



Health & Financial Benefits

HEALTHY LIVING. HEALTHY FUTURE.

2021-2022

Summary Plan Description

Employee Benefits and Wellness Programs



PPA Employees and Retirees

Welcome

We want you to understand what our total rewards package includes—and we want to give you the information you need to be a wise consumer of benefits. The more you know about the plans available to you, the more effectively you can use them. That’s where this Summary Plan Description (“SPD”), or benefits guide, comes in. It will serve as a reference book, helping you understand how to get the greatest value from your benefits. The guide is designed to be reader-friendly, presenting clear and convenient information all in one place about your various benefits. The Plan details are described in separate sections, with special boxes emphasizing key features and highlighting important points to remember.

Along with the *Quick Start Guide to Your City of Portland Benefits*—and the governing details in the Plan Document—all of the benefits information you need is at your fingertips.

This Summary Plan Description (SPD) is to serve as a reference guide for all your benefit questions. Inside you will find information to help you take advantage of the health, wellness and financial benefits the City of Portland offers active and retired employees and their families. You will learn how to be a better consumer of your benefits, understand what is covered and how to seek treatment or services, see how much you and the City pay toward your plans, find where to go for more details, and much more.

This SPD applies to retirees and full-time and part-time active employees. Each section clearly states who is eligible for the benefit, including your family members when appropriate. We encourage you to share this with your family and reference it when you need care or have any questions.

If you (and/or your dependents) have Medicare or will become eligible for Medicare in the next 12 months, a federal law gives you more choices about your prescription drug coverage. Please see page 197 for more details.

The information presented in this SPD is only a summary. The actual eligibility requirements, benefits, terms, conditions, limitations, and provisions that govern the plans are contained in the insurance contracts and plan documents (“Plan Documents”). If, in our efforts to make this summary easy to understand, any of the plans’ provisions have been omitted or misstated, the Plan Documents remain the final authority. The Plan Documents also govern the administration of the plans and payment of benefits. In the case of a dispute, the information in the Plan Documents will control to the extent permitted by law. Likewise, if any oral or written representations made by any City of Portland representative conflict with this SPD, the SPD will control and takes the place of any prior oral or written communication on the subject of the benefit.

Table of Contents

WELCOME	ii
BEFORE WE BEGIN	1
Benefits Overview.....	1
CONTACTS	4
GLOSSARY OF TERMS	7
ELIGIBILITY AND ENROLLMENT	11
Who Is Eligible?	11
When Coverage Begins	14
Newly Eligible Employees.....	14
All Employees.....	15
Retirees and All Other Self-Pay Continuation Participants (Including COBRA)	16
Contributions for Coverage.....	16
If You Need to Make Changes During the Year	18
Qualified Family Status Change	18
Effective Dates of Mid-Year Changes.....	24
When Coverage Ends	24
For Employees	24
For Retirees or Other Self-Pay Continuation Participants (including COBRA)	25
For Your Dependents	25
Leaves of Absence	26
Family and Medical Leave Act (FMLA).....	26
Oregon Family Leave Act (OFLA).....	27
City Paid Parental Leave	27
Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).....	28
Coverage Continuation Options	28
Continuation of Coverage: Workers' Compensation/Industrial Accident Leave	28
Continuation of Coverage: Legally Separated, Divorced or Widowed Spouses, or Registered Domestic Partners Age 55 or Older	29
Continuation of Coverage: Retirees and Other Self-Pay Participants	29
Continuation of Coverage During Strike or Lockout	30
Continuation of Coverage: COBRA.....	31

Health Insurance Marketplace.....	36
MEDICAL PLAN OPTIONS	37
Coverage Options	37
Preventive Care Initiative for all City Health Care Plans	37
NOTICE REGARDING WELLNESS PROGRAM.....	37
PCI Non-Compliant Rates	39
Protections from Disclosure of Medical Information	39
City of Portland HIPAA Authorization - EXAMPLE	40
Medical Opt-Out Dollars.....	41
Medical Plan Comparison.....	45
Kaiser Permanente Senior Advantage Benefit Summary	52
Medically Necessary Care.....	54
CityNet PPO Medical Plan.....	54
CityNet PPO Network.....	55
CityNet PPO Medical Plan: More Details	58
CityHDP High Deductible Medical Plan: More Details	59
Benefits for Special Medical Situations	62
CityNet PPO and CityHDP Plan Professional Providers.....	63
What Is Covered: CityNet PPO and CityHDP Medical Plan Services.....	63
What Is Not Covered: CityNet PPO Plan and CityHDP Plan Limitations and Exclusions	74
General Exclusions and Limitations.....	74
Exclusions Related to Miscellaneous Services and Items.....	76
Frequently Asked Questions About the CityNet and CityHDP Medical Plan	80
CityNet and CityHDP Plan Prescription Medication Program	81
What Is Covered	81
Express Scripts Online Account.....	82
More About Maintenance Medications	84
What Is Not Covered: CityNet and CityHDP Plan Prescription Medication Program Exclusions	85
Special Programs.....	86
MyModa Healthcare Cost Estimator	86
Care Coordination Services (Case Management)	87
Medical and Behavioral Management Services	87
Filing a Claim for CityNet PPO and CityHDP Plan Benefits	90
Telephone Inquiries: 503-243-3974 or 1-877-337-0649Third Party Liability	91
Claim Deadline	93
Explanation of Benefits (EOB)	93

