plan.

(b) The City does not guarantee Benefits payable under any insurance policy or other similar contract described or referred to herein, and any Benefits thereunder shall be the exclusive responsibility of the insurer or other entity that is required to provide such Benefits under such policy or contract.

## 1.04 Administrator

The Plan and its Component Plans shall be administered by the Administrator described in Section 2.02. The Administrator shall have responsibility for the general operation of the Plan and its Component Plans and shall have the power and duty to decide all questions arising in connection with the administration, interpretation, and application of the Plan and its Component Plans and shall take all actions and make all decisions that shall be necessary to carry out the provisions of the Plan and its Component Plans, including, but not limited to:

(a) Determining an Employee's eligibility to participate in any Benefits authorized by the Plan;

(b) Promulgating rules of procedure and keeping records necessary for the proper and efficient administration of the Plan;(c) Advising the insurers and Third Party Administrators with respect to Participants and with respect to contributions made on behalf of Participants;

(d) Furnishing the Council, Participants, and insurers with information they may require;

(e) Engaging the services of such agents as the Administrator may deem advisable to assist with or perform the Administrator's duties;

(f) Consulting with the City attorney with respect to the meaning or construction of the Plan and its Component Plans and the Administrator's duties thereunder; and

(g) Assuming responsibility for all applicable reporting and disclosure requirements and engaging the service of agents to assist with reporting and disclosure requirements.

The Administrator will be deemed to have properly exercised such discretionary authority, unless the Administrator has abused their discretion hereunder by acting arbitrarily and capriciously.

## 1.05 Plan Notification

Reasonable notification of the availability and terms of the Plan and its Component Plans shall be provided to all Eligible Employees by the Administrator.

# Chapter 2.
# Definitions

The following terms, as used in the Plan, shall have the meanings set forth below in this Chapter 2, unless a clearly different meaning is required by the context in which the term is used:

## 2.01 ACA

"ACA" means the Patient Protection and Affordable Care Act enacted on March 23, 2010, as amended by the Health Care and Education Reconciliation Act enacted on March 30, 2010.

## 2.02 Administrator

"Administrator" means the Manager, Benefits of the City of Portland.

## 2.03 Adverse Benefit Determination

"Adverse Benefit Determination" means any denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit, including any denial, reduction, termination, or failure to provide or make payment that is based on a determination of a Claimant's eligibility to participate in the Plan, and including a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a Benefit resulting from the application of any 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 medically necessary or appropriate.

## 2.04 Annual Enrollment Period or Annual Enrollment

"Annual Enrollment Period" or "Annual Enrollment" means the period immediately preceding the period of Benefit coverage, as designated by the Administrator, during which an Eligible Employee may file or amend their Benefit Election Form.

## 2.05 Beneficiary

"Beneficiary" means the person designated as a Participant's beneficiary with respect to any applicable Benefit.

## 2.06 Benefit

"Benefit" means each of the following benefits that are provided to Participants and Dependents under the Plan, as described in the applicable Component Plan and Related Document:

(a) Cafeteria Plan Benefits:

1. Premium Payment Benefit;
2. Dependent Care Flexible Spending Account (DFSA); and
3. Healthcare Flexible Spending Account (HFSA).

(b) Health Plan Benefits:

1. Medical (including prescription medication) benefits;
2. Dental benefits; and
3. Vision benefits.

(c) Other Benefits:

1. Long-term disability benefits;
2. Employee assistance program benefits;
3. Basic and supplemental life insurance; and
4. Fertility and family planning benefit.

## 2.07 Benefit Election Forms

"Benefit Election Forms" means the forms, including electronic enrollment forms, promulgated by the Administrator by which an Eligible Employee elects the Benefits of their choice pursuant to the Plan.

## 2.08 Cafeteria Plan

"Cafeteria Plan" means the provisions of the Plan that provide for salary reduction, in accordance with Code Sections 105, 106, and 125, to provide for Cafeteria Plan Benefits.

## 2.09 Casual Employee

"Casual Employee" means each person in a Casual/Casual Other appointment with the City. A Casual/Casual Other appointment is used for a position that occurs, terminates, and recurs periodically or regularly.

## 2.10 Change in Status

"Change in Status" means an event that allows an Eligible Employee or Participant to make changes in their Benefit elections, as defined in Chapter 4. Changes made to coverage and elections must be consistent with and on account of the specific Change in Status.

## 2.11 City

"City" means the City of Portland, Oregon.

## 2.12 Claimant

"Claimant" means each person who claims entitlement to any Benefit under the Plan or that person's duly authorized representative.

## 2.13 COBRA

"COBRA" means the federal Consolidated Omnibus Budget Reconciliation Act of 1985, as amended from time to time, and all applicable regulations thereunder.

## 2.14 COBRA Group Health Plan

"COBRA Group Health Plan" means each Component Plan that is a "group health plan" within the meaning of PHS Act Section 2208(1).

## 2.15 Code

"Code" means the federal Internal Revenue Code of 1986, as amended from time to time, and all applicable regulations and guidance thereunder.

## 2.16 Component Plan

"Component Plan" means each of the plans or programs identified in Appendix A that provides a Benefit offered under the Plan.

## 2.17 Council

"Council" means the members of the City Council of the City of Portland, Oregon.

## 2.18 Dependent

"Dependent" means each person who is defined in the applicable Component Plan and eligible for coverage thereunder as a Spouse, Domestic Partner, or child or other dependent of a Participant,

Spouse, or Domestic Partner and who has provided the Administrator with any documentation that the Administrator may request regarding such status, but only with respect to that Component Plan.

## 2.19 Dependent Care Account

"Dependent Care Account" means the Dependent Care Account established pursuant to Chapter 7.

## 2.20 Dependent Care Flexible Spending Account or DFSA

"Dependent Care Flexible Spending Account" or "DFSA" means the Dependent Care Flexible Spending Account established pursuant to Chapter 7.

## 2.21 Dependent Care Expenses

"Dependent Care Expenses" means a Participant's incurred expenses which (a) are incurred for the care of a Qualifying Individual, (b) are paid or payable to a Dependent Care Service Provider, and (c) are incurred to enable the Participant and Spouse, if married, to be gainfully employed for any period during which the Participant has one or more Qualifying Individuals. "Dependent Care Expenses" shall not include (i) amounts paid for services at an overnight camp, or (ii) expenses incurred for services outside the Participant's household for the care of a Qualifying Individual, unless such Qualifying Individual regularly spends at least eight (8) hours each day in the Participant's household.

## 2.22 Dependent Care Service Provider

"Dependent Care Service Provider" means a person who provides care for a Qualifying Individual for which the Participant incurs Dependent Care Expenses but shall not include (a) a dependent care center (as defined in Code Section 21(b)(2)(D)), unless the requirements of Code Section 21(b)(2)(C) are satisfied, or (b) a related individual described in Code Section 129(c).

## 2.23 Domestic Partner

"Domestic Partner" means an individual with whom the Employee must:

(a) Be a registered domestic partner as per the Oregon Family Fairness Act of 2007 or under the laws of any other state; or

(b) Be a civil union partner under the laws of any state; or

(c) Meet the criteria of the City's Domestic Partner Affidavit outlined below:

1. Each be 18 years of age or older;
2. Share the same permanent residence and household;
3. Be each other's exclusive domestic partner;
4. Not be married to anyone else;
5. Not be related by blood closer than would bar marriage in the state of residence;
6. Be mentally competent to consent to contract when domestic partnership begins; and
7. Be jointly responsible for each other's common welfare, including the provision and/or payment of "basic living expenses", such as food, shelter, and other necessities of life.

In taxable cases, the Domestic Partner and the Employee must jointly be responsible for "basic living expenses". The individuals need not contribute equally or jointly to the cost of these expenses, as long as they agree that both are responsible for the cost.

In non-taxable cases, the Employee must provide more than one half (1/2) of their Domestic Partner's financial support and be able to claim their Domestic Partner as a dependent on their individual tax form.

## 2.24 Effective Date

"Effective Date" means July 1, 2024, the effective date of this Plan.

## 2.25 Eligible Casual Employee

"Eligible Casual Employee" means a Casual Employee who is determined by the City to be a "full-time employee" within the meaning of the Code Section 4980H(c)(4), as described in the applicable Related Document.

## 2.26 Eligible Employee

"Eligible Employee" means an Employee who currently meets the eligibility requirements of Chapter 3 and who is:

(a) A permanent or temporary Full-time Employee appointed from an eligible list or appointed to an exempt position in a budgeted full-time position who is regularly scheduled to work at least 72 hours in a biweekly payroll period;

(b) A permanent Part-time Employee appointed from an eligible list or appointed to an exempt position;

(c) A Seasonal Maintenance Worker or Seasonal Park Ranger as described in the applicable collective bargaining agreement; or

(d) An Eligible Casual Employee.

The term "Eligible Employee" does not include an independent contractor.

## 2.27 Employee

"Employee" means:

(a) An elected official of the City;

(b) A non-represented employee of the City;

(c) A member of the Bureau of Police in the bargaining unit represented by the Portland Police Commanding Officers Association ("PPCOA");

(d) A member of the Bureau of Fire, Rescue, and Emergency Services in the bargaining unit represented by the Portland Fire Fighters Association ("PFFA");

(e) A member of the Bureau of Police in the bargaining unit represented by the Portland Police Association ("PPA");

(f) A member of the Bureau of Emergency Communications ("BOEC") in the bargaining unit represented by the Portland Police Association (PPA);

(g) A member in the bargaining unit represented by the District Council of Trade Unions ("DCTU");

(h) A member in the bargaining unit represented by Laborers' Local 483 (Recreation Employees);

(i) A member in the bargaining unit represented by PROTEC-17;

(j) A member in the bargaining unit represented by Portland City Laborer's (PCL);

(k) A member in the bargaining unit represented by AFSCME Local 189 representing the Auditors Office (Auditors);

(l) A Seasonal Maintenance Worker;

(m) A Seasonal Park Ranger; or

(m) A Casual Employee.

The term "Employee" does not include an independent contractor.

## 2.28 Employee Contribution

"Employee Contribution" means the portion of the Plan costs paid by the Participant.

## 2.29 Employer Contribution

"Employer Contribution" means the portion of the Plan costs paid by the City.

## 2.30 FMLA

"FMLA" means the federal Family and Medical Leave Act of 1993, as amended from time to time, and all applicable regulations thereunder.

## 2.31 FMLA Group Health Plan

"FMLA Group Health Plan" means each Component Plan that is a "group health plan" within the meaning of FMLA.

## 2.32 Full-time Employee

"Full-time Employee" means, for purposes of the Plan, an Employee in a Benefit eligible status and job class or equivalent designation and who is regularly scheduled to work the standard hours designation of 72 hours in a biweekly payroll period or as defined within the applicable labor agreement or within the meaning of the Code Section 4980H(c)(4), as described in the applicable Related Document.

## 2.33 Health Plan Benefits

"Health Plan Benefits" means the medical (including prescription medication), dental, and vision Benefits provided under the Component Plans, as described in this document and the applicable Related Documents.

## 2.34 HIPAA

"HIPAA" means the federal Health Insurance Portability and Accountability Act of 1996, as amended from time to time, and all applicable regulations thereunder.

## 2.35 HIPAA Group Health Plan

"HIPAA Group Health Plan" means each Component Plan that is a "group health plan" under PHS Act Section 2791(a) (42 U.S.C. 300gg-91(a)), to the extent it is not excepted from the applicable HIPAA requirements in accordance with PHS Act Section 2791(c) (42 U.S.C. 300gg-91(c)).

## 2.36 Medical Expenses

"Medical Expenses" means amounts paid for medical care for the Participant, their Spouse, and/or other Dependents, as defined in Code Section 213(d) and Revenue Ruling 2003-102, and as modified by the ACA including but not limited to Code Section 106(f) and IRS Notice 2010-59.

## 2.37 Healthcare Flexible Spending Account or HFSA

"Healthcare Flexible Spending Account" or "HFSA" means the Healthcare Flexible Spending Account established pursuant to IRS Publication 969.

## 2.38 HFSA Account

"HFSA Account" means the Healthcare Flexible Spending Account established pursuant to IRS Publication 969.

## 2.39 Participant

"Participant" means an Eligible Employee who enrolls in the Plan and one or more Component Plans.

## 2.40 Part-time Employee

"Part-time Employee" means, for purposes of the Plan, an Employee in a Benefit eligible status and job class or equivalent designation and who is regularly scheduled to work the standard hours designation of at least 40 hours (38 for BOEC represented employees) but less than 72 hours in a biweekly payroll period or as defined within the applicable labor agreement, as described in the applicable Related Document.

## 2.41 Plan

"Plan" means the City of Portland Employee Benefits Program, as set forth herein and as it may be amended from time to time.

## 2.42 Plan Year

"Plan Year" means the 12-month period beginning July 1 of one calendar year and ending June 30 of the following calendar year.

## 2.43 Premium Payment Benefit

"Premium Payment Benefit" means the component of the Cafeteria Plan under which Employee Contributions are made on a pre-tax basis pursuant to Chapter 6 for one or more Qualified Benefits that are Health Plan Benefits.

## 2.44 PHS Act

"PHS Act" means the federal Public Health Services Act, as amended from time to time, and all applicable regulations thereunder.

## 2.45 Qualified Beneficiary

"Qualified Beneficiary" means any person who is a "Qualified Beneficiary" as defined in COBRA and eligible for continuation coverage under a COBRA Group Health Plan.

## 2.46 Qualified Benefits

"Qualified Benefits" means the following Benefits for which Employee Contributions are made on a pre-tax basis under the Cafeteria Plan and as set forth in the Related Documents:

(a) Health Plan Benefits;

(b) Dependent Care Flexible Spending Account ("DFSA") described in Chapter 7; and

(c) Healthcare Flexible Spending Account ("HFSA") described in IRS Publication 969.

## 2.47 Qualifying Event

"Qualifying Event" means any event that, but for the continuation coverage provisions of the Plan, as described in the applicable Related Document, would result in the loss of COBRA Group Health Plan coverage of a Qualified Beneficiary.

## 2.48 Qualifying Individual

"Qualifying Individual" means, for purposes of the Dependent Care Flexible Spending Account ("DFSA"):

(a) A Dependent of the Participant who is under the age of 13 and for whom the Participant is entitled to a deduction for a personal exemption under Code Section 151(c);

(b) The Participant's Dependent child (not described in (a) above) who is physically or mentally incapable of self-care; or

(c) The Participant's Spouse or elderly parent residing in the Participant's home who is physically or mentally incapable of self-care.

## 2.49 Related Document

"Related Document" means each document that is identified in Appendix A as a "Related Document" with respect to the corresponding Component Plan, as the Related Document may be amended from time to time.

## 2.50 Seasonal Maintenance Worker

"Seasonal Maintenance Worker" means an individual in the Seasonal Maintenance Worker classification who is a member in the bargaining unit represented by Laborers' Local 483.

## 2.51 Seasonal Park Ranger

"Seasonal Park Ranger" means an individual in the Seasonal Park Ranger classification who is a member in the bargaining unit represented by Laborers' Local 483.

## 2.52 Spouse

"Spouse" means an Employee's legal spouse, unless the Employee and Spouse are legally separated.

## 2.53 Salary Reduction Agreement

"Salary Reduction Agreement" means a written or electronic agreement or collective bargaining agreement provision by which a Participant elects to reduce their compensation or to forego increases in compensation and directs the City to contribute such amounts, on behalf of the Participant, toward the cost of electing, purchasing, or funding one or more Qualified Benefits under the Cafeteria Plan. Such

agreement relates to compensation that has not been actually or constructively received by the Participant as of the date of the agreement and, subsequently, does not become currently available.

## 2.54 Third Party Administrator

"Third Party Administrator" means a company with which the City contracts to provide customer service and claims payment or reimbursement for the City's self-insured Health Plan Benefits, the Healthcare Flexible Spending Account ("HFSA), and the Dependent Care Flexible Spending Account ("DFSA").