Continuity of Care	94
Kaiser Permanente Medical Plan (HMO).....	98
Kaiser Service Area.....	100
What Is Covered.....	100
For Questions or Problems with Kaiser Care or Services	102
What Is Not Covered: Kaiser Permanente Limits and Exclusions.....	102
Grievances, Claims, Appeals, and External Review	106
Wellness Resources Available Through Your Medical Plan.....	108
Employee Assistance Program (EAP)	109
Substance Abuse.....	109
Fertility and Family Planning Benefit.....	110
Carrot Supports all Paths to Parenthood.....	110
Ready to get Started?	110
Wellness Education Programs.....	111
Introduction	111
CityStrong	111
Moda Health - Wellness Services.....	111
Healthy Foundations.....	111
Nutritional Counseling and Hospital-Based Weight Reduction Programs.....	111
Kaiser Permanente – Wellness Services	112
Health Engagement and Wellness Services.....	112
VISION PLANS	112
Coverage Options	113
Vision Plan Comparison	113
Your Vision Plan Benefits – More Details.....	117
Vision Service Plan (VSP) for CityNet PPO Medical Plan Participants	117
Filing a Claim for VSP Vision Plan Benefits.....	119
Kaiser Permanente Eye Care Services for Kaiser HMO Medical Plan Participants	120
DENTAL PLANS.....	122
Coverage Options	122
Plan Highlights	123
Dental Plan Comparison	123

Your Dental Plan Benefits – More Details	124
Delta Dental Plan of Oregon and Delta Dental Buy-Up Plan.....	124
Annual Deductible.....	124
Maximum Annual Benefit.....	125
Delta Dental Plan of Oregon and Delta Dental Buy-Up Plans: What Is Covered.....	125
Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plan: What Is NOT Covered	131
Special Program: Oral Health, Total Health.....	133
Frequently Asked Questions About the Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plan	134
Kaiser Dental Plan	136
Kaiser Dental Plan: What Is Covered	136
Kaiser Dental Plan: What Is NOT Covered	137
24-Hour Service Line.....	138
Frequently Asked Questions About the Kaiser Dental Plan	139
 FLEXIBLE SPENDING ACCOUNTS (FSAS).....	 140
Annual Enrollment.....	140
Flexible Spending Accounts & COVID.....	141
The Internal Revenue Service (IRS) issued new Flexible Spending Account (FSA) guidance due to the COVID-19 national emergency. In response, the City has made the following temporary changes to our current plan year Healthcare and Dependent Care Flexible Spending Accounts. These changes include:	141
The Before-Tax Advantage	141
How Your Flexible Spending Accounts Can Work For You.....	142
Healthcare FSA	143
How Does It Work?.....	143
How to Use Your Healthcare FSA.....	147
Tax Considerations.....	148
Healthcare FSA – What’s Covered	149
Healthcare FSA – What’s Not Covered	150
Dependent Care FSA	150
How Does It Work?.....	150
How to Use Your Dependent Care FSA.....	151
Dependent Care FSA – What Is Covered	151
More Details.....	152
The Dependent Care FSA vs. the Federal Tax Credit	152
Frequently Asked Questions About the Flexible Spending Accounts	152

LIFE INSURANCE	154
Basic Life Insurance	154
The “Basics” of Basic Life Insurance	154
Who Is Eligible?.....	154
Coverage Amount: Basic Life.....	154
Supplemental Life Insurance	155
The “Basics” of Supplemental Life Insurance.....	155
Who’s Eligible?.....	155
Coverage Amounts: Supplemental Life	156
Cost.....	156
Life Insurance Plan Details	156
Coverage Effective Date	156
Understanding the Importance of a Beneficiary	159
What’s Not Covered	160
If You Become Disabled	161
Waiver of Premium During Total Disability.....	161
If You Become Terminally Ill.....	161
When Coverage Ends	161
Converting Life Insurance Coverage	162
RETIREMENT AND SAVINGS	163
Fire & Police Disability & Retirement Fund and Oregon Public Service Retirement Plan	163
457(b) Deferred Compensation Plan	163
Pre-tax or Roth: What’s the Difference?.....	164
Enroll and Manage Your Account.....	167
Distribution of Benefits	168
Frequently Asked Questions About the 457(b) Plan	169
If You Need Help.....	169
HOW MUCH DO THE BENEFITS COST?	170
2021-22 Benefit Costs and Employee Premium Shares	170
PPA Full-Time Rates	170
PPA Part-Time Rates	171
Retirees & COBRA Rates.....	173
IMPORTANT PLAN INFORMATION	174

COORDINATION OF BENEFITS (COB)	175
CityNet PPO and CityHDP Medical Plan and Delta Dental Plans	175
Definitions	175
How COB Works	177
Which Plan Pays First?.....	178
Facility Correction of Payment.....	180
Right of Recovery	180
CLAIMS AND APPEALS	181
Medical	181
CityNet PPO and CityHDP Medical Plan: Appeals and External Review.....	181
Kaiser HMO Medical Plan – Claims and Appeals.....	184
Definitions	184
Time Limit for Submitting Appeals.....	185
The Review Process.....	185
First Level Appeals	185
Second Level Appeal	185
Kaiser Dental Plan	186
IMPORTANT NOTICES	187
What Is Included?	187
Patient Protection Act	187
HIPAA and Plan Information	191
HIPAA NOTICE OF PRIVACY PRACTICES	191
Prescription Coverage and Medicare	198
Important Notice From the City of Portland About Your Prescription Medication Coverage and Medicare	198
The Federal Newborns’ and Mothers’ Health Protection Act of 1996	200
Federal Women’s Health and Cancer Rights Act of 1998	200
Women’s Health Act Frequently Asked Questions	200
Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)	201

Before We Begin

City of Portland’s benefit plans start each year on July 1 and end the following June 30. This is called the “plan year.” You can change your benefit plan selections each year during the annual enrollment period (typically held in late spring) and also as a result of qualifying family status change, such as marriage or the birth of a child. Take a look at the benefit plans available from the City of Portland.

Benefits Overview

IMPORTANT NOTE FOR RETIREES: Please see the row at the bottom of the chart for the information that applies to you.