## 2.55 USERRA

"USERRA" means the federal Uniformed Services Employment and Reemployment Rights Act of 1994, as amended from time to time, and all applicable regulations thereunder.

# Chapter 3.
# Eligibility and Participation

## 3.01 General

All Eligible Employees who enroll in one or more Component Plans will become Participants during an Annual Enrollment Period or during initial enrollment upon initially becoming eligible. If an Eligible Employee does not enroll within 35 days of first becoming eligible, the Eligible Employee will be assigned default Benefits as described in Section 5.04.

## 3.02 Initial Eligibility

(a) Full-time and part-time non-represented, BOEC, PROTEC-17, DCTU, PCL, Auditors, and Recreation Employees shall become eligible to participate in the Plan the first day of the month following the date of hire.

(b) Full-time members of the PFFA, PPA, and PPCOA shall become eligible to participate in the Plan the first day of the month following 30 days of eligible service. If a benefit eligible non-represented, BOEC, PROTEC-17, DCTU, PCL or Recreation employee is hired into a PFFA, PPA, or PPCOA represented position, benefits would begin first day of the month following date of hire into a PFFA, PPA, or PPCOA position, as long as the minimum 30 day waiting period has been met in the previous position.

(c) Part-time members of the PFFA, PPA, and PPCOA shall become eligible to participate in the Plan the first day of the month following 174 hours of eligible service.

(d) Full time and part-time Seasonal Maintenance Workers and Seasonal Park Rangers shall become eligible to participate in the Premium Payment Benefit as described in the applicable collective bargaining agreement.

(e) Eligible Casual Employees shall become eligible to participate in accordance with the rules established by the City as described in the applicable Related Document.

## 3.03 Commencement of Participation

(a) For Eligible Employees who meet the requirements of Section 3.02 on July 1 of a Plan Year, an Employee's eligibility to participate in the Plan will commence on that date.

(b) For Employees who become Eligible Employees subsequent to the commencement of a Plan Year, participation will commence as of the first day of the month following the month in which the Employee satisfies the applicable eligibility requirements of Section 3.02.

(c) Eligible Employees must elect or purchase some or all of the Component Plans, subject to Section 5.04. If an Eligible Employee fails to file a Benefit Election Form within the time frame specified by the Administrator, the Eligible Employee shall automatically be deemed to have purchased the applicable default Benefits described in Section 5.04.

## 3.04 On-Going Eligibility

(a) City-paid Benefits will continue for non-represented, BOEC, PROTEC-17, DCTU, PCL, Auditors, and Recreation Employees each month in which they are actively employed in an eligible job class and status and working their regularly scheduled hours or are in a qualified leave status for the City, unless otherwise provided by a labor agreement. Eligible Employees who are Participants must make the required Employee Contributions.

(b) To maintain eligibility, PFFA, PPA, and PPCOA Employees must receive pay for a minimum of 80 hours each calendar month, or be in a qualified leave status, or as otherwise provided by an applicable labor agreement. Pay includes compensation for hours worked, vacation leave, sick leave, Administrative Pay and comp time or as otherwise provided under the applicable collective bargaining agreement. Pay does not include lump sum payouts of vacation and/or sick leave. Pay does not include time loss payments for workers' compensation paid by Risk Management, disability payments from the Fire and Police Disability, Retirement and Death Benefit Plan, or payments made pursuant to a long-term disability plan do not count towards the 80-hour requirement.

(c) To maintain eligibility, Seasonal Maintenance Workers and Seasonal Park Rangers must satisfy the requirements specified in the applicable collective bargaining agreement and, if Participants, make the required Employee Contributions.

(d) To maintain eligibility, an Eligible Casual Employee must continue to be considered by the City to be a Full-time Employee within the meaning of the Code Section 4980H(c)(4), as described in the applicable Related Document and the Eligible Casual Employee who is a Participant must make the required Employee Contributions.

(e) Employees who are on non-paid military leave or personal leave without pay do not receive City-paid Benefits, except as required by USERRA.

(f) Participants must enroll their eligible Dependents in the Plan at the same time the Participant becomes first eligible for the Plan either during initial enrollment or during the Annual Enrollment Period, except as allowed below and as permitted by PHS Act Section 2704(f):

1. A new Spouse/eligible stepchildren may be added within 60 days from the date of marriage. Coverage will be pended for approval and not submitted to the carriers until Participant provides the Administrator with a copy of the marriage certificate, and a copy of birth certificates for eligible stepchildren. Once received and approved by Administrator, coverage will become effective the first of the month following the date the Participant completed the Benefit Election Form. A failure to provide a copy of the marriage certificate and copies of birth certificates for eligible stepchildren within 60 days of the date of marriage is considered an intentional misrepresentation of a material fact and prohibited by the terms of the plan or coverage, therefore coverage for the new Spouse/eligible stepchildren will not become active and Participant must wait until an eligible enrollment period to re-elect coverage such as annual open enrollment or a qualified life event.
2. A new Domestic Partner/eligible children may be added within 60 days from the date of domestic partnership. Coverage will be pended for approval and not submitted to the carriers until Participant provides the Administrator with a notarized Affidavit of Benefit Eligible Dependent Status form for the Participant and Domestic Partner/eligible children (or a copy of the Oregon State Certificate of Registered Domestic Partnership or other similar documentation that the Administrator may require) and a copy of a birth certificate for each child added (as applicable). Children of a Domestic Partner cannot be added independently without also adding the Domestic Partner. Once received and approved by Administrator, coverage will become effective the first of the month following the date the Participant completes a Benefit Election Form. A failure to provide a notarized Affidavit of Benefit Eligible Dependent Status form for the Participant and Domestic Partner/eligible children (or a copy of the Oregon State Certificate of Registered Domestic Partnership or other similar documentation that the Administrator may require) and a copy of a birth certificate for each child added within 60 days of the date of domestic partnership is considered an intentional misrepresentation of a material fact and prohibited by the terms of the plan or coverage, therefore coverage for the new Domestic Partner/eligible children will

not become active and Participant must wait until an eligible enrollment period to re-elect coverage such as annual open enrollment or a qualified life event.

3. Newborn children will be covered from birth, and claims will be paid for the newborn for the first 31 days. The Participant must add the newborn child by completing the Benefit Election Form within 60 days of the birth for continued eligibility. Coverage will be pended for approval and not submitted to the carriers until Participant provides the Administrator with a copy of the hospital or state issued birth certificate. A failure to provide a copy of the hospital or state issued birth certificate within 60 days of the date of birth is considered an intentional misrepresentation of a material fact and prohibited by the terms of the plan or coverage, therefore coverage for the child will not become active after the 31st day from birth and Participant must wait until an eligible enrollment period to re-elect coverage such as annual open enrollment or a qualified life event.
4. Adopted children may be added within 60 days of being physically placed in the Participant's home. Coverage may begin the date the child was placed in the home if the Participant is assuming and retaining a legal obligation for financial support of the child. Coverage will be pended for approval and not submitted to the carriers until Participant provides a completed Benefit Election Form and submits a copy of the adoption or placement papers to the Administrator. A failure to provide a copy of the adoption or placement papers within 60 days of the placement is considered an intentional misrepresentation of a material fact and prohibited by the terms of the plan or coverage, therefore coverage will not become active and Participant must wait until an eligible enrollment period to re-elect coverage such as annual open enrollment or a qualified life event.
5. A newborn child of an eligible Dependent child will be covered from birth, and claims will be paid for the Dependent's newborn for the first 31 days. The Participant must add the newborn child by completing the Benefit Election Form within 60 days of the birth for continued eligibility. Coverage will be pended for approval and not submitted to the carriers until Participant provides the Administrator with a copy of the hospital or state issued birth certificate. A failure to provide a copy of the hospital or state issued birth certificate within 60 days of the placement is considered an intentional misrepresentation of a material fact and prohibited by the terms of the plan or coverage, therefore coverage for the child will not become active after the 31st day from birth and Participant must wait until an eligible enrollment period to re-elect coverage such as annual open enrollment or a qualified life event.
6. A grandchild or other child may be added within 60 days from the date custody and guardianship are granted, so long as the child qualifies as a Dependent under the Plan. Coverage will be pended for approval and not submitted to the carriers until Participant provides a completed Benefit Election Form and submits a copy of the court order granting custody and appointing the guardian and a copy of the letters of guardianship to the Administrator. A failure to provide a copy of the court order granting custody and appointing the guardian and a copy of the letters of guardianship within 60 days of the placement is considered an intentional misrepresentation of a material fact and prohibited by the terms of the plan or coverage, therefore coverage will not become active and Participant must wait until an eligible enrollment period to re-elect coverage such as annual open enrollment or a qualified life event.
7. An adult disabled child may continue coverage if (a) the Participant provided a statement from a physician certifying that the adult child has an ongoing disability that prevents the adult child from engaging in self-sustaining employment; (b) the adult child was covered by a parent's plan for at least 2 years immediately before the time the child reached age 26; and (c)(i) the Participant claims the child as a tax dependent; (c) (ii) the child's tax return shows adjusted gross income that does not exceed 150% of the federal poverty level; or (c) (iii) the Participant is the legal guardian of the child. The above requirements for adult disabled

dependent coverage can be satisfied by completing an “Adult Disabled Dependent Child Eligibility Acknowledgement” form and returning to the City’s Benefits Office for review and approval before coverage is continued.

8. **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 Eligible Employee’s child, then the Eligible Employee may change their election to (a) add coverage if the order requires coverage for the child under the 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 Eligible Employee, the Administrator will add the child to the Eligible Employee’s coverage and will change any required Employee Contributions.
9. **HIPAA Special Enrollment Rights**: Mid-year election changes are allowed if an individual who was eligible for coverage but who did not enroll because of other existing coverage with another health plan at the time of initial enrollment subsequently loses the other coverage (and loss of coverage was due to reasons other than failing to pay premiums on a timely basis) or if the other employer stops contributing toward that other coverage. Both the Eligible Employee and their eligible Dependents are eligible to enroll. If an Eligible Employee has a new Dependent as a result of marriage, birth, adoption, or placement for adoption, the Eligible Employee may enroll both them and their eligible Dependents. A Benefit Election request must be made within 60 days from the end date or previous coverage.
10. **Medicaid or Children’s Health Insurance Program (CHIP) Coverage**: If an Eligible Employee or their eligible Dependent is not enrolled in the Health Plan Benefits, the Eligible Employee may request special enrollment in the Health Plan Benefits if the Eligible Employee or their eligible Dependent loses coverage under a Medicaid plan or under a state child health plan due to loss of eligibility for such coverage. In addition, an Eligible Employee may request special enrollment in the Health Plan Benefits if the Eligible Employee or their eligible Dependent becomes eligible for assistance, with respect to coverage under the Health Plan Benefits, under such Medicaid plan or state child health plan. A Benefit Election request must be made within 60 days of the event. Documentation from Medicaid or the state child health plan must be provided.

## 3.05 Termination

(a) Participation in the Plan shall terminate when a Participant ceases to be an Employee or when it is determined by the Administrator that the Employee no longer meets the eligibility criteria of Section 3.04 and/or fails to make the required Employee Contributions by the due date established by the Administrator.

(b) City-paid Benefits for non-represented, BOEC, PROTEC-17, DCTU, PCL, Auditors, and Recreation Employees will end on the last day of the month in which an Employee terminates employment, enters an unpaid status because of military leave (except as required by USERRA) or personal unpaid leave, or is unable to meet the minimum work requirements within their job class and/or standard hours designation.

(c) Coverage for non-represented, BOEC, PROTEC-17, DCTU, PCL, Auditors, and Recreation Employees and their eligible Dependents may be reinstated retroactively to the first of the month in which the Employee returns to their regular work schedule.

(d) Coverage for PFFA and their eligible dependents may be reinstated retroactively to the first of the month in which the Employee returns to their regular work schedule.

(e) Coverage for PPA and PPCOA Employees will end on the last day of the month in which an Employee has been paid at least 80 hours in the prior calendar month, unless otherwise provided under an applicable labor agreement. The 80 hours of pay must consist of regular work hours, vacation, sick, holiday, jury duty pay, or comp time paid for absence from regular work hours. No other type of pay or benefit applies to make up the hours required. Lump sum vacation or sick leave payments at retirement or termination, time loss payments for workers' compensation paid by Risk Management, disability payments from the Fire and Police Disability, Retirement and Death Benefit Plan.

(f) Coverage for Seasonal Maintenance Workers and Seasonal Park Rangers will end as described specified in the applicable collective bargaining agreement.

(g) Coverage for Eligible Casual Employees will end when they cease to be considered by the City to be Full-time Employees within the meaning of the Code Section 4980H(c)(4), or as otherwise described in the applicable Related Document.

(h) Any required catch-up Employee Contributions will be deducted from the first paycheck the Participant receives upon returning from unpaid leave to paid status, unless other repayment arrangements have been made.

(i) Notwithstanding any provision to the contrary in the Plan, to the extent required by COBRA, a Participant and their Spouse and other Dependents, whose Health Plan Benefits and/or HFSA coverage terminates because of a Qualifying Event, shall be given the opportunity to continue on a self-pay basis the same coverage they had under the Plan the day before the Qualifying Event for the periods prescribed by COBRA (subject to all conditions and limitations under COBRA).

## 3.06 Reinstatement of Participation

A former Participant shall become a Participant again if and when they again satisfy the eligibility requirements of Section 3.02. Except as provided in this Chapter 3 and Chapter 4, if a Participant ceases to be an Eligible Employee during a Plan Year and, during the same Plan Year and within 30 days after their termination of employment, is reinstated as a Participant, they shall, upon such reinstatement, continue to be bound by their previous election for Qualified Benefits. If a Participant ceases to be an Eligible Employee during a Plan Year and, either during a subsequent Plan Year or more than 30 days after their termination of employment in the same Plan Year, is reinstated as a Participant, they shall make a separate election for such Plan Year for Qualified Benefits.

## 3.07 Qualifying Leave Under FMLA

(a) Notwithstanding any provision to the contrary in the Plan, if a Participant goes on a qualifying leave under the FMLA, then to the extent required by the FMLA, the City will continue to maintain the Participant's FMLA Group Health Plan Benefits on the same terms and conditions as if the Participant were still an active Employee. That is, if the Participant elects to continue their coverage while on FMLA leave, the City will continue to pay the Employer Contributions. If a Participant's coverage ceases while on FMLA leave, the Participant will be permitted to re-enter the Plan upon return from such leave on the same basis the Participant was participating in the Plan prior to the leave or as otherwise required by the FMLA.

(b) A Participant may elect to continue their coverage under the FMLA Group Health Plan Benefits (including the HFSA) during the FMLA leave. If the Participant falls into an unpaid status and elects to continue coverage while on FMLA leave, the Administrator may terminate the FMLA Group Health Plan Benefits if the Participant fails to make the required Employee Contributions. The Administrator may fund coverage during the FMLA leave if the Participant agrees to payment of "catch-up" amounts either through withholdings or an acceptable repayment schedule upon the Participant's return. During an FMLA leave, a Participant is eligible to participate in the Annual Enrollment Period. If the Participant does not return to work after the approved FMLA leave, reimbursement of all the City Benefit

payments will be requested, unless there is a continuation, recurrence, or onset of a serious health condition.

### 3.08 Unclaimed Benefits

If, within one (1) year after any amount becomes payable hereunder to a Participant and the same shall not have been claimed or any check issued under the Plan remains uncashed, provided reasonable care shall have been exercised in attempting to make such payments, the amount thereof shall be forfeited and shall cease to be a liability of the Plan, unless otherwise required.

# Chapter 4.
# Method and Timing of Elections

## 4.01 Employee Elections

(a) An Eligible Employee's election of Benefits shall be on the prescribed Benefit Election Form and filed with the Administrator during either the initial enrollment or the Annual Enrollment Period. For Qualified Benefits, the Eligible Employee shall also execute such Salary Reduction Agreement as the Administrator shall require. When a new Benefit is first offered under the Plan, an Eligible Employee may file a Benefit Election Form with respect to that Benefit within an initial enrollment period established by the Administrator. Employees who become Eligible Employees subsequent to the expiration of the Annual Enrollment Period must elect Benefits within their initial enrollment period as described in Section 3.01.

(b) After making an election of one or more Qualified Benefits, a Participant may not revoke that election until the next Annual Enrollment Period after the Plan Year has commenced, except if both the revocation and the new election are made on account of and are consistent with a Change in Status or other event described in Section 4.02.

## 4.02 Mid-Plan Year Election Changes for Qualified Benefits

A Participant's election to apply their salary reduction to the payment of Qualified Benefits will be irrevocable for the remainder of the Plan Year, except in certain situations described in this Section 4.02. Any of the following elections and revocations shall be made pursuant to procedures adopted by the Administrator and shall be effective no sooner than the first day of the month following a qualifying event or the first day of the month following the date the Participant files a new Benefit Election Request with the Administrator. An election change can be funded through pre-tax salary reduction only on a prospective basis, except for the retroactive enrollment rights under PHS Act Section 2704(f), which applies in the case of an election made within 31 days of birth, adoption, or placement for adoption. A Participant otherwise entitled to make a new election under this Chapter must do so within 60 days of the event. The circumstances under which a Participant may make a mid-year change of election vary with the type of Qualified Benefit at issue, as follows:

(a) **Change in Status**: A Participant may change an election during the Plan Year for Qualified Benefits if a Change in Status has occurred and the requested election change is consistent with the Change in Status. For purposes of this Section, the following events are Changes in Status:

1. An event that changes the Participant's legal marital status (including marriage, death of Spouse, divorce, legal separation, or annulment);
2. An event that changes the Participant's number of non-Spouse Dependents (including birth, death, adoption, or placement for adoption of a Dependent);
3. A change in the employment status of the Participant or their eligible Dependent (including termination or commencement of employment, a strike or lockout, a reduction or increase in hours of employment that affects eligibility for benefits, a commencement of or return from an unpaid leave of absence, or a change in worksite);
4. An event that causes a non-Spouse eligible Dependent to satisfy or cease to satisfy the eligibility requirements for coverage due to attainment of limiting age or any other circumstance as provided by a Component Plan; and
5. A change in the place of residence of the Participant or their eligible Dependent that affects eligibility for Benefits.

(b) "Consistency" with the Change in Status requires that: (i) the Change in Status affects coverage eligibility of a Participant, the Participant's Spouse, or the Participant's other Dependent under the Plan or another plan offered by the employer of the Participant, Spouse, or other Dependent, and (ii) the election change be on account of and

correspond with the Change in Status. The Administrator, in its sole discretion, shall determine whether an election change meets the consistency requirement based on prevailing IRS guidance.

1. **Loss of Eligibility Due to Family Change**: If the Change in Status is the Participant's divorce, annulment, or legal separation from a Spouse, then a Participant's election to cancel Qualified Benefits for any individual other than the Spouse would not be consistent with the Change in Status, unless they are the child of the former Spouse and not the child of the Participant. Similarly, if the Change in Status is the death of the Participant's Spouse or other Dependent, then a Participant's election to cancel Qualified Benefits for an individual other than that deceased Spouse or other Dependent would not be consistent with the Change in Status. In addition, if one of the Participant's Dependents ceases to satisfy the eligibility requirements for Qualified Benefits coverage under the Plan, the Participant's election to cancel Qualified Benefits for any other Dependent, for the Participant, or for the Participant's Spouse would not be consistent with the Change in Status.
2. **Gain of Eligibility Under Other Employer's Plan**: If a Participant, a Participant's Spouse, or a Participant's other Dependent gains eligibility for coverage under a premium only plan offered by the employer of the Participant's Spouse or other Dependent as a result of a Change in Status that is a change in marital or employment status, then a Participant's election to cease or decrease coverage for the Participant, Spouse, or Dependent under the Plan is consistent with the Change in Status only if coverage for that individual becomes applicable or is increased under the other employer's plan.

(c) **HIPAA Enrollment Rights**: A Participant may revoke an election with respect to Qualified Benefits and make a new election that corresponds with the Participant's special enrollment rights granted the Participant under PHS Act Section 2704(f), as described in Section 3.04(f). HIPAA special enrollment rights, under this Subsection (c), do not apply to the DFSA or excepted benefits as defined under PHS Act Section 2791.

(d) **FMLA Leave**: A Participant who takes FMLA leave may revoke an existing election of Qualified Benefits and make such other election for the remaining portion of the Plan Year as may be provided for under the FMLA. An election to contribute to the DFSA will end automatically and no reimbursements from the DFSA will be permitted for the expenses incurred during the FMLA leave.

(e) **Judgments, Decrees, and Orders**: If a judgment, decree, or order (an "Order") resulting from the divorce, legal separation, annulment, or change in legal custody requires accident or health coverage for a Participant's child or for a foster child who is a Dependent of the Participant, a Participant may change their election of Qualified Benefits to:

1. Provide coverage for the child (provided that the Order requires the Participant to provide coverage for the child under the Plan); or
2. Cancel coverage for the child if the Order requires the Spouse, former Spouse, or other individual to provide coverage for the child and that coverage is, in fact, provided.

No changes are permitted to the DFSA under this Subsection (e).

(f) **Medicare and Medicaid**: If a Participant, Spouse, or other Dependent who is enrolled in Qualified Benefits becomes entitled to (enrolled in) Medicare or Medicaid (other than coverage consisting solely of benefits under Section 1928 of the Social Security Act providing for pediatric vaccines), the Participant may make a prospective election change under the Plan to cancel or reduce coverage for that Participant, Spouse, or other Dependent under the Plan. In addition, if a Participant, Spouse, or other Dependent who has been entitled to Medicare or Medicaid loses eligibility for such coverage, the Participant may make a prospective election to increase coverage for that Participant, Spouse, or other Dependent under the Plan.

(g) **Changes in Cost**

1. **Automatic Changes**: If the cost of a Qualified Benefit increases (or decreases) during the Plan Year and, under the terms of the Component Plan, Participants are required to make a corresponding change in their Employee Contributions, the Administrator will automatically make a prospective increase (or decrease) in affected Participants' Employee Contributions to the Plan.
2. **Significant Cost Changes**: If the cost charged to a Participant for a Qualified Benefit significantly increases or significantly decreases during the Plan Year, the Participant may make a corresponding change in election. Changes that may be made include: (i) commencing participation hereunder for a Qualified Benefit with a decreased cost, or (ii) revoking an election for the Qualified Benefit with an increased cost and, in lieu thereof, either receiving on a prospective basis coverage under another Qualified Benefit providing Similar Coverage or dropping coverage if no Similar Coverage is available. The Administrator, in its sole discretion, will decide whether an increase or decrease in cost is significant and whether Participants may change their election based on the cost change. "Similar Coverage" is defined in Subsection (h)4 (Definitions) below.
3. If the amount charged to a Participant by a Dependent Care Service Provider significantly increases or decreases during the Plan Year, or if the Participant changes Dependent Care Service Providers resulting in a significant increase or decrease in costs, the Participant may revoke an election under the DFSA and make a new election to reflect the increase or decrease in the Dependent Care Service Provider's cost. This subsection applies to the DFSA only if the cost change is imposed by a Dependent Care Service Provider who is not a relative of the Participant, as described in Code Section 152(a)(1) – (8). Documentation from the Participant showing the significant change in Dependent Care cost must be submitted to the Administrator.
4. No part of this Subsection (g) applies to the HFSA.

(h) **Changes in Coverage**

1. **Loss of Coverage**: If a Participant, the Participant's Spouse, or the Participant's other Dependent has a Loss of Coverage (as defined below) under a Qualified Benefit, the Participant may revoke their election under the Plan for that Qualified Benefit, and, in lieu thereof, elect either to receive coverage under another Qualified Benefit providing Similar Coverage or to drop coverage if no Similar Coverage is available. If the Participant has a Loss of Coverage under the DFSA, the Participant may revoke their election under the DFSA and, in lieu thereof, either make a new election under the DFSA to receive coverage through another Dependent Care Service Provider or drop coverage under the DFSA.
2. **Significant Curtailment of Coverage**: If a Participant, the Participant's Spouse, or the Participant's other Dependent has a Significant Curtailment of Coverage (as defined below) under a Qualified Benefit, which is not a Loss of Coverage, then that Participant may revoke their election for that coverage and, in lieu thereof, receive coverage under another Qualified Benefit providing Similar Coverage. If a Participant has a Significant Curtailment of Coverage (that is not a Loss of Coverage) under the DFSA, then that Participant may revoke their election for that coverage and, in lieu thereof, make a new election under the DFSA.
3. **Addition or Improvement of a Benefit Package Option**: If, during the Plan Year, a new Qualified Benefit is offered, a new coverage option is added to a Qualified Benefit, or coverage under an existing Qualified Benefit is significantly improved, Eligible Employees and Participants may revoke their elections under the Plan and, in lieu thereof, make new election on a prospective basis for coverage under the new or improved Qualified Benefit.
4. **Definitions**: As used in this Subsection (h):
   a. "Loss of Coverage" means a complete loss of coverage under a Qualified Benefit or under the DFSA (including elimination of a Qualified

Benefit for purposes of the Plan or loss of a Dependent Care Service Provider for purposes of the DFSA). In addition, the Administrator may, in its discretion, treat the following as a Loss of Coverage:

(1) A substantial decrease in the medical care providers available under the Qualified Benefit;
(2) A reduction in the benefits for a specific type of medical condition or treatment with respect to which the Participant or the Participant's Spouse or other Dependent is currently in a course of treatment; or
(3) Any similar fundamental loss of coverage.

b. "Significant Curtailment of Coverage" means an overall reduction in coverage provided under the Qualified Benefits or by a Dependent Care Service Provider under the DFSA so as to constitute reduced coverage generally. The Administrator, in its sole discretion, will determine whether a Significant Curtailment of Coverage has occurred, based on prevailing IRS guidance.

c. "Similar Coverage" means coverage for the same category of benefits for the same individuals (e.g. family to family or single to single). For example, two plans that provide coverage for major medical care are considered Similar Coverage. Similar Coverage may be offered by a qualified plan of the Participant's Spouse's or other Dependent's employer. The Administrator, in its sole discretion, will determine whether coverage is "similar" based on all the facts and circumstances.

5. No part of this Subsection (h) applies to the HFSA.

(i) **Change in Coverage Under Another Employer Plan**

1. A Participant may make a prospective election change that is on account of and corresponds with a change made under a plan of the Participant's Spouse's or other Dependent's employer ("Other Employer Plan"), so long as: (a) the Other Employer Plan permits its participants to make an election change that would be permitted under Code Section 125; or (b) the Plan permits Participants to make elections based on a Plan Year that is different from the plan year under the Other Employer Plan. The Administrator shall determine, based on prevailing IRS guidance, whether a requested change is on account of and corresponds with a change made under the Other Employer Plan.
2. No part of this Subsection (i) applies to the HFSA.

(j) **Loss of Coverage Under Other Group Health Coverage**

1. A Participant may elect on a prospective basis to add coverage under the Plan for the Participant or the Participant's Spouse or other Dependent if the Participant or the Participant's Spouse or other Dependent loses coverage under any group health coverage sponsored by a governmental or educational institution, including the following: (i) a State's children's health insurance program (SCHIP) under Title XXI of the Social Security Act; (ii) a medical care program of an Indian Tribal government (as defined in Code Section 7701(a)(40)), the Indian Health Service, or a tribal organization; (iii) a State health benefits risk pool; or (iv) a foreign government group health plan.
2. No part of this Subsection (j) applies to the HFSA or the DFSA.

(k) **Change in Coverage Under Federal Healthcare Exchange**

1. A Participant may cancel coverage for self and/or family members from the City's healthcare plan if they become eligible and enrolls in a qualified health plan through the exchange for one or more coverage months as permitted under section 36B of the Internal Revenue Code.

(l) **Reduction in Work Hours**: A Participant may revoke their election for medical coverage under the Component Plans for himself/herself and his/her eligible Dependents due an employment status change; provided that: (i) the Participant had been in an employment status with the City under which they were reasonably expected to average at least 30

hours of service per week and there is a change in his/her employment status so they are reasonably expected to average less than 30 hours of service per week, even though the reduction in hours does not result in him/her ceasing to be eligible for medical coverage under the Plan; and (ii) the Participant certifies they and their eligible Dependents have enrolled or intend to enroll in other medical coverage that provides minimum essential coverage, with the new coverage effective no later than the first day of the second month following the month that includes the date the Plan's medical coverage is revoked.

(m) **Duration of Plan Elections**: A Participant may not elect a Qualified Benefit for any period of time less than a Plan Year, unless the Participant becomes eligible to enroll in the Plan during the Plan Year or makes an election on account of and consistent with a Change in Status or other event described above during the Plan Year. Elections made pursuant to this Chapter shall be effective for the balance of the Plan Year following the change of election, unless a subsequent event allows for a further election change or as provided in Section 3.04(f) for HIPAA special enrollment rights. All election changes shall be effective on a prospective basis only (i.e., election changes will become effective no earlier than the first day of the calendar month following the date that the election change was filed). A Participant may also change elections for each Plan Year during the Annual Enrollment Period by filing a new Benefit Election Form with the Administrator within the Annual Enrollment Period.

(n) **Change in Residence Affecting Coverage Area**: A participant may make a prospective health plan election change if participant and/or enrolled dependents experience a change of residence, such as moving outside of the affected network coverage area of the current elected health plan.

(o) The Administrator may establish rules similar to those in this Chapter 4, to the extent consistent with Code Section 125, with respect to events such as entering or terminating a domestic partnership, death of a Domestic Partner, or adding or dropping coverage of a Domestic Partner's children.

# Chapter 5.
# Benefits Offered and Funding

## 5.01 Benefits Offered Under the Cafeteria Plan

When first eligible during initial enrollment or during the Annual Enrollment Period as described in Chapter 3, Eligible Employees will be given the opportunity to elect one or more of the following Cafeteria Plan Benefits (for Qualified Benefits), unless otherwise provided under a collective bargaining agreement:

(a) Premium Payment Benefit (for Qualified Benefits that are Health Plan Benefits) described in Chapter 6;

(b) Dependent Care Flexible Spending Account described in Chapter 7; and/or

(c) Healthcare Flexible Spending Account described in IRS Publication 969.

## 5.02 Other Benefits Offered Under the Plan

Other Benefits offered under the Plan include:

(a) Long-term disability benefits;

(b) Employee assistance program benefits;

(c) Basic and supplemental life insurance; and

(d) Fertility and family planning benefit.

When first eligible during initial enrollment, Eligible Employees will be automatically enrolled in basic coverages under these Benefits, as determined by the Administrator, based on their Employee status and as provided under a collective bargaining agreement. Eligible Employees may not opt-out of these basic coverages.

When first eligible during initial enrollment or during the Annual Enrollment Period as described in Chapter 3, Eligible Employees will be given the opportunity to elect supplemental coverages under these Benefits, as determined by the Administrator, based on their Employee status and as provided under a collective bargaining agreement.

## 5.03 Funding

The Benefits will be funded through Employer Contributions and/or Employee Contributions, which may be made on a pre-tax basis pursuant to Salary Reduction Agreements between the Participants and the City or on an after-tax basis.

(a) **Employer Contributions**: The City may, but is not required to, make available contributions on behalf of Participants. The amount of the Employer Contributions shall be set forth in the annual enrollment materials. Employer Contributions may either be limited to the purchase of a particular Benefit, or they may be unrestricted, as described in the enrollment materials. The amount of the Employer Contribution for each Participant shall be based on the Eligible Employee's standard hours designation or as otherwise provided in the applicable collective bargaining agreement.

(b) **Employee Contributions**: The City shall withhold from the Participant's compensation on a pre-tax basis or on an after-tax basis, deductions in an amount equal to the Employee Contributions required for the Benefits elected by the Participant, less any applicable Employer Contribution allocable to such Benefits. One twenty-fourth (1/24) of the annual Employee Contribution to fund each Benefit elected

by the Participant shall be credited to the Participant's Plan accounts the first and second pay period of each month pay for that month's coverage. In the event of a shortage of reducible compensation, an amount deemed appropriate by the Administrator not to exceed the actual cost of the Participant's election in a Plan Year shall be withheld from current and future compensation in that Plan Year.