	Health Benefits (Medical, Prescription Medication, Dental, Vision)	Flexible Spending Accounts: HealthCare FSA and Dependent Care FSA	Life Insurance (Basic and Supplemental)	Retirement [457(b) Deferred Compensation Plan, Oregon PERS and OPSRP, Fire and Police Disability and Retirement Fund (FPDR)]
Why do we have this coverage?	To help pay the costs of routine health care, serious illness, or injury. And, to help cover the cost of routine dental and vision care.	To take advantage of tax savings for qualifying health care and dependent care expenses not paid by the health plans.	To protect you (and your family) from the financial effects of death.	To encourage and protect your financial resources through systematic savings—to help you prepare for your future.
Is the benefit automatic, or is enrollment required?	<p>Full-time employees:</p> <ul style="list-style-type: none"> Enrollment is required. (If you do not enroll and choose a plan, you will be defaulted into single (employee-only) coverage in the CityNet PPO Plan, the Delta Dental Plan of Oregon and the Vision Service Plan.) 	Enrollment is required if you want to participate in either account.	<p>Basic Life: Automatically enrolled</p> <p>Supplemental Life: Enrollment is required if you want this coverage</p>	Enrollment into the pension plans is automatic. Enrollment into the 457 plan is required if you want to participate.

	Health Benefits (Medical, Prescription Medication, Dental, Vision)	Flexible Spending Accounts: HealthCare FSA and Dependent Care FSA	Life Insurance (Basic and Supplemental)	Retirement [457(b) Deferred Compensation Plan, Oregon PERS and OPSRP, Fire and Police Disability and Retirement Fund (FPDR)]
	<p>Part-time employees:</p> <ul style="list-style-type: none"> Medical, Dental and Vision: Enrollment is required if you want this coverage. 			
When does coverage begin?	<p>PPA Employees:</p> <ul style="list-style-type: none"> Full-time employees working a minimum of 72 hours per pay period are eligible for benefits on the first of the month following 30 days of employment. Part-time employees working a minimum of 20 hours and less than 36 hours per week are eligible for benefits the first of the month following 174 hours of continuous eligible employment 	<p>Current employee: On the first day of the plan year (July 1), if you properly enroll</p> <p>New hire: Same as Medical, Dental and Vision; see the "Health Benefits" section to the left.</p>	<p>Basic Life: See the "Health Benefits" section to the left for eligibility dates.</p> <p>Supplemental Life: Please see the <i>When Coverage Begins</i> chart in the <i>Eligibility, When Coverage Is Effective</i> section of this SPD.</p>	<p>457(b) Deferred Compensation: After completing a 30-day waiting period</p> <p>Oregon PERS (OPSRP): After completing a six-month waiting period</p>
How do I enroll?	Online through the City's BenefitsOnline website at www.portlandoregon.gov/benefits	Online through the City's BenefitsOnline website at www.portlandoregon.gov/benefits	Online through the City's BenefitsOnline website at www.portlandoregon.gov/benefits	<p>457(b) Deferred Compensation: Online through the City's Employee Portal website at www.portlandoregon.gov/ep</p> <p>OPSRP: Automatically enrolled</p>

	Health Benefits (Medical, Prescription Medication, Dental, Vision)	Flexible Spending Accounts: HealthCare FSA and Dependent Care FSA	Life Insurance (Basic and Supplemental)	Retirement [457(b) Deferred Compensation Plan, Oregon PERS and OPSRP, Fire and Police Disability and Retirement Fund (FPDR)]
Who pays for coverage?	Active Employees: You and the City share the cost of medical, basic vision and core dental. You pay the full cost for buy-up vision and buy-up dental coverage. Contributions are pre-tax.	You pay the cost of coverage with before-tax contributions.	<p>Basic Life:</p> <ul style="list-style-type: none"> ▪ Full-time: The City pays the cost ▪ Part-time: You and the City share the cost <p>Supplemental Life: You pay the cost of coverage</p>	<p>457(b) Deferred Compensation: You contribute to the Plan</p> <p>OPSRP (for those hired after 7/1/2007): Pension benefits based on your employment with the City</p> <p>FDPR (for those hired before 7/1/2007): Pension and disability benefits based on your employment with the City</p>
RETIREEES	<p>Is enrollment automatic or required for Medical, Dental and Vision? Enrollment is required if you want this coverage.</p> <p>When does coverage begin? Eligible on the first of the month following retirement date (initial enrollment).</p> <p>How do I enroll? Using a paper annual enrollment form, or change form when changes are needed.</p> <p>Who pays for coverage? You pay the full cost of coverage on an after-tax basis.</p>	Retirees are not eligible.	Retirees are not eligible.	Retirees are not eligible to make additional contributions or have contributions made by the City on their behalf. This is the time when you access these benefits for your secure retirement.

Contacts

When you have questions, we want to be sure you get the answers you need quickly. Many resources are available to you and your family. First, you can find many of the details about your benefits throughout this SPD. If you're unable to find the answer you're looking for, please reach out to the Health & Financial Benefits Office, or contact the service provider directly. (**New hires:** please note you may not be able to access a service provider unless you are enrolled and receiving benefits.)

For questions about...	Contact the following...
<p>CityNet Medical Plan</p> <p>The City of Portland partners with Moda Health to support the CityNet and CityHD Health Plans. Moda can assist you with claims questions, finding a provider, and other services ensuring you have support to maintain your health and well-being</p>	<ul style="list-style-type: none"> ▪ www.modahealth.com or www.mymoda.com for general information and information on specific claims ▪ Network : Connexus ▪ Customer Service: 503-243-3974 or 1-877-337-0649 ▪ Prior authorization: 503-243-4496 or 1-800-258-2037 <ul style="list-style-type: none"> ○ For inpatient or residential mental health or chemical dependency: 503-624-9382 or 1-800-799-9391 ▪ Disease Management & Health Promotion : 503-948-5561 or 1-800-592-8283 ▪ Member Health Advocate : 1-855-466-6340 and via email at cityadvocate@modahealth.com ▪ Healthy Foundations : 1-855-232-6899 and via email at healthyfoundations@modahealth.com or online at http://www.healthyfoundationspdx.com/ ▪ CityStrong, worksite wellness education and support www.portlandoregon.gov/citystrong <p>Prescription Plan</p> <p>Express Scripts</p> <ul style="list-style-type: none"> ▪ www.express-scripts.com or 1- 800-818-9289 ▪ For specialty medications : www.Accredo.com
<p>Kaiser Medical Plan, Kaiser Dental Plan, and Kaiser Vision Plan</p>	<ul style="list-style-type: none"> ▪ 503-813-2000 or www.kp.org ▪ 24-hour advice nurse:1-800-813-2000 ▪ Pharmacy Help Line: 503-261-7900
<p>Delta Dental Plan of Oregon</p>	<ul style="list-style-type: none"> ▪ 503-265-5680 or 1-877-277-7280 ▪ Provider Directory : www.modahealth.com or 503-243-3974
<p>Vision Service Plan (VSP)</p>	<ul style="list-style-type: none"> ▪ 1-800-877-7195 or www.vsp.com ▪ Network: Signature Plan
<p>Flexible Spending Accounts (FSA) Healthcare FSA and Dependent Care FSA through HealthEquity/WageWorks</p>	<ul style="list-style-type: none"> ▪ 877-WageWorks or 877-924-3967 (M-F 8am-8pm eastern) ▪ Third Party Administrator: HealthEquity/WageWorks