(c) **Opt-Out Dollars**: Except for Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees, Opt-out dollars are a residual benefit determined at initial enrollment and annually thereafter at the time of the Annual Enrollment Period. Opt-out dollars are generated under the Plan solely as a result of the Eligible Employee's affirmative choice not to elect coverage for Health Plan Benefits under Chapter 6 for the Plan Year. As described in section 5.04 below, an Eligible Employee must show proof of enrollment in other group medical coverage. Opt-out dollars elected by an Eligible Employee shall be a fully taxable benefit.

## 5.04 Required and Default Benefits

(a) **Required Benefits**: All Health Plan Benefits are optional Employee elections, except as follows:

1. All eligible Full-time Employees, except Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees, must elect a Health Plan Benefit under the Plan, unless the Eligible Employee provides evidence of enrollment in another employer's group medical coverage. The determination to allow the Eligible Employee to opt-out of the Plan's Health Plan Benefits coverage is made at the discretion of the Administrator after review of documentation the Eligible Employee has health coverage through another employer group medical plan. It shall be the responsibility of the Eligible Employee to immediately notify the Administrator upon cessation of any such other group medical coverage.
2. All eligible Full-time Employees, except Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees, shall automatically receive a basic group term life Benefit.
3. All eligible Part-time Employees, except Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees, must elect a group term life Benefit under the Plan irrespective of other life insurance coverage or financial resources of the Eligible Employee.
4. All eligible Full-time Employees, except PPA, Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees, must elect a group long-term disability Benefit under the Plan irrespective of other long-term disability benefit coverage or financial resources of the Eligible Employee.
5. All eligible Part-time Employees, except PPA, Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees, must elect a group long-term disability Benefit under the Plan irrespective of other long-term disability benefit coverage or financial resources of the Eligible Employee.
6. All eligible full-time and part-time Seasonal Maintenance Workers and Seasonal Park Rangers and all Eligible Casual Employees are deemed to have elected employee only CityBasic medical (including prescription drug) Benefits and CityBasic dental Benefits, and related vision Benefits, unless the Eligible Employee provides evidence of enrollment in another employer group medical, dental, and vision plan. The determination to allow the Eligible Employee to opt-out of the Plan's medical, dental, and vision coverage is made at the discretion of the Administrator after review of documentation that the Eligible Employee has coverage through another employer group plan. It shall be the responsibility of the Eligible Employee to immediately notify the Administrator upon cessation of any such other group coverage as described in the Benefit Election Form.
7. Notwithstanding any other language in this Chapter, Eligible Employees enrolled in the long-term disability Benefits shall, for all purposes under the Code, be

treated as having received cash equal to the amount required to purchase such Benefit(s) and then as purchasing such Benefits(s) with after-tax dollars.

8. Notwithstanding any other language in this Chapter, Eligible Employees who purchase any medical, dental, vision, or life insurance Benefits and elect coverage for someone other than a Spouse or other Dependent, as permitted by the applicable Component Plan, shall, for all purposes under the Code, be treated as having received cash equal to the amount required to purchase such coverage and then as purchasing such coverage with after-tax dollars.

(b) **Default Benefits**: Any Eligible Employee who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected the following default Benefits:

1. For any Plan Year in which any one or all of the Health Plan Benefits, life Benefits, and disability Benefits have not been substantially changed as determined by the Administrator, any Participant who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected:

    a. The same Benefit coverages, if any, as were in effect for the Participant just prior to the end of the preceding Plan Year; and
    b. A Salary Reduction Agreement to a reduction in the Participant's compensation for such Plan Year equal to the Employee Contributions for such Plan Year for such Qualified Benefits coverage.

2. For any Plan Year in which any one or all of the Health Plan Benefits, life Benefits and long-term disability Benefits have been substantially changed as determined by the Administrator or for which no prior election was made by an Eligible Employee, any Eligible Employee or Participant who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected:

    a. For initial enrollment, the non-represented, BOEC, PROTEC-17, DCTU, PCL, PFFA, PPCOA, Auditors, and Recreation Eligible Employees will be enrolled in Eligible Employee only coverage with the self-insured CityCore medical Benefit, the vision Benefit offered with the self-insured medical Benefit, the dental Benefit with the lowest total premium cost other than Kaiser Dental, the City-funded group term life insurance Benefit, and the City-funded group long-term disability Benefit, as applicable.
    b. For initial enrollment, the Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees will be enrolled in Eligible Employee only coverage under the CityBasic self-insured medical Benefit, the vision Benefit offered with the self-insured CityBasic medical Benefit, and the CityBasic self-insured dental plan.
    c. For initial enrollment, the PPA Eligible Employees will be enrolled in Eligible Employee only coverage under the self-insured CityNet medical Benefit, the vision Benefit offered with the CityNet medical Benefit, the dental Benefit with the lowest total premium cost other than Kaiser Dental, and the City funded group term life insurance Benefit.
    d. For the Annual Enrollment Period, the non-represented, BOEC, PROTEC-17, DCTU, PCL, PFFA, PPCOA, Auditors, and Recreation Eligible Employees will be enrolled in the Component Plans they were enrolled in as of June 30th (except for the HFSA and DFSA) at the same tier (i.e. Employee only, employee + 1, or employee + family) as elected for the prior Plan Year; the City-funded group term life insurance Benefit,

the City-funded group long-term disability Benefit; and, if previously enrolled, the Employee-funded group long-term disability Benefit buy-up, the Employee-funded vision buy-up, and the Employee-funded term supplemental life insurance Benefit.

e. For the Annual Enrollment Period, the PPA Eligible Employees will be enrolled in the Component Plans they were enrolled in as of June 30th (except for the HFSA and DFSA) at the same tier (i.e. Employee only, employee + 1, or employee + family) as elected for the prior Plan Year; the City-funded group term life insurance Benefit, the Employee-funded vision buy-up, and the Employee-funded term supplemental life insurance Benefit.

f. For the Annual Enrollment Period, the Seasonal Maintenance Workers, Seasonal Park Rangers, and Eligible Casual Employees will be enrolled in the Component Plans at the same tier they were enrolled in as of June 30th.

## 5.05 Plan Benefits

(a) **Description of Benefits**: The types and amounts of coverages and Benefits available under the Component Plans, the requirements for participating in the Component Plans, claims and appeal procedures, and the other terms and conditions of coverage under the Component Plans shall be as set forth from time to time in the applicable Related Documents governing the Component Plans.

(b) **Payment of Benefits**: All Benefits other than cash shall be paid by or through the applicable insurer or Third Party Administrator. The applicable insurer or Third Party Administrator will process a claim for those Benefits and, if the claim is approved, pay such Benefits to the Participant, their Dependent, or their Beneficiary, as applicable, at such time(s) and in such manner as specified by the applicable Component Plan.

(c) **Conversion/Portability Rights**: A Participant whose group insurance coverage ceases under any Component Plan may have the option of converting the group insurance coverage into individual insurance coverage or retaining individual coverage under the policy (as applicable), but only if and to the extent permitted by the Related Documents governing the Component Plan.

# Chapter 6.
# Premium Payment Benefit

## 6.01 Benefits

(a) The Health Plan Benefits are offered under the Premium Payment Benefit. Notwithstanding any other provision in the Cafeteria Plan, the Health Plan Benefits are subject to the terms and conditions of the Component Plans and Related Documents, and no changes can be made with respect to such Health Plan Benefits (such as mid-year changes in elections) if such changes are not permitted under the Component Plan and Related Document.

(b) Health Plan Benefits will be provided by the options as provided in the Component Plan, not the Cafeteria Plan. The specific Benefits, amounts of Benefits, the participation requirements, and the other terms and conditions of coverage are set forth in the Component Plan and Related Document. All claims to receive Health Plan Benefits shall be subject to and governed by the terms and conditions of the Component Plan and the rules, regulations, polices, and procedures adopted in accordance therewith, as may be amended from time to time.

## 6.02 Funding

The annual Employee Contributions for a Participant's Premium Payment Benefit is equal to the amount as authorized by the City in Chapter 5.

## 6.03 Elections

Eligible Employees can (i) elect the Premium Payment Benefit by electing to pay their Employee Contributions for the applicable Health Plan Benefits on a pre-tax salary reduction basis, or (ii) elect no Premium Payment Benefit and pay their Employee Contributions, if any, for the Health Plan Benefits with after-tax dollars outside of the Cafeteria Plan.

Unless an exception applies as described in Chapter 4, pre-tax elections are irrevocable for the duration of the Plan Year to which the election relates.

All Health Plan Benefits are optional Employee elections, except as provided in Section 5.04.

## 6.04 Default Benefits

With respect to the Plan Year commencing on July 1, 2024 and for any subsequent Plan Year, any Eligible Employee who fails to make a proper election for such Plan Year, on or before the specified due date, in conformance with the procedures prescribed by the Administrator, shall be deemed automatically to have elected default Benefits as provided in Section 5.04.

## 6.05 Claims Procedure

All claims shall be made directly to the Third Party Administrator or insurer providing claims payment or coverage. Notwithstanding the foregoing, claims and appeals for medical Benefits shall be subject to and administered according to the provisions of the ACA.

# Chapter 7.
# Dependent Care Assistance Plan

## 7.01 Purpose

This Chapter is to be known as the City of Portland Dependent Care Flexible Spending Account ("DFSA"). The purpose of this Chapter is to reimburse Participants for Dependent Care Expenses incurred by such Participants. This Chapter is intended to qualify as a plan providing dependent care assistance within the meaning of Code Section 129(d)(1), and it is intended that the amounts reimbursed pursuant to this Chapter be eligible for exclusion from the income of a Participant under Code Section 129(a).

## 7.02 Eligibility and Enrollment

(a) Each Eligible Employee, except a Seasonal Maintenance Worker, Seasonal Park Ranger, or Eligible Casual Employee, who is a Participant in the Plan described in Chapter 3 may become a Participant in this DFSA by completing and filing an online Benefit Election with the Administrator indicating the Eligible Employee's application to participate in the DFSA and fund the Dependent Care Account with salary reductions.

(b) An election to participate in the DFSA shall be irrevocable after the Plan Year has commenced, unless the Participant experiences a Change in Status or as allowed in Chapter 4. A Participant may revoke their election to participate in the DFSA after the Plan Year has commenced and may make a new election with respect to the remainder of the Plan Year if both the revocation and the new election are made on account of and are consistent with a Change in Status or as described in Chapter 4.

(c) Participation in the DFSA shall terminate when a Participant ceases to be an Employee or ceases to make required Employee Contributions or when it is determined by the Administrator that the Employee no longer meets the Plan eligibility criteria in Chapter 3, whichever occurs first. Participation in the DFSA may thereafter be renewed upon the satisfaction of the eligibility requirements described in Chapter 3. Contributions are not made into the DFSA and no reimbursements can be made for expenses incurred during an Employees qualified leave.

(d) If a Participant elects not to participate in the DFSA, they may later elect to participate during the Annual Enrollment Period, effective as of the following July 1, or on account of a Change in Status or as described in Chapter 4.

## 7.03 Establishing an Account; Payment of Expenses

The Administrator will establish and maintain a Dependent Care Account for each Participant hereunder. From amounts credited to a Participant's Dependent Care Account during the Plan Year, there shall be paid from time to time reimbursement of Dependent Care Expenses incurred by the Participant during the Plan Year.

## 7.04 Benefits

(a) Upon becoming eligible, each Participant may elect to participate in the DFSA by completing a Benefit Election Form to reduce their salary in the first two pay periods of each month and to have the amount of the salary reduction contributed to a Dependent Care Account on such Participant's behalf. The Benefit Election Form shall be filed with the Administrator prior to the date the Participant is enrolled in the DFSA. Such election may not reduce the Participant's salary by more than $5,000 each Plan Year, or $2,500 in the case of married individuals filing separately. The maximum amount a Participant may receive for any Plan Year for reimbursement for Dependent Care Expenses shall be the lesser of:

A. The amount credited to their Dependent Care Account during the Plan Year; or
B. In the case of a Participant who is not married at the close of such taxable year, the earned income of such Participant for such taxable year; or
C. In the case of a Participant who is married at the close of such taxable year, the lesser of:

1. The earned income of such Participant for such taxable year, or
2. The earned income of the Spouse of such Participant for such taxable year. In determining the earned income of a Spouse who is actively seeking employment, a student, or incapable of self-care, it shall be deemed for each month during which such Spouse is a student at an educational institution or is incapable of self-care that such Spouse has an earned income not less than:

   (i) $250, if there is one Qualifying Individual with respect to the Participant; or
   (ii) $500, if there are two or more Qualifying Individuals with respect to the Participant; or

3. $5,000, or $2,500 in the case of a separate return filed by a married Participant.

(b) Reimbursements shall be made to the Participant for Dependent Care Expenses incurred by the Participant for Qualifying Individuals during the Plan Year for which the Participant's election is effective. No reimbursement shall exceed the balance in the Participant's Dependent Care Account at the time the Participant requests reimbursement.

(c) Reimbursement will not be paid to a Participant for Dependent Care Expenses provided by an individual for whom a deduction is allowable under Code Section 151(c) (relating to personal exemptions for dependents) to a Participant or the Participant's Spouse. Reimbursement will not be paid to a Participant for Dependent Care Expenses provided by a child of the Participant within the meaning of Code Section 151(c)(3) under the age of 19.

(d) Notwithstanding the previous Subsection, a Participant will not receive reimbursement for the cost of Dependent Care Expenses provided by a Dependent Care Services Provider, unless the Dependent Care Service Provider complies with all applicable laws and regulations of the state or unit of local government where such center is located (e.g., requirements for licensing, if applicable, and building and fire code regulations).

(e) A Participant who terminates participation prior to the end of a Plan Year shall have the right to submit claims for reimbursement for Dependent Care Expenses incurred during the remainder of the Plan Year at any time until 90 days following the end of the Plan Year. No reimbursement shall exceed the balance in the Participant's Dependent Care Account for the Plan Year in which the Dependent Care Expenses were incurred.

## 7.05 Forfeiture

(a) Participants in this DFSA are ineligible to receive any reimbursement under this Chapter except as reimbursement for Dependent Care Expenses and shall not receive any funds which may remain in their Dependent Care Accounts after reimbursement for all Dependent Care Expenses has been made. Any unused funds remaining in Dependent Care Accounts at the end of a Plan Year may not be carried over to a subsequent Plan Year, shall not be available to the Participants in any other form or manner, and the Participants shall forfeit all rights with respect to the unused funds. Such forfeited funds shall be applied to the costs of administering the DFSA.

(b) Reimbursement under this DFSA shall be made only in the event, and to the extent, that reimbursement for amounts expended or payment for Dependent Care Expenses is not provided for under any other dependent care assistance plan or under any federal or state law. If there is such a policy, plan, or law in effect providing for such reimbursement or payment in whole or in part, then to the extent of the coverage under such policy, plan, or law no reimbursement shall be made hereunder.

## 7.06 Funding

Funding for participation in the DFSA is as described in Chapter 5. It is intended that the Dependent Care Accounts authorized under this Chapter be funded by funds made available pursuant to a Salary Reduction Agreement affirmed by the Participant.

## 7.07 Claims Procedure

(a) In order to obtain reimbursement for Dependent Care Expenses, a Participant shall submit an application in electronic form or in writing to the Administrator or designated Third Party Administrator, in such form as the Administrator or designated Third Party Administrator may prescribe, no later than the end of three (3) months following the end of the Plan Year, setting forth:

1. The amount, date, and nature of the Dependent Care Expense with respect to which payment is requested;
2. The name of the person, organization, or entity to which the Dependent Care Expense was or is to be paid, and taxpayer identification number (Social Security Number if an individual);
3. Such other information as the Administrator or designated Third Party Administrator may from time to time require;
4. The relationship, if any, of the person performing the services for the Participant;
5. If the dependent care services are being performed by a child of the Participant, the age of the child;
6. A statement as to where the dependent care services were or will be performed;
7. If any of the dependent care services are to be performed outside the Participant's household, a statement as to whether the Dependent for whom such services are being performed spends at least eight (8) hours a day in the Participant's household; and
8. If the services are being performed in a dependent care center, a statement that:
    a. The dependent care center complies with all applicable laws, regulations, and ordinances of the state, county, and city where it is located;
    b. The dependent care center provides care for more than six (6) individuals (other than individuals residing at the center); and
    c. The amount of the fee paid to the dependent care center.

(b) Such applications shall be accompanied by bills, invoices, receipts, canceled checks, or other statements showing the amounts of such Dependent Care Expenses. The Participant must provide a written statement from an independent third party verifying the Dependent Care Expenses incurred and the amount of such Dependent Care Expenses and must verify in writing that the Dependent Care Expenses have not been reimbursed under any other dependent care assistance plan.

(c) The Participant shall be reimbursed from the Participant's Dependent Care Account for Dependent Care Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Chapter. Dependent Care Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the Dependent Care Expenses. Dependent Care Expenses that were incurred before the Effective Date or before the date the Participant was enrolled in the DFSA will not be reimbursed. The Administrator or Third Party Administrator may, at its option, pay a Dependent Care Expense directly to the Dependent Care Service Provider in lieu of reimbursing the Participant.

(d) Requests for reimbursement should normally be processed within 30 days of the receipt of the claim. Where additional information is required to process the claim or where no benefit is payable, a written notice/explanation shall be sent to the Claimant within 30 days of claim filing. The eligibility of all claims shall be determined within 60 days of the receipt of proper documentation. The decision of the Administrator or designated Third Party Administrator regarding claim eligibility shall be final.

(e) If approved Dependent Care Expenses exceed the amount credited to a Participant's Dependent Care Account, the Administrator or designated Third Party Administrator shall reimburse claims up to the Dependent Care Account balance and hold the remainder of the claims until sufficient funds are credited to the Dependent Care Account in the year in which the claims were incurred.

# Chapter 8.
# Healthcare Flexible Spending Account

## 8.01 Purpose

This Chapter is to be known as the City of Portland Healthcare Flexible Spending Account ("HFSA"). The purpose of this Chapter is to reimburse Participants for certain Medical Expenses enumerated herein. This Chapter is intended to qualify as an accident and health plan within the meaning of Code Sections 105 and 106, and it is intended that the benefits payable under this Chapter be eligible for exclusion from the Participant's income.

## 8.02 Eligibility and Enrollment

(a) Each Eligible Employee, except a Seasonal Maintenance Worker, Seasonal Park Ranger, or Eligible Casual Employee, who is a Participant in the Plan described in Chapter 3 may become a Participant in this HFSA by completing and filing an online Benefit Election with the Administrator indicating the Eligible Employee's application to participate in the HFSA and fund the HFSA Account with salary reductions.

(b) An election to participate in the HFSA shall be irrevocable after the Plan Year has commenced, unless the Participant experiences a Change in Status as allowed in Chapter 4. A Participant may revoke their election to participate in the HFSA after the Plan Year has commenced and may make a new election with respect to the remainder of the Plan Year if both the revocation and the new election are made on account of and are consistent with a Change in Status as described in Chapter 4.

(c) Participation in the HFSA shall terminate when a Participant ceases to be an Employee, ceases to make required Employee Contributions, or when it is determined by the Administrator that the Employee no longer meets the Plan eligibility criteria in Chapter 3, whichever occurs first. Participation in the HFSA may thereafter be renewed upon the satisfaction of the eligibility requirements described in Chapter 3. In the event that a Participant ceases to make required Employee Contributions, the Participant will not be permitted to again contribute to the HFSA Account for the remaining portion of the Plan Year during which the cessation of Employee Contributions occurred.

(d) To the extent required by COBRA, a Participant, and the Participant's Spouse and other Dependents, whose coverage terminates under the HFSA on account of a Qualifying Event shall be given the opportunity to continue coverage under the HFSA on an after-tax basis for the period prescribed by COBRA. However, if the following two conditions are satisfied, a special COBRA rule will apply, as discussed below, that limits the extent to which COBRA must be offered under the HFSA. The two conditions which must be satisfied are:

1. **The HFSA is exempt from HIPAA**: The HFSA is exempt from HIPAA (i.e., a major medical plan is available to all Eligible Employees who are eligible for the HFSA, and the same eligibility and same entry rules apply to both, and the HFSA benefit does not exceed two (2) times the salary reduction or, if greater, the salary reduction plus $500); and
2. **The COBRA premium equals or exceeds the HFSA benefit**: For the Plan Year in which the Qualifying Event occurs, the maximum amount the Qualified Beneficiary could be required to pay for a full year of HFSA coverage equals or exceeds the maximum benefit available to the Qualified Beneficiary for the Plan Year.

Individuals will be eligible for COBRA continuation coverage only if they have a positive HFSA Account balance at the time of a Qualifying Event (taking into account all claims submitted before the date of the Qualifying Event). Such individuals will be notified if eligible for COBRA continuation coverage. If COBRA continuation coverage is elected, it will be available only for the Plan Year in which the

Qualifying Event occurs; such COBRA continuation coverage for the HFSA will cease at the end of the Plan Year and cannot be continued for the next Plan Year.

(e) If a Participant elects not to participate in the HFSA, they may later elect to participate during the Annual Enrollment Period, effective as of the following July 1, or on account of a Change in Status as described in Chapter 4.

## 8.03 Establishing an Account; Payment of Expenses

The Administrator will establish and maintain a HFSA Account for each Participant hereunder. From amounts credited to a Participant's HFSA Account during a Plan Year, there shall be paid from time to time reimbursement of Medical Expenses incurred by the Participant, their Spouse, and/or their other Dependents during the Plan Year.

## 8.04 Benefits

(a) Upon becoming eligible, each Participant may elect to participate in the HFSA by completing a Benefit Election Form to reduce their salary in the first two pay periods of each month and to have the amount of the salary reduction contributed to a HFSA Account on such Participant's behalf. The Benefit Election Form shall be filed with the Administrator prior to the date the Participant is enrolled in the HFSA. Such election may not reduce the Participant's salary by more than $3,200, as indexed under the Code, during a Plan Year. The minimum election for a salary reduction is $120.

(b) Reimbursements shall be made to the Participant for Medical Expenses incurred by the Participant or their Dependents during the Plan Year for which the Participant's election is effective. Reimbursement for such Medical Expenses incurred in any Plan Year may be received up to the annual dollar amount elected by the Participant in their Benefit Election Form, but not exceeding $3,200, as indexed.

(c) A Participant who terminates participation prior to the end of a Plan Year shall have the right to submit claims for reimbursement for Medical Expenses incurred through the day on which the Participant terminates employment or ceases to be an Eligible Employee at any time until 90 days following the end of the Plan Year, subject to the provisions of Subsection 8.02(d).

## 8.05 Forfeiture

(a) Participants in this HFSA are ineligible to receive any reimbursement under this Chapter except as reimbursement for Medical Expenses and shall not receive any funds which may remain in their HFSA Accounts after reimbursement for all Medical Expenses has been made. Except as provided in subsection (b) of this Section 8.05, any unused funds remaining in HFSA Accounts at the end of a Plan Year may not be carried over to a subsequent Plan Year, shall not be available to the Participants in any other form or manner, and the Participants shall forfeit all rights with respect to the unused funds. Such forfeited funds shall be applied to the costs of administering the HFSA.

(b) A Participant may carry over to the following Plan Year an amount equal to the lesser of (i) any unused amounts from the immediately preceding Plan Year; or (ii) $640 (as indexed). For this purpose, "unused amounts from the immediately preceding Plan Year" means the amount of money greater than or equal to $50 remaining after Medical Expenses have been reimbursed at the end of the HFSA's run-out period, if any, for the Plan Year. Amounts that are carried over can be used only to pay or reimburse Medical Expenses as described in the applicable Related Document. Unused amounts may not be cashed out or converted to another type of taxable or non-taxable account. Reimbursements of all claims for Medical Expenses that are incurred in the current Plan Year are reimbursed first from unused amounts credited for the current Plan Year. Any unused amount remaining in a Participant's HFSA as of termination of employment is forfeited unless the Participant elects COBRA continuation coverage with respect to the HFSA.

(c) A Participant may receive reimbursements for Medical Expenses, but only to the extent that the Participant is not reimbursed (or entitled to reimbursement) for the Medical Expense through any insurance or otherwise.

## 8.06 Funding

Funding for participation in the HFSA is as described in Chapter 5. It is intended that the HFSA Accounts authorized under this Chapter be funded by funds made available pursuant to a Salary Reduction Agreement affirmed by the Participant. However, if, at the time reimbursement is payable to a Participant, the Medical Expenses exceed the amount of funds available in the Participant's HFSA Account from such sources, the City will fund the HFSA Account in an amount necessary to make up the difference between such available funds and the amount required to reimburse the Participant for their Medical Expenses.

The maximum funding to be provided by the City under this Subsection in any Plan Year shall be $3,200 (as indexed), minus the sum of any funds available in the HFSA Account and the amount of any reimbursement previously received by the Participant for Medical Expenses incurred during the Plan Year.

## 8.07 Claims Procedure

(a) In order to obtain reimbursement for Medical Expenses, a Participant shall submit an application in writing or as otherwise allowed by the Administrator or designated Third Party Administrator in such form and in such detail as the Administrator or designated Third Party Administrator may prescribe, no later than the end of three (3) months following the end of the Plan Year, with the following information:

1. The amount, date, and nature of the Medical Expense;
2. The name of the person, organization, or entity to which the Medical Expense was or is to be paid;
3. Such other information as the Administrator or designated Third Party Administrator may from time to time require; and
4. The name of the person for whom Medical Expenses were incurred and, if such person is not the Participant requesting reimbursement, the relationship of such person to the Participant and that such person is a Dependent of such Participant.

(b) Such applications shall be accompanied by bills, invoices, receipts, cancelled checks, or other statements showing the amount of such Medical Expenses. The Participant must provide a written statement from an independent third party verifying the Medical Expenses incurred and the amount of such Medical Expenses and must verify in writing that the Medical Expenses have not been reimbursed and are not reimbursable under any other health plan.

(c) The Participant shall be reimbursed from the Participant's HFSA Account for Medical Expenses incurred during the Plan Year for which the Participant submits documentation in accordance with this Chapter. Medical Expenses will be treated as having been incurred when the care is provided, and not when the Participant is formally billed, charged for, or pays for the Medical Expenses. Medical Expenses that were incurred before the Effective Date or before the date the Participant was enrolled in the HFSA will not be reimbursed. The Administrator or Third Party Administrator may, at its option, pay a Medical Expense directly to the medical care provider in lieu of reimbursing the Participant.

(d) Requests for reimbursement should normally be processed within 30 days of the receipt of the claim. Where additional information is required to process the claim or where no benefit is payable, a written notice/explanation shall be sent to the Claimant within 30 days of claim filing. The eligibility of all claims shall be determined within 60 days of the receipt of proper documentation. The decision of the Administrator or designated Third Party Administrator regarding claim eligibility shall be final.

(e) Notwithstanding the above, claims and appeals for reimbursement from the HFSA Accounts shall be subject to and administered according to the provisions established by the Third Party Administrator.

# Chapter 9.
# Health Plan Benefits

## 9.01 General

The Health Plan Benefits are a variety of insured and self-insured medical (including prescription medication), dental, and vision Benefits. The terms and conditions of coverage and Health Plan Benefits shall be as set forth from time to time in the applicable Related Documents governing the applicable Component Plans.

## 9.02 Coordination of Benefits ("COB")

(a) A Participant and/or Dependent may be covered under more than one health care plan. For example, a husband and wife/Domestic Partner both work and may be covered under a medical, dental and/or vision plan at his and her places of employment. If each individual covers the other and/or their children, stepchildren, or Domestic Partner's children, there might be questions as to which plan should pay what amount in the event of illness or injury.

(b) Coordination of Benefits is a method of determining the amount that each plan should pay when there is coverage under two or more health care plans.

1. For purposes of COB, plan includes:

    a. Individual and group insurance contracts and group-type contracts;
    b. HMO (Health Maintenance Organization) coverage;
    c. Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
    d. Medical care components of group long-term care contracts, such as skilled nursing care;
    e. Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law;
    f. Other arrangements of insured or self-insured group or group-type coverage; or
    g. Any individual automobile no-fault insurance plan.

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

    a. Hospital indemnity coverage or other fixed indemnity coverage;
    b. Accident-only coverage;
    c. Specified disease or specified accident coverage;
    d. School accident coverage;
    e. Benefits for non-medical components of group long-term care policies;
    f. Long-term disability benefits;
    g. Medicare supplement policies;
    h. Medicaid policies; or
    i. Coverage under other federal governmental plans, unless permitted by law.

3. 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.

(c) For purposes of COB, the following definitions apply:

1. An "Allowable Expense" shall mean 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.

2. The following are examples of expenses that are not Allowable Expenses:

    a. The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the plans provides coverage for private hospital room expenses;
    b. The amount of the reduction by the primary plan because a 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;
    c. 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;
    d. 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;
    e. 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; or
    f. 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 Code Section 223, 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 Code Section 223(c)(2)(C).

3. "Complying Plan" is a plan that complies with these COB rules.
4. "Non-complying Plan" is a plan that does not comply with these COB rules.
5. "Claim" means a request that benefits of a plan be provided or paid.
6. "Claimant" means the enrollee for whom the Claim is made.
7. "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.
8. "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 has contracted with or is 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.

9. "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.

## 9.03 Coordination of Benefit – Payment of Claims

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.

(a) 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.

(b) 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.

(c) 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 Claimant uses an out-of-network provider, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

(d) 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:

1. If this Plan is primary, it will provide its benefits first.
2. 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.
3. If the Non-complying Plan reduces its benefits so that the Claimant receives less in benefits than they 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 the Third Party Administrator 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 Claimant against the Non-complying Plan.

(e) **Order of Claim Payments for Claimants**: 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:
    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 outlined below. (This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.)
    d. The plan covering the Custodial Parent;
    e. The plan covering the Spouse or Domestic Partner of the Custodial Parent;
    f. The plan covering the non-Custodial Parent; and then
    g. The plan covering the Spouse or Domestic Partner of the non-Custodial Parent.
4. **Dependent Child Covered by Individual Other than Parent**: For a Dependent child covered under more than one plan of 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.
9. **Other**. Where part of a plan coordinates benefits and a part does not, each part will be treated as a separate plan.

(f) **Effect of COB on City Plan Benefits**: 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.

(g) **Third Party Administrator's Right To Collect and Release Needed Information**: Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other plans. The Third Party Administrator 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. The Third Party Administrator need not tell, or get the consent of, any person to do this. Each Claimant under this Plan must give the Third Party Administrator any facts it needs to apply those rules and determine benefits payable.

(h) **Facility of Payment**: If another plan makes payments this Plan should have made under this COB provision, the Plan can reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under this Plan, and the Plan will be released from liability to the Claimant 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.

(i) **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. Where the Plan does not have to pay its full benefits because of COB, the savings will be credited to the Claimant for the Plan Year. These savings are then applied to any unpaid Allowable Expense during the Plan Year.

## 9.04 Leave Provisions

(a) The Component Plans for Health Plan Benefits comply with the health continuation provisions of the FMLA, Oregon Family Leave Act ("OFLA"), USERRA, and the applicable City leave ordinances.

(b) The Participant and his/her enrolled Dependents will remain eligible to be covered under the Plan during an approved FMLA leave as outlined in Section 3.07, City Administrative Rule 6.05, or as otherwise determined by collective bargaining agreement.

(c) If a Participant leaves their job to perform military service, they have the right to elect to continue their existing Health Plan Benefits coverage and coverage for enrolled Dependents for up to 24 months while in the military, as provided for under USERRA. If the Participant does not elect to continue coverage during military service, the Participant has the right to be reinstated in the Health Plan Benefits upon reemployment, generally without any waiting periods or exclusions, except for service-connected illnesses or injuries.