For questions about...	Contact the following...
Employee Assistance Program (EAP) through Cascade Centers	<ul style="list-style-type: none"> ▪ 1-800-433-2320 ▪ www.cascadecenters.com
Carrot Family Planning & Fertility Benefits	<ul style="list-style-type: none"> ▪ support@get-carrot.com
Life Insurance through City of Portland Health & Financial Benefits Office Insurer: Standard Insurance Group #488980	<ul style="list-style-type: none"> ▪ 503-823-6031 ▪ www.portlandoregon.gov/benefits ▪ benefits@portlandoregon.gov ▪ For specifics regarding an application for Supplemental Life Insurance ▪ Medical Underwriting: 800-843-7979
457(b) Deferred Compensation Plan	Voya Financial <ul style="list-style-type: none"> ▪ 503-937-0378 or 1-800-238-6281 ▪ https://prime.beready2retire.com
Public Employees Retirement System PERS/OPSRP	<ul style="list-style-type: none"> ▪ 503-598-7377 ▪ Toll free: 888-320-7377 ▪ www.oregon.gov/PERS/
Fire and Police Disability & Retirement (FPDR)	<ul style="list-style-type: none"> ▪ 503-823-6823 ▪ http://www.portlandoregon.gov/fpdr/
Retirees	<ul style="list-style-type: none"> ▪ Retiree Benefit Information Line <ul style="list-style-type: none"> ○ 503-823-6136 ○ retireebenefits@portlandoregon.gov ▪ PERS Health Insurance <ul style="list-style-type: none"> ○ www.PERShealth.com ○ 503-224-7377 or 1-800-768-7377 ▪ SHIBA (Senior Health Insurance Benefits Assistance) <ul style="list-style-type: none"> ○ <i>In Oregon:</i> <ul style="list-style-type: none"> ▪ 1-800-722-4134 ▪ www.oregon.gov/DCBS/SHIBA ○ <i>In Washington:</i> <ul style="list-style-type: none"> ▪ 1-800-562-6900 ▪ www.insurance.wa.gov/shiba ▪ Social Security Administration <ul style="list-style-type: none"> ○ 1-800-772-1213 ○ www.ssa.gov ▪ Medicare <ul style="list-style-type: none"> ○ 1-800-633-4227 ○ www.medicare.gov

The City of Portland Health & Financial Benefits team also is dedicated to you. Please contact us when you have questions about your benefits:

- **Online:** Access your personalized benefit information on the City of Portland's BenefitsOnline website at www.portlandoregon.gov/benefits
- **By phone:** Call the Benefit Information Line at **503-823-6031** for answers to some frequently asked questions. (Please leave a message with your name, your question, your daytime phone number, and the best time to reach you. A benefit team member will return your call.)
 - **RETIREEES:** Please call **503-823-6136**
- **Via email:** Send an email to benefits@portlandoregon.gov
 - **RETIREEES:** Please email retireebenefits@portlandoregon.gov

Glossary of Terms

Active Work Requirement – Used to determine eligibility in the life insurance benefit. The ability to perform your own occupation duties at your employer’s usual place of business. If you are incapable of doing so, on the day before the scheduled effective date of your insurance or an increase in your insurance, your coverage will not become effective until the day after you meet the active work requirement for one full day as a qualified employee.

Annual Enrollment – Your once-a-year opportunity to review your benefit options and, if necessary, make changes to your coverage and/or dependent information. At the City of Portland, this is typically held in the late spring for a July 1 effective date. Outside of annual enrollment, you can make changes only if you have a qualified family status change.

Beneficiary(ies) – The person(s) who will receive benefits in the event of the death of the insured person.

Chemical Dependency (including alcoholism) – An addictive relationship with any drug or alcohol characterized by a physical and/or psychological relationship that interferes on a recurring basis with an individual’s social, psychological or physical adjustment to common problems. Chemical dependency does not mean an addiction to or dependency upon foods, tobacco or tobacco products.

COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1985, as amended, which offers you the opportunity to continue your health care coverage when coverage would otherwise end.

Coinsurance – Coinsurance defines the percentages of a covered expense for which you and the plan are responsible. For example, an in-network coinsurance of 80% means that, after you satisfy the deductible, the plan pays 80% of covered expenses and you pay 20%.

Copayment – A copayment, or copay, is a pre-determined flat dollar amount you pay each time you have a specified health care service. For example, Kaiser requires that you pay a \$10 copayment for each primary care office visit, regardless of the type or level of services provided during the visit.

Covered Expenses – Expenses that are eligible for reimbursement under a plan. The amount of reimbursement depends on the Plan’s provisions.

Custodial Care - Custodial Care means care that helps a member conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care includes care that is primarily for the purpose of keeping a member safe of for holding a member awaiting admission to the appropriate level of care.

Deductible – The amount of covered expenses you must pay each year before a plan begins to contribute toward expenses. At the City, the deductible is an annual amount you must meet each plan year. You pay the full cost of services until you reach the deductible amount, but in some situations, only a copay is required (and you do not need to meet the deductible first); see each plan description for details.