(d) The City will pay the cost of continuing to provide Health Plan Benefit coverage under USERRA for up to 24 months for the Dependents of Participants 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 Participant was at work. The Dependents of Participants who have dual coverage through the City or a Spouse/Domestic Partner's employer are not eligible for this benefit. For Participants on military leave less than 31 days, their City-paid coverage will continue.

(e) Notwithstanding the above, the continuation of Benefits during any other personal leave of absence shall be as described in the Related Documents, the City's Administrative Rules, or as otherwise determined by collective bargaining agreement.

## 9.05 Continuation of Benefit Coverage

Under certain conditions, Participants and/or their eligible Dependents may continue Health Plan Benefits when such coverage would otherwise terminate. The types of continuation coverage may include: Worker's Compensation/Industrial Accident Leave; Survivor Benefits, Legally Separated, Divorced, or Widowed Spouses Over 55 Years of Age; Disabled Employees; Retirees; COBRA Qualified Beneficiaries; and/or other temporary state and federal continuation programs. The continuation provisions associated with applicable ongoing continuation provisions are described below:

(a) **Continuation of coverage during Worker's Compensation or Industrial Accident Leave**: Health Plan Benefits may continue during a Worker's Compensation or Industrial Accident Leave, the applicable Labor Agreement, and/or Administrative Rule 6.13. Participants must continue to pay any applicable Employee Contributions in order to continue coverage, even while in an unpaid status.

(b) **Survivor Benefits for Nonrepresented FPDR Members:** The City shall provide to the spouse and dependent children of a nonrepresented FPDR Member, who dies before retirement or separation as a result of an illness or injury that FPDR has determined qualifies as service-connected or occupational under subsection 5-306(a), (b), (c), or (d) of the FPDR Plan, the same medical, dental and vision benefit plans available to Active Members. The City agrees to provide coverage for the spouse and dependent children until the spouse remarries, reaches age sixty-five, becomes Medicare eligible, or the employee would have retired with 30 years' service, whichever comes first, and for each dependent child to the age which meets the eligibility requirements of the health plan in which they are enrolled.

(c) **Legally Separated, Divorced, or Widowed Spouses Over 55 Years of Age**: A surviving Spouse of a deceased Participant or a legally separated or divorced Spouse age 55 or over, and their eligible Dependents, may continue Health Plan Benefits coverage until (i) Medicare eligibility for the surviving, divorced, or legally separated Spouse, and (ii) until the Dependents reach the maximum eligibility age limits under the Plan in the same manner as provided under Oregon law. The surviving, legally separated, or divorced Spouse and any Dependents whose coverage under the Plan otherwise would terminate because of the death of, or legal separation/divorce from, the Participant, may continue coverage if the Spouse is 55 years of age or older at the time of the death, legal separation, or divorce. Coverage will be subject to all other regulations governing COBRA administration but is not considered a second Qualifying Event.

Notwithstanding the above, for self-insured medical and dental Benefits, continuation will end on the earliest of any of the following events: (i) failure to pay premiums when due, including any grace period allowed by the Plan; (ii) the date the medical or dental Benefit terminates, unless a different group policy is made available to the covered individual; (iii) the date the covered individual becomes insured

under any other group health plan; (iv) the date the covered individual remarries or registers another domestic partnership; or (v) the date the covered individual becomes eligible for Medicare.

(d) **Disabled Employee Continuation**: City disabled Participants and their eligible Dependents may continue Health Plan Benefits by self-paying the monthly cost of the Benefits. Where collective bargaining agreement language deviates from this Plan, the collective bargaining agreement language will be the governing language.

1. **Eligibility**: In order to be eligible for disabled Participant continuation of coverage, the Participant must meet the following conditions:
   a. Be eligible to receive disability benefits from the Oregon Public Employees Retirement System ("PERS") system, the Oregon Public Service Retirement Plan ("OPSRP"), or the Fire and Police Disability and Retirement Fund ("FPDR"); and
   b. Must have been covered under the active Plan on a City-paid basis in the month preceding disability.
2. **PERS Disabled Participant Continuing Eligibility**: Disabled Participants not eligible for Medicare and their non-Medicare eligible, covered Dependents are able to continue coverage under the Plan by self-paying the monthly cost of the Health Plan Benefits by the due date set by the Administrator. Once a disabled Participant and/or Dependent becomes eligible for Medicare, they are no longer eligible for the Health Plan Benefits.
3. **Fire and Police Disability and Retirement Fund Disabled Continuing Eligibility**: Disabled Participants not eligible for Medicare and their non-Medicare eligible Dependents are able to continue coverage under the Plan by self-paying the monthly cost of the Health Plan Benefits by the due date set by the Administrator. Once a disabled Participant and/or Dependent becomes eligible for Medicare, they are no longer eligible for the Health Plan Benefits.

   Fire fighters and police officers who reach age 65 and establish through formal documentation that they are not entitled to Medicare through any means are eligible to continue coverage under the Plan by self-paying the monthly cost of the Health Plan Benefits, except dental. If a Participant becomes entitled to Medicare at a later date based on their Spouses' or ex-Spouse's Social Security eligibility, they will no longer be eligible for the Health Plan Benefits.
4. **Termination of Coverage**: If disabled Participants elect to terminate coverage under the Plan prior to age 65, they can only re-enroll in the Health Plan Benefits in which they were previously enrolled if they are not Medicare-eligible and they maintain continuous medical and dental group (employer sponsored) coverage between the time they leave the Plan to the date they want to re-enroll. Participants who purchase coverage from the City may move to a Healthcare Exchange plan one time prior to age 65. To re-enroll in the Health Plan Benefits, they must provide proof of continuous medical coverage. An independent election for dental Benefits is not allowed if the Participant continues to maintain other group medical coverage. Written verification from the other employer-sponsored plan will be required.
5. **Coordination with other Continuation Rights**: Retiree or disabled Participant continuation rights run concurrently with COBRA and Workers Compensation continuation rights. In the case of disability, the Administrator can approve eligibility if the disabled Participant has shown continued coverage on a self-pay basis. Where collective bargaining agreement language deviates from this Plan, the collective bargaining agreement language will be the governing language.

(e) **Retirees**: City retirees and their eligible Dependents may continue Health Plan Benefits by self-paying the monthly cost of the Benefits on an after-tax basis. Where collective bargaining

agreement language deviates from this Plan, the collective bargaining agreement language will be the governing language.

1. **Eligibility**: In order to be eligible for retiree continuation of coverage, the retired Participant must meet the following conditions:
    a. Be eligible to receive retirement income from the Oregon Public Employees Retirement System ("PERS") system, the Oregon Public Service Retirement Plan ("OPSRP"), or the Fire and Police Disability and Retirement Fund ("FPDR"); and
    b. Must have been covered under the Plan on a City-paid basis in the month preceding retirement.
    c. **Retirees Continuing Eligibility**: Retired Participants not eligible for Medicare and their non-Medicare eligible Dependents are able to continue coverage under the Plan by self-paying the monthly cost of the Health Plan Benefits on an after-tax basis by the due date set by the Administrator. Once a Retired Participant and/or Dependent becomes eligible for Medicare, they are no longer eligible for the Health Plan Benefits.
    d. Fire fighters and police officers who reach age 65 and establish through formal documentation received from the Social Security Administration that they are not entitled to Medicare through any means are eligible to continue coverage under the Plan by self-paying the monthly cost of the Health Plan Benefits on an after-tax basis. If a retired Participant becomes entitled to Medicare at a later date based on their Spouses' or ex-Spouse's Social Security eligibility, they will no longer be eligible for the Health Plan Benefits.
2. **Termination of Coverage**: If retirees elect to terminate coverage under the Plan prior to age 65, they can only re-enroll in the Health Plan Benefits in which they were previously enrolled if they are not Medicare-eligible and they maintain continuous medical and dental group (employer sponsored) coverage between the time they leave the Plan to the date they want to re-enroll. Retirees who purchase coverage from the City can move to a Healthcare Exchange plan one time prior to age 65. To re-enroll in the Health Plan Benefits, they must provide proof of continuous medical coverage. An independent election for dental coverage is not allowed if the retiree continues to maintain other group medical coverage. Written verification from the other employer-sponsored plan will be required.

## 9.06 Continuation of Coverage: "COBRA Provisions"

COBRA requires that the Component Plans for Health Plan Benefits offer Participants and their eligible Dependents ("Qualified Beneficiaries") the opportunity to elect a temporary extension of Health Plan Benefit coverage in certain instances where coverage under the Plan would otherwise end ("Qualifying Events").

Each COBRA Group Health Plan shall provide continuation coverage to Qualified Beneficiaries in the manner and to the extent required by Title XXII of the PHS Act.

There are four group health components to the Plan's COBRA continuation coverage: (i) medical/vision, (ii) dental, (iii) Employee Assistance Program (EAP), and (iv) the Healthcare Flexible Spending Account ("HFSA"). COBRA applies only to these Component Plans and not to any other Benefits offered by the Plan. The Plan provides no greater COBRA rights than what COBRA requires, except as otherwise provided above for Domestic Partners and their children.

## 9.07 Federal Health Insurance Exchange

The federal government has established a health insurance exchange where residents of Oregon and other states can compare plans and access financial assistance to help pay for individual healthcare coverage. For Participants and Dependents whose Health Plan Benefit coverage has been terminated, the exchange provides additional options for coverage other than COBRA.

## 9.08 Washington State Health Insurance Exchange

As required and allowed under the ACA, Washington State has established a health insurance exchange where Washington State residents can compare plans and access financial assistance to help pay for individual healthcare coverage. For Participants and Dependents whose Health Plan Benefit coverage has been terminated, the exchange provides additional options for coverage other than COBRA.

## 9.09 Medical and Behavioral Health Management Services

(a) To assist Participants with their health care needs and to assure that medical treatments are medically necessary, appropriate, and reasonable, the Health Plan Benefits include medical and behavioral health management services in the medical Benefit options. The programs include prior authorization for specialized services, medical review of complex or high cost cases, case management of complex or high cost cases, disease management of assistance for chronic conditions, and wellness services, including maternity care program and diabetes coaching. These services are described in the Related Documents.

(b) **Hospital Bill Audit Program**: If a Participant finds an incorrect charge on an itemized hospital bill after the applicable Third Party Administrator has processed and paid the amount, and the Participant notifies the Third Party Administrator of the billing error as soon as possible, the Participant will receive 50% of any savings realized by the Third Party Administrator on the incorrect charges, with a minimum payment of $25 up to a maximum payment of $500 per inpatient hospital confinement.

## 9.10 Acts of Third Parties

(a) **Third-Party Liability**: In situations in which a third party, including a Participant's or another liability insurer, is responsible for the charges for health care services, the Plan will seek reimbursement to the extent possible for expenses paid. For example, if a Participant is injured in a store, the owner or the owner's insurance carrier may be responsible for payment of the charges for the Participant'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 Coverage section.)

1. **Assumption or Adjudication of Responsibility**: If a third party has accepted financial responsibility or been adjudicated to be liable for all or a portion of the charges for the Participant'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 Participant'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 Participant or the Plan or to be reimbursed from the third party or from Participant’s or another liability insurer. The Plan will not provide services unless the Participant 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 Participant with information regarding the amount of these charges. If the Participant 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 Participant 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 Participant agrees to cooperate in protecting the interest of the Plan under this provision. The Plan can require the Participant to testify for the Plan and to sign and deliver all legal papers necessary to secure the Participant's and the Plan's rights. If the Plan asks the Participant to sign an agreement to reimburse the Plan and to hold the proceeds of any recovery in trust for the Plan, they must do so. The Participant must agree to sign a subrogation agreement that allows the Plan to bring an action in the Participant'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 Participant fails to complete required paperwork after the payment of claims, the Plan will issue a retroactive denial of claims, and the Participant 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 Participant 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.

(b) **Motor Vehicle Coverage**

1. 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 Participant must give the Plan information about any personal injury protection insurance available to the Participant or covered Dependents.
2. 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 Participant makes from a claim or legal action related to the motor vehicle injury. This includes claims the Participant makes against the Participant's own uninsured or under-insured motorist coverage. The Participant 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:

    a. The Plan may use an inter-insurer reimbursement proceeding to obtain direct reimbursement from the motor vehicle liability insurer.

b. 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 Participant 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 Participant 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 the Plan has furnished benefits, less its portion of expenses, costs, and attorney fees incurred by the Participant in connection with recovery of the amount of the lien. The Participant must include as damages in the claim or legal action the charges for services for which the Plan furnished benefits.

c. If the Plan elects not to file a lien, it is entitled to the proceeds of any settlement or judgment the Participant 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 Participant in connection with the Participant's recovery. The Participant 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 Participant agrees to cooperate in protecting the Plan's interest under this provision.

(c) If the Plan requests in writing that the Participant take such action necessary or appropriate to recover benefits provided for the Participant, the Participant must agree to do so. The Plan can require the Participant to testify for the Plan and to sign and deliver all legal papers necessary to secure the Participant’s and the Plan’s rights. For example, the Plan can require a Participant to sign a subrogation agreement that allows the Plan to bring an action in the Participant’s name. The Plan will also be reimbursed out of the recovery made from this action for the Participant’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.

(d) The Plan’s first lien rights will not be reduced because of the Participant’s own negligence, the Participant not being made whole, or due to attorney fees or costs.

(e) The subrogation and right of recovery provisions apply to any funds recovered from a third party on behalf of an Employee’s minor covered Dependent, the estate of any Participant, or on behalf of any incapacitated person.

## 9.11 Extension of Hospitalization Benefits

The Plan’s self-insured Health Plan Benefits (CityCore, CityNet, CityHD, CityHDP, and CityBasic Medical Plan) cover the hospitalization for a terminated Participant or covered Dependent when such individual is hospitalized at the time of termination. The coverage extends for the duration of the confinement, but not for any subsequent related hospitalizations.

## 9.12 Federal Newborns’ and Mothers’ Health Protection Act of 1996

The Plan is administered in accordance with the Newborns’ and Mothers’ Health Protection Act of 1996 and provides that 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 and a hospital stay following a cesarean section may generally not be limited to less than 96 hours for both the mother and newborn child.

## 9.13 Federal Women's Health and Cancer Rights Act of 1998

The Plan is administered in accordance with the federal Women's Health and Cancer Rights Act of 1998 and provides benefits for mastectomy-related services including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and treatment of complications resulting from a mastectomy (including lymphedema).

## 9.14 Genetic Information and Nondiscrimination Act of 2008 ("GINA")

The Plan shall comply with the provisions of GINA and, accordingly, shall not, unless expressly permitted by GINA or corresponding regulations, restrict enrollment or adjust premiums based on genetic information or require or request genetic information or genetic testing prior to, or in connection with, enrollment.

## 9.15 Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

The Plan is administered in accordance with the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008.

## 9.16 ACA Group Market (Insurance) Reforms

The Plan shall comply with the provisions of the ACA group market (insurance) reforms. A medical Health Plan Benefit that is not exempt or an excepted benefit, as defined in Sections 2722 and 2763 of PHSA, shall comply with the applicable group market (insurance) reforms that apply to medical Health Plan Benefits under the ACA. The medical Health Plan Benefits offered by the City are not grandfathered health plans. Accordingly, the Plan will comply with the following list of group market (insurance) reforms and such compliance will occur not earlier than the time required.