Domestic Partner – An individual with whom you (a) are a registered domestic partner as per the Oregon Family Fairness Act of 2007 or under the laws of any other state, (b) are a civil union partner under the laws of any state, or (c) meet the criteria of the City’s Domestic Partner Affidavit.

Emergency Services – Health care items and services furnished in an emergency department of a hospital, including all ancillary services routinely available to the emergency department (to the extent they are required for the stabilization of a member, performed within the capabilities of the staff and

facilities available at the hospital, when such further medical examination and treatment are required to stabilize a member).

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

Evidence of Insurability (EOI) – Life insurance may require you to submit EOI in order to increase your coverage amount or elect coverage over a certain dollar amount. An EOI Form includes questions about your health. Depending on the information you provide, you or your covered dependent may be asked additional questions and may have to have a physical exam. The insurance carrier must approve your EOI before coverage under the option you elected will begin.

HIPAA – Health Insurance Portability and Accountability Act of 1996. This law protects an individual's personal health information, among other things. See the *Important Notices* section for more details.

Maximum Plan Allowance (MPA) – The maximum amount that Moda Health, the plan administrator, will reimburse providers under the CityNet medical plan. For an *in-network provider*, the MPA is the amount the provider has agreed to accept for a particular service.

The MPA for an *out-of-network provider* is based on the lesser of the amount payable under any supplemental provider fee arrangements Moda Health may have in place and the 90th percentile of fees commonly charged for a given procedure in a given area, based on a national database. If a dollar value is not available in the national database, Moda Health will consider 90% of the billed charge as the MPA. In certain instances, when a dollar value is not available in the database, the claim is reviewed by Moda Health's medical consultant, who determines a comparable code to the one billed. Once a comparable code is established, the claim is processed as described above. MPA for emergency services by an out-of-network facility will be processed as follows: the maximum amount allowed will be the greatest of (1) the median in-network rate, (2) the maximum amount as calculated according to this definition for out-of-network facility and (3) the Medicare allowable amount. *When using an out-of-network provider, any amount above the MPA is the member's (your) responsibility, unless you are using an in-network facility and unable to choose the provider in which the provider cannot charge you the difference between the maximum plan allowance and the billed charge. See Special Circumstances: Surprise Billing.*

Member – You, when you join a health plan. A subscriber, dependent of a subscriber or person otherwise eligible for a group health benefit plan who has enrolled for coverage under the terms of the plan.

Mental Illness – **Includes all** mental disorders covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-5).

Network or In-network – A group of providers (physicians, dentists, other health care professionals) or health care facilities that contract with a health plan to offer services at negotiated rates.

Normal Retirement Age (NRA) – **Any age selected by an employee in writing at which age you have the right to retire and receive immediate and unreduced retirement benefits from the pension plan of which you are a member: PERS/OPSRP or Police & Fire Disability & Retirement. The earliest date is the date you first meet the eligibility requirements. An employee may select a later date up to the age 70- ½.**

Out-of-Network – Physicians, hospitals and other health care providers and facilities that do not have an agreement with the plan to charge members discounted rates—these providers do not participate in a plan's network. Expenses incurred for services provided by out-of-network health professionals may not be covered (Kaiser), or may only be partially covered after a higher deductible and coinsurance (CityNet plans). You pay more when you use out-of-network providers.

Out-of-Pocket Maximum – The maximum amount you pay out-of-pocket every plan year, including the deductible, coinsurance and some copays. If you obtain both network benefits and non-network services, two separate out-of-pocket maximums apply. If you reach the out-of-pocket maximum in a plan year, the plan will pay 100% of eligible expenses for the remainder of the plan year. (**Note:** In the Kaiser HMO medical plan, the out-of-pocket maximum accumulates on a calendar-year basis (January 1 – December 31) instead of the plan year (July 1 – June 30).

Outpatient Surgery – Surgery that does not require an inpatient admission or overnight (less than 24 hour) stay. A stay of less than 24 hours is not considered overnight, even if the duration of the stay is a nighttime.

Partial Hospitalization An appropriately licensed mental health for chemical dependency facility providing no less than 4 hours of direct, structured treatment services per day.

Plan Year – The plan year for the City’s benefit plans is July 1 through June 30.

Premium – The amount you pay for coverage each month. Also called a “contribution” or “premium share.”

Preventive Care Initiative – PPA represented employees enrolled in the CityNet or Kaiser medical plan will be asked to seek a preventive health care screening at least once during a two (2) calendar year period to maintain the City’s contribution level of 95% for full-time employees (prorated for eligible part-time employees). Kaiser **premium share may have a different calculation.**

Preventive Care Standard - A preventive health exam with a primary care provider (including naturopathic providers for non-Kaiser participants) once every 2 calendar years; or medical care received through an in-patient hospital stay, pre-natal services, primary and/or specialty care services related to chronic and/or complex medical conditions; or as defined under Kaiser Permanente NW; and agreement from the employee to share information as stated within the acknowledgement explaining the City’s application of protected health information (PHI) in the administration of an employee wellness program.

Prior Authorization – Approval by Moda Health for a member in the CityNet plan to be admitted to a hospital, inpatient facility, partial hospitalization or residential program that is *granted prior to the admittance* and for other services rendered. The goal of prior authorization is to ensure that individual members do not receive services that are not covered by the plan, including services that are not medically necessary. A complete list of services that require prior authorization is available on www.modahealth.com (log into myModa) or by contacting Moda Health’s Customer Service.

Providers – Doctors, dentists, hospitals and other health care professionals and facilities that *provide* the care, treatment or advice you need when you seek care.

Qualified Family Status Change – A qualified family status change, also known as a “life event” or “change in status event,” is a significant change in your life—such as marriage, the birth of a child, divorce or a job transfer—that impacts your benefit needs. The changes you can make to your benefits as a result of a qualified family status change event are regulated by Section 125 of the Internal Revenue Code. In most cases, you must notify the City’s Health & Financial Benefits Office within 60 days of a qualified change in order to make relevant changes to your benefits coverage.

Residential Program – A state-licensed program or facility providing a full- or part-day program of treatment. Residential programs provide overnight 24-hour-per-day care and include programs for treatment of mental illness or chemical dependency.

Self-Administered Medications - Prescription medications labeled by the FDA for self-administration, which can be safely administered by the member or the member’s caregiver outside of a medical

supervised setting (such as a hospital, physician office or infusion center) and that does not usually require administration by a licensed medical provider.

Self-insured Medical Plan – Claims are paid by the employer instead of by an insurance company in a self-insured plan. The CityNet and CityHDP plans are self-insured. This means the City pays a third party administrator (Moda Health) to administer the plans and the City pays the costs (claims costs plus administration) directly out of the PPA City health fund.

Spouse –Spouse will include your opposite-sex or same-sex spouse. When applied to the dependent life insurance, your “spouse” means your legal spouse, who is mentally competent and who was not legally separated from you at the time of your death.

Terminal Illness – A terminal illness will be considered to exist if a person becomes terminally ill with a prognosis of 12 months or less to live, as diagnosed by a physician.

Eligibility and Enrollment

Who Is Eligible?

Check the chart below to see who is eligible for the benefits described in this SPD.

Family Member	Eligibility Requirement
<p>Employee</p> <p>Portland Police Association (PPA) full-time and part-time employees</p>	<p>To be eligible:</p> <ul style="list-style-type: none"> ▪ You must be paid a minimum of 80 benefit-eligible hours in a month to be eligible for benefits in the following month; or ▪ You are in a qualified leave status for the City and make the required premium contribution. <p>The City complies with the Affordable Care Act (ACA) in determining coverage for employees who may otherwise be dropped from the City's benefit plans. If you should lose coverage because you are not working your regularly scheduled hours, you may be eligible for continued coverage under ACA if the following applies:</p> <p>For on-going employees:</p> <ul style="list-style-type: none"> ▪ You average 26 working hours per week during a 6-month standard measurement period ▪ Standard measurement period: <ul style="list-style-type: none"> ○ October 1, 2020 to March 31, 2021 – for benefits beginning July 1, 2021 ○ April 1, 2021 to October 1, 2021 – for benefits beginning January 1, 2022
<p>Your Spouse/Domestic Partner</p> <p>Note: The same eligibility rules apply for a retiree's spouse/domestic partner.</p>	<ul style="list-style-type: none"> ▪ Your legal spouse, including same-sex and opposite-sex <ul style="list-style-type: none"> ○ A divorced or legally separated spouse is not eligible for City-paid coverage ▪ Your domestic partner <ul style="list-style-type: none"> ○ A registered domestic partner as per the Oregon Family Fairness Act of 2007 or under the laws of any other state, or ○ A civil union partner under the laws of any state, or ○ Meet the criteria of the City of Portland Domestic Partner Affidavit, or

Family Member	Eligibility Requirement
<p>Your Dependent Child(ren)</p> <p>Note: The same eligibility rules apply for a retiree's children.</p>	<ul style="list-style-type: none"> ▪ Your child (whether married or single) under the age of 26 <ul style="list-style-type: none"> ○ Includes your biological or legally adopted child (from the time the child is <i>placed</i> for adoption), stepchild who is living with you, child of your enrolled domestic partner who is living with you, and any other child for whom you are legal guardian or who is required to be covered by you or your spouse as a result of a divorce decree or court order. ○ Note: Only unmarried eligible children may be enrolled in supplemental life insurance ▪ Your unmarried, incapacitated child of any age who lives with and is dependent on you for support as a result of a physical or mental disability <ul style="list-style-type: none"> ○ Your child must be properly enrolled for coverage under the plan (as your eligible dependent) prior to their 26th birthday and must have had continuous medical plan coverage; New Hires adding an incapacitated child do not need to show continuous medical plan coverage prior to enrolling dependent child ○ Proof of your child's disability must be provided and approved for coverage to begin initially; you will also be required to provide proof of your child's ongoing disability from time to time ▪ A newborn child of your enrolled dependent for the first 31 days of the newborn's life <ul style="list-style-type: none"> ○ After 31 days, the child of your enrolled dependent may be covered only as long as the child's parent is your eligible and enrolled dependent <i>and</i> both grandchild and birth parent live in your home (proof of residence for your enrolled child and grandchild is required.)
<p>Retiree</p>	<ul style="list-style-type: none"> ▪ Eligible to receive retirement income from the Oregon Public Employees Retirement System (PERS), the Oregon Public Service Retirement Plan (OPSRP) or the Fire and Police Disability and Retirement Fund; and ▪ Have been covered under the active employee health plans on a City-paid basis in the month preceding retirement ▪ Note: <i>Retirees who do not elect to continue coverage upon retirement, or who terminate coverage under City plans prior to age 65:</i> You may only return to the City's medical and dental plans in which you were previously enrolled <i>IF</i> you are not Medicare-eligible and you can provide written verification that you have maintained continuous medical and dental coverage between the time of leaving the City and the date of your return. This includes: <ul style="list-style-type: none"> ○ <i>Other group (employer sponsored) coverage, and</i> ○ <i>Individual plans purchased through the federal exchange. The option to return from an individual plan to the City's plans is limited to one time per participant.</i> ▪

Did You Know?

If you become ineligible for City-paid benefits, you can continue coverage on a self-paid basis in accordance with state and federal law and any applicable labor agreement.

Are your dependents eligible?

Dependents add significant cost to the benefit plans. Ensuring that only eligible dependents are covered is one of the ways we manage the City's plans and keep the benefits sustainable and affordable. For this reason, the city will conduct random audits of employees and their dependents to determine whether a spouse/domestic partner and children meet the eligibility requirements. Selected employees will be asked to provide information to confirm their dependents meet the City's eligibility requirements. If the information is not provided, the employee may be responsible for premiums and claims paid on the dependent's behalf and disciplinary action may be taken, up to and including termination of employment.

Who Is "You"?

Throughout this Plan summary, "you" generally refers to **you** (the eligible employee or retiree) when describing elections (e.g., how to enroll, how to change coverage) or **you or any eligible dependent** when describing the provisions of the benefits plans (e.g., what is covered and what is not).