The ACA group market (insurance) reforms that apply to all medical Health Plan Benefits that are not exempt or excepted benefits under Sections 2722 and 2763 of PHSA are:

(1) Prohibition of preexisting condition exclusions under PHSA 2704;

(2) Prohibiting discrimination against participants and beneficiaries based on a health factor under PHSA 2705;

(3) Prohibition on waiting periods that exceed 90 days under PHSA 2708;

(4) Prohibition on lifetime or annual dollar limits on essential health benefits under PHSA 2711;

(5) Prohibition on rescissions under PHSA 2712;

(6) Eligibility of children until at least age 26 under PHSA 2714;

(7) Summary of benefits and coverage and uniform glossary under PHSA 2715; and

(8) Solely with respect to insured medical Health Plan Benefits, the medical loss ratio requirements under PHSA 2718;

(9) Accommodations in connection with coverage of preventive health services under PHSA 2713;

(10) Internal claims and appeals and external review process under PHSA 2719;

(11) Consumer patient protections (choice of health care professional and coverage of emergency services) under PHSA 2719A;

(12) Provider nondiscrimination under PHSA 2706(a);

(13) Limitations on cost sharing (i.e., the out-of-pocket expense maximum requirements) under PHSA 2707(b);

(14) Coverage for individuals participating in approved clinical trials under PHSA 2709; and

(15) Transparency in coverage provisions, including the internet-based price comparison tool under PHSA 2715A.

While not referenced in this Plan document, the medical Health Plan Benefits that are subject to the group market (insurance) reforms will comply with respect to both regulatory and sub-regulatory guidance. To the extent that the U.S. Department of Labor, Internal Revenue Service, or Department of Health and Human Services, as applicable, implements additional group market (insurance) reforms required by the Affordable Care Act, the Plan shall comply to the extent necessary.

## 9.17 Families First Coronavirus Response Act and the Coronavirus Aid, Relief, and Economic Security Act (ended May 11, 2023)

A group health plan option that is not exempt or an excepted benefit, as defined in Sections 2722 and 2763 of PHSA, shall cover testing to determine if a Participant has been infected with SARS-CoV-2 or the diagnosis of COVID-19, including tests that detect antibodies against SARS-CoV-2 virus, at no cost to the Participant, as determined by the Participant's attending healthcare provider to the extent required by the Families First Coronavirus Response Act (FFCRA) as amended by the Coronavirus Aid, Relief, and Economic Security (CARES) Act, during the Federal Public Health Emergency Period as declared by the Department of Health and Human Services (HHS). Furthermore, on or after January 15, 2022, over-the-counter tests to determine infection with SARS-CoV-2 will be covered at no cost to the Participant during the Federal Public Health Emergency Period.

In accordance with Section 3203 of the CARES Act and related guidance and effective as of 15 business days (not including weekends or holidays) after the date the USPSTF or ACIP makes an applicable recommendation regarding a qualifying coronavirus preventive service, a group health plan option that is not exempt or an excepted benefit, as defined in Sections 2722 and 2763 of PHSA shall cover at no cost all COVID-19 vaccines that have received a recommendation that makes them a qualifying coronavirus preventive service with respect to the individual involved, and their administration in accordance with applicable guidance, in- and out-of-network until the end of the Federal Public Health

Emergency Period. The vaccine will be covered in-network at no cost thereafter, to the extent that it continues to be deemed a “preventive health service” as defined by the ACA under PHSA 2713.

## 9.18 Consolidated Appropriations Act, 2021

a) Provider directory information. A directory of providers is available online from the insurer and/or the Third Party Administrator, or at a participant’s request, the insurer and/or the Third Party Administrator will send participants a directory of network providers free of charge. Participants generally should receive a response within one (1) business day of a telephonic request. The Plan will send participants a directory of network providers free of charge. The insurers and Third Party Administrators strive to keep this information as current as possible; however, a provider’s network status may change. If a participant receives a covered item or service from a non-network provider and were informed incorrectly prior to receipt of the item or service that the provider was a network provider, either through a database, provider directory, or in a response to your request for such information (via telephone, electronic, web-based or internet-based means), participants will not be responsible for paying a cost sharing amount that is higher than the amount that would have applied if the participant had seen a network provider. Further, any cost-sharing amounts paid by the participant will count towards their in-network deductible and out-of-pocket maximum.

b) Continuity of care benefits. If a participant is currently receiving treatment for covered health services from a provider whose network status changes from in-network to out-of-network during such course of treatment due to expiration or nonrenewal of the provider's contract, the participant may be eligible to request continued care from their current provider at the network benefit level for specified conditions (for example, undergoing a course of treatment for a serious and complex condition, in institutional or inpatient care, scheduled for non-elective surgery, pregnant, or terminally ill) and may last up to the earlier of 90 days or until the participant is no longer a continuing care patient. (This provision does not apply to provider contract terminations for failure to meet applicable quality standards or for fraud.) If a participant would like help finding out if they are eligible for continuity of care benefits, they should call the telephone number on their ID card.

c) No Surprises Act and balance billing. When a participant receives emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgery center, they are protected from balance billing by federal law. For designated network benefits and network benefits for covered health services provided by a network provider, participants are not responsible for any difference between eligible expenses and the amount the provider bills (other than their usual cost sharing obligations). There are certain situations where participants may consent to be balance billed, but such consent must be in writing and obtained in advance of services performed. Participants are not responsible, and the non-network provider may not bill them, for amounts in excess of their copayment, coinsurance, or deductible, for the following:

1. For covered health services that are ancillary services received at certain network facilities on a non-emergency basis from non-network providers;
2. For covered health services that are non-ancillary services received at certain network facilities on a non-emergency basis from non-network providers who have not satisfied the notice and consent criteria or for unforeseen or urgent medical needs that arise at the time a non-ancillary service is provided for which notice and consent has been satisfied;
3. For covered health services that are emergency health services provided by a non-network provider;
4. For covered health services that are Air Ambulance services provided by a non-network provider.

Participants should call the number on their ID card for assistance if they are billed for amounts in excess of their applicable cost sharing. For more information on these balance billing protections, please visit www.cms.gov/nosurprises.

## 9.19 National Medical Support Notice

The Plan shall provide Health Plan Benefits in accordance with the applicable requirements of any national medical support notice, within the meaning of Section 401(e) of the Child Support Performance and Incentive Act of 1998 (CSPIA), received by the Plan, in accordance with such written procedures as shall be established by the Administrator. Except to the extent permitted by CSPIA Section 401(e)(3), no qualified medical child support order shall require the Plan to provide any type or form of Benefit or option not otherwise provided by the Plan.

## 9.20 Health Care Outcomes

The adoption, establishment, and operation of the Plan, including, without limitation, any determination made by the Administrator and the payment for Benefits by the City, shall not constitute any express or implied representation, warranty, or covenant by or on behalf of the Plan, the Administrator, or the City, either jointly or severally, with respect to the outcome of any Health Plan Benefit provided or rendered to any Participant or Dependent.

## 9.21 Responsibility for Health Care

The provisions of the Plan shall not be construed to limit a Participant or Dependent with regard to the choice of health care, such choices including, but not limited to, the kind, type, duration, amount, or results thereof. Obtaining health care and determining which health care to utilize shall be at the sole discretion of the Participant or Dependent and shall not be construed, interpreted, or deemed as resulting from the Plan. Each Participant or Dependent shall be solely responsible for deciding the health care they receive and shall make such a decision as to their health care independent of any determinations to whether reimbursement will or will not be made under the Plan for a health care expense. The determination of whether or not a health care expense is medically necessary is made solely for purposes of determining whether payments will be made under the Plan and is not intended to be advice to a Participant or Dependent concerning their health care. Each Participant or Dependent shall be solely responsible for selecting the health care professionals, hospitals, and other providers who will provide health care to him or her.

# Chapter 10.
# HIPAA Privacy

## 10.01 Health Insurance Portability and Accountability Act

(a) The City (the "Plan Sponsor") sponsors HIPAA Group Health Plans. Employees of the Benefit Office have access to the individually identifiable health information of individuals for administrative functions of the HIPAA Group Health Plans. When this health information is provided from the HIPAA Group Health Plans to the Plan Sponsor, it is Protected Health Information ("PHI"). HIPAA restricts the HIPAA Group Health Plans' and Plan Sponsor's ability to use and disclose PHI.

(b) The Benefits of the Plan that are not subject to HIPAA shall not be subject to this Chapter.

(c) The Plan Sponsor shall have access to PHI from the HIPAA Group Health Plans only as permitted under this Chapter or as otherwise required or permitted by HIPAA.

(d) Protected Health Information (PHI) shall mean information that is created or received by the HIPAA Group Health Plans and relates to the past, present, or future physical or mental health or condition of the individual; the provisions of health care to an individual; or the past, present, or future payment for the provision of health care to an individual, and that identifies the individual or for which there is a reasonable basis to believe the information can be used to identify the individual. PHI includes information of persons living or deceased.

## 10.02 Permitted Disclosure of Enrollment/Disenrollment Information

The HIPAA Group Health Plans shall disclose to the Plan Sponsor information on whether the individual is participating in the HIPAA Group Health Plans.

## 10.03 Permitted Uses and Disclosure of Summary Health Information

(a) "Summary Health Information" shall mean information that summarizes the claims history, claims expenses, or type of claims experienced by individuals for whom a Plan Sponsor has provided Health Plan Benefits under the HIPAA Group Health Plans. The summary will only identify the general geographical location of the individual and will not include any information by which a particular individual can be identified.

(b) The HIPAA Group Health Plans may disclose Summary Health Information to the Plan Sponsor, provided the Plan Sponsor requests the Summary Health Information for the purpose of (i) obtaining premium bids from the HIPAA Group Health Plans for providing health insurance coverage, or (ii) modifying, amending, or terminating the HIPAA Group Health Plans.

## 10.04 Permitted and Required Uses and Disclosure of PHI

(a) Unless otherwise permitted by law, and subject to the conditions of disclosure described in Subsection 10.05 and to obtaining written certification pursuant to Section 10.07, the HIPAA Group Health Plans may disclose PHI to the Plan Sponsor, provided the Plan Sponsor uses or discloses such PHI only for plan administration purposes. "Plan administration purposes" shall mean administration functions performed by the Plan Sponsor on behalf of the HIPAA Group Health Plans, such as quality assurance, claims processing, auditing, and monitoring. Plan administration functions do not include functions performed by the Plan Sponsor in connection with any other benefit of the Plan Sponsor, and they do not include any employment-related functions. In no event shall the Plan Sponsor be permitted to use or disclose PHI in a manner that is inconsistent with 45 CFR §164.504(f).

(b) The HIPAA Group Health Plans may use or disclose an individual's PHI without the consent or authorization of the individual for purposes of payment, health care operations, and any other purpose for which use or disclosure is permitted or required under the HIPAA Privacy Rule.

(c) Notwithstanding anything herein to the contrary, the HIPAA Group Health Plans may disclose PHI to the Plan Sponsor in accordance with an individual's authorization or as otherwise permitted or required by the HIPAA Privacy Rule.

(d) The Plan Sponsor shall report to the HIPAA Group Health Plans any uses and disclosures of PHI of which it becomes aware that are inconsistent with uses and disclosures provided for under this Chapter.

## 10.05 Conditions of Disclosure for Plan Administration Purposes

The Plan Sponsor agrees, that with respect to any PHI (other than enrollment/disenrollment information and Summary Health Information, which are not subject to these restrictions) disclosed to it by the HIPAA Group Health Plans, the Plan Sponsor shall:

(a) Not use or further disclose the PHI other than as permitted or required by the HIPAA Group Health Plans or as required by law.

(b) Ensure that any agent, including a subcontractor, to whom it provides PHI received from the HIPAA Group Health Plans, agrees to the same restrictions and conditions that apply to the Plan Sponsor with respect to PHI.

(c) Not use or disclose the PHI for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor.

(d) Make available PHI to comply with HIPAA's right to access in accordance with 45 CFR §164.524.

(e) Make available PHI for amendment and incorporate any amendments to PHI in accordance with 45 CFR §164.526.

(f) Make available the information required to provide and accounting of disclosure in accordance with 45 CFR §164.528.

(g) Make its internal practices, books, and records relating to the use and disclosure of PHI received from the HIPAA Group Health Plans available to the Secretary of the U.S. Department of Health and Human Services for purposes of determining compliance by the HIPAA Group Health Plans with HIPAA's privacy requirements.

(h) Report to the Plan any uses and disclosures of PHI of which it becomes aware that are inconsistent with uses and disclosures provided for under this Chapter.

(i) If feasible, return or destroy all PHI received from the HIPAA Group Health Plans that the Plan Sponsor still maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made; except that, if such return or destruction is not feasible, the Plan Sponsor shall limit further uses or disclosures of the PHI to those purposes that make the return or destruction of the PHI infeasible.

(j) Ensure that the adequate separation between HIPAA Group Health Plans and Plan Sponsor (i.e., the "firewall"), required in 45 CFR §504(f)(2)(iii), is satisfied.

## 10.06 Adequate Separation Between HIPAA Group Health Plans and Plan Sponsor

The Plan Sponsor shall allow the following City Employees access to PHI: Benefit Office Employees, Payroll Employees, the Bureau of Technical Services Employees that provide technical support for the Participant database, the City Attorney's Office for the provision of legal advice and representation as to any matter or issue regarding the HIPAA Group Health Plans or Participants, and the Council as may be required by law or administrative rule to administer, authorize, and approve issues related to the HIPAA Group Health Plans. No other persons shall have access to PHI. These specified classes of Employees shall only have access to and use PHI to the extent necessary to perform the plan administration functions that the Plan Sponsor performs for the HIPAA Group Health Plans. In the event that any of these specified classes of Employees do not comply with the provisions of this Chapter, that Employee shall be subject to disciplinary action up to and including discharge by the Plan Sponsor for non-compliance.

## 10.07 Certification of Plan Sponsor

The HIPAA Group Health Plans shall disclose PHI to the Plan Sponsor only upon the receipt of a certification by the Plan Sponsor that the HIPAA Group Health Plans have been amended to incorporate the provisions of 45 CFR §164.504(f)(2)(ii) and that the Plan Sponsor agrees to the conditions of disclosure set forth in Section 10.05 above.

## 10.08 HIPAA Security Rule

This Section is included in the HIPAA Group Health Plans pursuant to the Standards for the Security of Electronic PHI as set forth in 45 CFR Parts 160 and 162 and Part 164, Subpart C (the "Security Standards"). The HIPAA Group Health Plans shall comply with the following provisions:

(a) The Plan Sponsor shall implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the Electronic PHI that it creates, receives, maintains, or transmits on behalf of the HIPAA Group Health Plans, consistent with the requirements of the Security Standards.

(b) The Plan Sponsor shall ensure that the adequate separation requirement set forth in 45 CFR §164.504(f)(2)(iii) is supported by reasonable and appropriate security measures, consistent with the requirements of the Security Standards.

(c) The Plan Sponsor shall take reasonable steps to ensure that any agent, including a subcontractor, to whom it provides the Electronic PHI agrees to implement reasonable and appropriate security measures to protect such information.

(d) The Plan Sponsor shall report to the HIPAA Group Health Plans any security incident, as defined in the HIPAA Security Standards, of which it becomes aware.

## 10.09 Health Information Technology for Economic and Clinical Health Act

The Plan Sponsor shall comply with the breach notification provisions as set forth in the Health Information Technology for Economic and Clinical Health (HITECH) Act and addressed under Notification in the Case of Breach of Unsecured Protected Health Information at 45 CFR Part 164, Subpart D.

## 10.10 Nondisclosure of Genetic Information for Underwriting Purposes

The Plan shall not use or disclose PHI that is Genetic Information (as set forth in 45 CFR §160.103) for underwriting purposes, as defined in 45 CFR §164.502(a)(5)(i).

## 10.11 HIPAA Notice of Privacy Practices

The HIPAA Group Health Plans shall distribute a Notice of Privacy Practices pursuant to HIPAA and to relevant administrative rules.

# Chapter 11.
# Amendment and Termination

## 11.01 Amendment and Termination

The Plan was established with the bona fide intention that it will be continued indefinitely, but the City has no obligation to maintain the Plan or any Component Plan and reserves the right to amend, change, terminate, or cancel the Plan described herein or any of its Component Plans and provisions, in any manner at any time, subject to the City's obligations under the Public Employees Collective Bargaining Act; provided, however, that no amendment, change, or termination shall reduce or eliminate benefits retroactively. If the Plan is amended or terminated, it will not affect coverage for services provided prior to the effective date of the change.

## 11.02 Authority of Administrator

The Administrator shall have authority to modify or amend the Plan from time to time, as may be necessary to enable the Plan to meet any applicable requirements under the Code and to implement any Component Plans.