When Coverage Begins

Newly Eligible Employees

Check the chart below to see when coverage is effective for new hires or employees who become benefits eligible:

Who can be covered?	When does coverage begin?
Employee Note: Eligibility assumes you are in a benefits-eligible job class and status.	<ul style="list-style-type: none"> ▪ Portland Police Association (PPA) full-time employees are eligible for benefits on the first of the month following 30 days of eligible employment ▪ Portland Police Association (PPA) part-time employees are eligible for benefits the first of the month following 174 hours of continuous eligible employment ▪ Note: PPA employees must be paid a minimum of 80 benefits-eligible hours in a calendar month to be eligible for benefits the following month
Your spouse/domestic partner and children	Coverage for eligible dependents is effective on the first of the month following or coinciding with the later of: <ul style="list-style-type: none"> ▪ The effective date of the employee's coverage; ▪ The date the individual becomes a dependent; or ▪ The date the employee submits completed enrollment forms (or enrolls online) and provides all required documentation to the Health & Financial Benefits Office
Retiree	You are eligible if you were covered under a City plan in the month prior to retirement and you are not Medicare eligible.
Retiree Spouse/Domestic Partner and Children	Coverage for eligible dependents is effective on the first of the month following or coinciding with the later of: <ul style="list-style-type: none"> ▪ The effective date of the retiree's coverage; ▪ The first of the month following the date the individual becomes a dependent, provided the retiree submits completed enrollment forms and provides all required documentation to the Health & Financial Benefits Office

Initial Enrollment

When you enroll for your benefits for the *first time*:

1. Review all the plans available to you. If you enroll for the flexible spending accounts (be sure to estimate your out-of-pocket health care and dependent care expenses before contributing for the remainder of the plan year.
2. Go to BenefitsOnline at www.portlandoregon.gov/benefits to enroll in your benefits. You will have 35 days from your date of hire into a benefits eligible position to enroll online (the deadline will be included in your enrollment package).

If you have enrolled after the first of the month in which you were eligible for City-paid benefits, your coverage will be retroactive to the first of the month in which you were eligible. If you have missed a premium share contribution, your contribution will be charged to you, in addition to your regular premium share contribution for coverage, on the first available payroll period.

3. When you save your online enrollment, you may save a benefits summary statement for your records.

Note: You must submit documentation for your spouse or domestic partner and children within 35 days of your hire date. You will be required to submit copies of marriage certificates, birth certificates, and/or domestic partner affidavits or registrations as it applies to your enrollment. Failure to provide documentation within the required timeframe may result in the retroactive removal of your dependent(s) back to the original effective date.

If you do not enroll...

The City wants all employees to have the security and protection the benefits offer. If you do not complete your initial enrollment, you will be defaulted into certain benefits and you will not receive coverage in other plans. **All plans in which you are automatically enrolled will be for “employee only” coverage. Any applicable premium share will be deducted from your paycheck on a pre-tax basis.**

Full-Time Employees	
Medical/Vision	Automatically enrolled in the CityNet PPO medical plan with vision coverage through Vision Service Plan (VSP)
Dental	Automatically enrolled in the Delta Dental Plan of Oregon
Basic Life	Automatically enrolled*
Part-Time Employees working less than 30 hours per week	
Medical/Vision	No coverage
Dental	No coverage
Basic Life	Automatically enrolled*

* Keep in mind: If you choose to enroll in supplemental life insurance coverage at a later time, health information will be required.

All Employees

Annual Enrollment

Each spring you will receive an email announcement (if you have a City email account) and information sent to your home address about the option to change your benefits or coverage levels, as needed. Any changes you make during this Annual Enrollment period will become effective July 1 and remain in effect throughout the plan year (July 1 through June 30.)

To *change/review* your benefits during annual enrollment you must go to BenefitsOnline:

1. Review your current benefits and the options available for the new plan year and determine whether changes are needed. If you enroll for the flexible spending accounts (Healthcare FSA and/or Dependent Care FSA) be sure to estimate your out-of-pocket health care and dependent care expenses before contributing for the plan year. (Remember: a new election is required each year you want to participate in either FSA plan.)
2. Review the dependents you cover under each plan and determine whether they are still eligible. During the annual enrollment period, you are verifying that your dependents meet the City’s benefit eligibility requirements.
3. Go to BenefitsOnline at www.portlandoregon.gov/benefits to enroll in your benefits (and make any subsequent changes) by the annual enrollment deadline. You may access your benefit information, make changes and enroll via any smart phone, lap-top, or computer.
4. When you save your online enrollment, you may print a benefits summary statement for your records.

If you do not change your elections during annual enrollment...

Your benefits will default to the plans, dependents and coverage levels in effect as of June 30 of the prior plan year, with two exceptions: ***your participation in the flexible spending will NOT roll over.*** Contributions default to \$0 in the flexible spending accounts unless you actively enroll. Your premium share contribution may be affected if you have not met the Preventive Standard, which may include affirming your consent to share whether you met the standard for the administration of the Preventive Care Initiative.

Retirees and All Other Self-Pay Continuation Participants (Including COBRA)

Annual Enrollment

Each spring you are mailed information about the option to change your benefits or coverage levels, as needed. Any changes you make during this Annual Enrollment period will become effective July 1 and remain in effect throughout the plan year (July 1 through June 30.)

To *change* your benefits during annual enrollment:

1. Review the materials mailed to your home address about your current benefits and the options available for the new plan year. Determine whether changes are needed.
2. Review the dependents you cover under each plan and determine whether they are still eligible. During the annual enrollment period, you are verifying that your dependents meet the City's benefit eligibility requirements.
3. If you want to make changes, you must complete and return the signed annual enrollment form (included in the materials mailed to your home) to the Health & Financial Benefits Office by the deadline provided in the annual enrollment materials. We can accept scanned, faxed or mailed change forms. Instructions on how to get your information back to our Office will be included within the materials mailed to your home.

If You Do Not Send Back Your Form...