## 11.03 Effect of Termination

Upon complete or partial termination of the Plan, the Administrator shall provide for the payment of benefits to each Participant with respect to whom benefits are payable on the date of termination and for the payment of all expenses and charges properly payable hereunder and of any payments due to the Third Party Administrator.

# Chapter 12.
# Miscellaneous

## 12.01 Administrator

The Administrator may appoint such agents, counsel, accountants, consultants, and other persons as may be required to assist in administering the Plan. In addition, the Administrator may allocate and delegate their respective responsibilities under the Plan and designate other persons to carry out any of their respective responsibilities under the Plan, and any such allocation, delegation, or designation shall be made by written instrument and in accordance with applicable requirements of law.

## 12.02 Indemnification

The City agrees to indemnify and to defend to the fullest extent permitted by law any Employee or the Plan Administrator performing administrative duties with respect to the Plan against all liabilities, damages costs, and expenses (including reasonable attorneys' fees and amounts paid in settlement of any claims approved by the City) occasioned by any act or omission to act in connection with the Plan.

## 12.03 Insurers

The applicable insurer shall provide Benefits in accordance with the terms and conditions of the applicable fully insured Component Plan. The applicable insurer serves as the final authority to decide all claims and all appeals of Adverse Benefit Determinations under each Component Plan that is insured pursuant to an insurance policy.

## 12.04 Third Party Administrator Responsibilities

The applicable Third Party Administrator shall process, and make the initial determination on, all claims under the applicable self-insured Component Plan in accordance with the Relevant Documents.

## 12.05 Nondiscrimination

Any discretionary acts to be taken under the terms and provisions of the Plan by the Administrator shall be uniform in their nature and in their application to all those similarly situated Participants, and no discretionary acts shall be taken that would be discriminatory under any relevant provisions of the Code.

The Administrator shall have the power to reduce the amount of any pre-tax Employee Contributions or nontaxable Benefits, or otherwise modify or revoke any election, at any time (to the extent permitted under the Code) if the Administrator considers the reduction, modification, or revocation necessary to prevent the Plan from becoming discriminatory within the meaning of any applicable provision of the Code. The Administrator shall determine (in its sole discretion) in which order and to what extent Component Plans shall be affected by the reduction, modification, or revocation.

If the Administrator determines, before or during any Plan Year, that any Component Plan may fail to satisfy for that Plan Year any of the nondiscrimination requirements which may apply to the Component Plan, the Administrator may modify the elections of Participants in accordance with the provisions of the Component Plan.

The Administrator may disaggregate the Plan and any Component Plan into any number of separate plans as it determines is appropriate, solely for purposes of satisfying the nondiscrimination requirements of the Code, to the extent permitted by the Code.

The Administrator shall have authority to take all other reasonable steps it considers necessary or desirable to conform the operation of the Plan to the nondiscrimination requirements of the Code or other applicable law.

## 12.06 Payment

Unless specifically provided to the contrary in the Plan or under the terms of a Related Document, payment of any claim for Benefits will be made to the Participant, Beneficiary, or Qualified Beneficiary (as applicable), unless they have previously authorized, in accordance with applicable Plan terms, the payment to a person rendering services, treatment, or supplies.

If a person entitled to any Benefits dies before all remaining Benefits to which they are entitled have been paid, the Benefits will be paid to the individual's estate.

If a person entitled to any Benefits is a minor, or not competent to give a valid receipt for payment of any Benefit due him or her under the Plan and if no request for payment has been received from a duly appointed guardian or other legally appointed representative of that person, payment may be made directly to the individual or institution that has assumed the custody or the principal support of that person.

When a person entitled to any Benefits is under a legal disability or, in the opinion of the Administrator, is in any way incapacitated so as to be unable to manage his or her financial affairs, the Administrator may, in its discretion, either:

(a) Direct the payment of the Benefits to the person's legal representative or immediate relative, for that person's benefit;

(b) Direct the application of the Benefits for the benefit of the person in such manner as the Administrator considers advisable; or

(c) Hold the payment until a legal representative is appointed.

Notwithstanding any other provision of the Plan, the City or Third Party Administrator may withhold from any payment to be made under the Plan such amount or amounts as may be required for purposes of complying with the tax withholding provisions of the Code or any other applicable law.

Any payment made in accordance with this Section shall be a full and complete discharge of any liability for payment under the Plan.

## 12.07 Complete Statement of Plan

The Plan supersedes all prior plans governing the types of Benefits provided under the Plan. This document, including the Related Documents, contains a complete statement of the terms of the Plan. The right of any person to any Benefit of a type provided under the Plan shall be determined solely in accordance with the terms of the Plan. No other evidence, whether written or oral, shall be taken into account in determining the right of any person to any Benefit of a type provided under the Plan.

Notwithstanding any provision of the Plan, the Related Documents shall apply in all cases. The provisions of the Plan shall be interpreted to apply in conjunction with and in addition to those provisions. In the event of a direct conflict between the provisions of a Related Document and the provisions of the Plan, the provisions of the Plan shall prevail. Where terms and provisions specifically applicable to an individual Related Document are not addressed in the Plan document, the terms and provisions as set forth in such Related Document will govern.

This document, including the Related Documents, legally governs the operation of the Plan.

## 12.08 Plan Records

All Plan records shall be kept on a Plan Year basis.

## 12.09 Plan Interpretation

If, due to errors in drafting, any Plan provision does not accurately reflect its intended meaning, as demonstrated by consistent interpretations or other evidence of intent, or as determined by the Administrator in its sole and exclusive judgment, the provision shall be considered ambiguous and shall be interpreted by the Administrator in a fashion consistent with its intent, as determined by the Administrator in its sole discretion. The Plan shall be amended retroactively to cure any such ambiguity. Neither this Section nor any other Plan provision, may be invoked by any person to require the Plan to be interpreted in a manner that is inconsistent with its interpretation by the Administrator.

## 12.10 Mistake of Fact

Any mistake of fact or misstatement of fact shall be corrected when it becomes known, and the Administrator may make such adjustment as it considers equitable and practical. However, neither the Administrator nor the City shall be liable for losses incurred on account of any determination of fact made in good faith.

## 12.11 Physical Examination and Autopsy

The Administrator or its delegate, or any insurance company under a Component Plan, at its own expense, shall have the right and opportunity to have any Participant or covered Dependent, whose injury or sickness is the basis of a claim, examined by a physician designated by it, when and as often as it may reasonably require during the pendency of a claim under any Component Plan and to make an autopsy in case of death, provided it is not otherwise prohibited by law.

## 12.12 No Guarantee of Tax Consequences

Neither the City nor the Administrator makes any warranty or other representation (i) as to whether any pre-tax Employee Contributions made to or on behalf of any Participant under the Cafeteria Plan will be treated as excludable from gross income for local, state, or federal income tax purposes, or (ii) that any amounts paid or allocated to or for the benefit of a Participant or covered Dependent under the Plan will be excludable from the Participant's gross income for federal, state, and/or local income tax purposes, or (iii) that any other federal, state, and/or local tax treatment will apply or be available to any Participant. If for any reason it is determined that any amount paid for the benefit of a Participant or covered Dependent is includible in the Participant's gross income for local, state, or federal income tax purposes, then under no circumstances shall the Participant have any recourse against the Administrator or the City with respect to any increased taxes or other losses or damages suffered by the Participant as the result thereof.

## 12.13 Notices

Any notice, application, instruction, designation, or other form of communication required to be given or submitted by any Participant shall be in such form as is prescribed from time to time by the Administrator, sent by inter-office mail or first class mail, or delivered in person to the Administrator. Any notice, statement, report, or other communication from the City, or the Third Party Administrator, to any Participant, Dependent, or Eligible Employee required or permitted by the Plan shall be deemed to have been duly delivered when given to such person or mailed by first class mail to such person at the address last appearing on the records of the City. Any communication, statement, or notice addressed to a Participant, Dependent, or Eligible Employee at their last post office address as filed with the Administrator will be binding upon the person for all purposes of the Plan, and neither the Administrator nor the City shall be obliged to search for or ascertain the whereabouts of any person. Each person entitled to receive Benefits under the Plan shall file in accordance herewith their complete mailing address and each change therein.

## 12.14 Limitations of Rights

Neither the establishment of the Plan, any amendment thereof, the creation of any fund or account, the provision of any coverage, nor the payment of any Benefits shall be construed as giving to

any Participant or other person a legal or equitable right against the City or the Administrator, except as provided in the Plan. Any and all rights or Benefits accruing to any person under the Plan shall be subject to all terms and conditions of the Plan.

The adoption and maintenance of the Plan shall not constitute a contract between the City and any Employee or be a consideration for, or an inducement or condition of, employment of any Employee. Participation in the Plan shall not give any Employee a right to be retained in the employ of the City, nor shall it interfere with the right of the City to discharge any Employee at any time. Under no circumstances shall the terms of employment of any Employee be modified or in any way affected by the provisions of the Plan.

Nothing in the Plan shall require the continuation of coverage following the failure of a Participant to make any required Employee Contributions. The City shall not be liable for the payment of a person's portion of any insurance premium or any loss that may result from the failure of a person to pay their portion of an insurance premium.

The City shall not be responsible for the validity of any insurance contract issued under the Plan, for the failure on the part of the insurer to make payments provided for under any insurance contract, or for the action of any person which may delay or render unenforceable, in whole or in part, any insurance contract.

With respect to any insured Benefits, the liability of the Plan and the City to any person shall be limited to any payment from the insurer. If any insurance contemplated by the Plan shall not be in force during any period for any reason, no Benefits shall be payable with respect to such period.

Once insurance is obtained, the City shall not be liable for any loss that may result from the failure to pay premiums to the extent premium notices are not received by the City. To the extent premium notices are received by the City, the City's liability for the payment of such premiums shall be limited to the amount of such premiums and shall not include liability for any other loss which may result from the failure to pay such premiums.

## 12.15 Quality of Services

The selection by the City of the coverages that may be financed through the Plan does not constitute any warranty, express or implied, as to the quality, sufficiency, or appropriateness of the services provided by any insurer or Third Party Administrator, nor does the City assume or accept any responsibility with respect to the denial by any prospective insurer or Third Party Administrator of access to, or financial support for, any service, whether or not such denial is appropriate under the circumstances.

Each Participant or covered Dependent shall look only to the applicable insurer or Third Party Administrator, and not to the Plan, City, Administrator, or any other person, for Benefits and Benefits-related services that may be covered under the Plan.

## 12.16 Nonalienation of Benefits

Except as otherwise provided by law, the Benefits provided to Participants hereunder shall not be subject to assignment, anticipation, alienation, attachment, levy, or transfer, and any attempt to do so shall not be recognized.

Notwithstanding any provision of the Plan, a Participant may not assign their rights to bring a lawsuit under the Plan to any providers or other persons who may provide or render any treatment or services to the Participant or any Dependent.

## 12.17 No Vested Rights

To the maximum extent permitted by law, and except as otherwise provided in the Plan, no person shall acquire any right, title, or interest in or to any Benefits otherwise than upon actual payment of such Benefits.

## 12.18 Conflict with Employee Benefit Laws or Regulations

No Benefits will be paid which are in conflict with any applicable law pertaining to employee benefits.

## 12.19 Right to Receive and Release Necessary Information

For purposes of Plan administration, the Plan may, without the consent of or notice to any person and except as otherwise expressly provided in the Plan, release to or obtain from any insurance company or other organization or person any information, with respect to any person, which the Plan deems to be necessary for such purposes.

## 12.20 Information to be Furnished

Each Eligible Employee or other interested person shall file with the Administrator, in the manner and form specified by the Administrator, all pertinent information, and sign all relevant documents, as the Administrator may reasonably request from time to time for the purpose of administration of the Plan, including Social Security numbers and proof or continued proof of dependency or eligibility. The Eligible Employee or other interested person shall not have rights or be entitled to any Benefits or further Benefits unless the information is filed by the person or on their behalf.

## 12.21 Fraud

No payments with respect to Benefits will be paid if the Participant or the provider of services for which payment is sought attempts to perpetrate a fraud upon the Plan with respect to any claim. The Administrator shall have the right to make the final determination of whether a fraud has been attempted or committed upon the Plan or if a misrepresentation of fact has been made, and its decision shall be final, conclusive, and binding upon all persons. The Plan shall have the right to fully recover any amounts, with interest, improperly paid by the Plan by reason of fraud, attempted fraud, or misrepresentation of fact by a Participant or service provider and to pursue all other legal or equitable remedies.

## 12.22 No Waiver or Estoppel

No provision of the Plan shall be deemed to have been waived, and there shall be no estoppel against the enforcement of any provision of the Plan, except by written instrument of the party charged with such waiver or estoppel. No such written waiver shall be deemed a continuing waiver unless specifically stated therein, and each such waiver shall operate only as to the specific provision waived and shall not constitute a waiver of such provision for the future or as to any act other than that specifically waived.

## 12.23 Headings and Number

Headings are included for convenience only and shall not be construed as defining or limiting the subject matter contained thereunder. Words used in the singular or plural shall each be deemed to refer to the other whenever the context so requires.

## 12.24 Severability

If any provision of the Plan is held to be illegal, invalid, or unenforceable for any reason, that illegality, invalidity, or unenforceability will not affect the remaining provisions of the Plan, and the Plan shall be construed and enforced as if such provision had never been included in the Plan.

## 12.25 Governing Law and Venue

Except to the extent that the Plan or any of its Component Plans are governed by federal law, the Plan and all of its Component Plans shall be construed, administered, enforced, and governed by and in accordance with the applicable laws of the State of Oregon, even if Oregon's choice of laws otherwise would require application of the law of a different jurisdiction.

The exclusive venue for all disputes arising out of and relating to the Plan is in any court of appropriate jurisdiction located in Oregon.

## 12.26 Legal Process

Service of legal process involving the Plan may be delivered to the Plan Administrator in care of:

1120 SW Fifth Ave, Room 987 Portland OR 97204, attention Benefits Manager

# Appendix A
# Component Plan Information

The following identifies certain information regarding Component Plans, including the Related Documents that set forth the terms and conditions for Benefits, the insurer, and the Third Party Administrator, with respect to the corresponding Component Plan:

| Component Plan | Related Documents | Insurer | Third Party Administrator | Status |
|---|---|---|---|---|
| **Cafeteria Plan Benefits** | | | | |
| **Premium Payment Plan** | This Document | NA | NA | NA |
| **Dependent Care FSA** | This document, SPD, administrative service agreement | NA | Navia | NA |
| **Healthcare FSA** | This document, SPD, administrative service agreement | NA | Navia | NA |
| **Health Plan Benefits** | | | | |
| **Medical Benefits** | This document, SPD, SBC, highlights, group policy, groups agreements, administrative service agreement | Kaiser | Moda Health Plan | Insured and Self-Insured |
| **Prescription Medication Benefits** | This document, SPD, SBC, highlights, group policy, groups agreements, administrative service agreement, prescription plan service agreement | Kaiser | Express Scripts | Insured and Self-Insured |
| **Dental Benefits** | This document, SPD, SBC, highlights, group policy, groups agreements, administrative service agreement | Kaiser | Moda Health Plan Delta Dental of Oregon | Insured and Self-Insured |
| **Vision Benefits** | This document, SPD, SBC, highlights, group policy, groups agreements | Kaiser | Vision Service Plan (VSP) | Insured and Self-Insured |
| **Other Benefits** | | | | |
| **Employee Assistance Program** | This document, SPD | Canopy, Inc. | NA | Insured |
| **Employee Assistance Program** | This document, SPD | ComPsych Corporation | NA | Insured |
| **Life Insurance Plan – Basic and Supplemental** | This document, SPD, Certificate of Coverage, group agreement | Standard Insurance, Inc. | NA | Insured |
| **Long-Term Disability Plan** | This document, SPD, Certificate of Coverage, group agreement | Standard Insurance, Inc. | NA | Insured |
| **Fertility and Family Planning Benefits** | This document, SPD | Carrot | NA | Insured |