If you do not return a completed and signed annual enrollment form before the deadline, your enrollment will default to the medical/vision and dental plan coverage (if any) in effect as of June 30 of the prior plan year. Eligible dependents will continue to be covered as long as they remain eligible. All CityNet plan participants will default to the CityNet Plan; CityHDP Plan participants will default to the CityHDP Plan; Kaiser members will default to the Kaiser plan. The appropriate premium cost to you will change to the new rates in effect as of July 1.

Contributions for Coverage

See the *Cost of Coverage > How Much Do the Benefits Cost?* section of this SPD for more details.

You pay the full cost for coverage under the benefit program on an after-tax basis in one of three ways:

- **Direct Debit from Your Bank Account:** The bank account you choose will be debited on the 6th of each month (if the 6th falls on a weekend, the deduction will occur the following Monday).

- **Pension Check Deductions (FPDR participants only):** Contributions are deducted from your monthly pension check. Deductions are withheld as soon as administratively possible after you elect this option.
- The Health & Financial Benefits Office will provide you with payment coupons so you may send monthly premium payments **via check or money order**.

Your premium payment is due on the first of each month for that month's coverage. You have a 30-day grace period. Claims may be delayed if you pay after the 15th of the month.

Full-Time Employees

Health coverage includes medical/vision and dental coverage for you and your eligible dependents. For full-time employees, the City of Portland will pay:

- 95% of the cost of the CityNet medical/VSP Vision and either choice of Delta Dental Plan of Oregon coverage or Kaiser Dental and you will contribute 5% of the cost of this coverage. This is called your "premium share." The City will pay 100% of the cost of the CityHDP medical/VSP Vision and 95% of either choice of Delta Dental Plan of Oregon or Kaiser Dental and you will pay 5% of the cost of the dental coverage. If you elect the Kaiser plan, your premium share will depend on the cost of the Kaiser plans in relation to the cost of the CityNet/VSP/Delta Dental Plan of Oregon plans. If the cost is less than 95% of the CityNet plans, then you will not have a premium share for the Kaiser plans. If the cost is greater than the CityNet plans, then you will pay the difference.
- As part of the City's Preventive Care Initiative, the 5% premium share will remain for those employees who have received a preventive health exam (or equivalent treatment e.g. prenatal, chronic disease and in-patient hospital as defined by Moda Health or Kaiser and within this document). Participating employees who do not meet the Preventive Standard will contribute 10% of the costs of their bundled CityNet medical, vision and dental premium. Because of the different funding method for Kaiser participants, if a PPA member does not meet the Preventive Standard, they will contribute 5% of the premium if there is otherwise no premium due, or if they have a premium share, they will contribute the same amount of additional premium share as those who enroll in CityNet in addition to their Kaiser calculated premium share based on the above language.
- For the 2021-22 plan year participating employees who do not meet the Preventive Standard will contribute 10% of the costs of their bundled medical, vision and dental premium.
- Employees who do not meet the Preventive Standard may elect the CityHD plan and the City will pay 100% of the cost of the CityHD medical/VSP vision monthly premium and 95% of either choice of Delta Dental Plan of Oregon or Kaiser Dental NW and you will pay 5% of the cost of the dental coverage.

Basic life insurance premiums are paid in full by the City of Portland. If you elect to enroll in any buy-up plan, flexible spending account or purchase supplemental life insurance for yourself and eligible dependents, you pay the full cost of those elections.

Part-Time Employees

Eligible part-time employees may elect the City's medical/vision and dental plans. Part-time employees are responsible for paying 50% of the premiums, in addition to 50% of the cost of basic life insurance, which cannot be waived. You may elect to waive medical and dental coverage. If you elect to enroll in any

buy-up plan, flexible spending account or purchase supplemental life insurance for yourself and eligible dependents, you pay the full cost of those elections.

As part of the Preventive Care Initiative, part-time employees are held to the same standards as full-time employees. Because part-time employees already pay a greater share of the premium contribution for their coverage, the 5% difference will be added to their monthly premium share amount. After this initial qualifying period, each employee will be required to have at least one preventive visit every two years to requalify and maintain their part-time premium contribution.

If You Need to Make Changes During the Year

Once your benefits are effective for a new plan year or as a new hire, you may not make changes outside of the Annual Enrollment window unless you experience certain changes called “qualified family status changes.” For example, if you get married, you can add your spouse to your benefits coverage. Each change you make will require documentation (e.g. marriage certificate, birth certificate, divorce decree)

It is your responsibility to notify the Health & Financial Benefits Office of a qualifying family status change. **You have 60 days to report a change and provide the required supporting documentation.** Go to BenefitsOnline at www.portlandoregon.gov/benefits to initiate the change.

IMPORTANT NOTE: If you are a retiree, or other self-pay continuation participant, contact the Health & Financial Benefits Office at **503-823-6136**.

The effective date of the change is generally the later of the first of the month following the qualifying event (such as marriage) or the first of the month following the date of your enrollment.

Did You Know?

If you don't report your change within 60 days of the qualifying event date, you will not be able to make changes to your benefits until the next Annual Enrollment period (for an effective date of July 1).

When adding a dependent, you may be required to provide certain documentation (e.g. marriage certificate). If the documentation is not received within 60 days of the qualifying event date, changes you've made online will be reversed and your dependent's eligibility will be terminated. You will be required to reimburse the plan for any benefits paid or received on your dependent's behalf.

For complete details, please contact the City of Portland Health & Financial Benefits Office.

Qualified Family Status Change

Check the chart for examples of qualified family status changes that may allow you to make certain changes to your health and welfare benefits coverage during the year.

Qualifying Event	Medical, Dental and Vision Plans	Flexible Spending Accounts	Life Insurance
Change in Marital or Relationship Status			
Marriage	<ul style="list-style-type: none"> ▪ Add spouse, children as applicable ▪ Change tier or cancel coverage 	Increase coverage	Can change or add life coverage, and add spouse, children as applicable

Qualifying Event	Medical, Dental and Vision Plans	Flexible Spending Accounts	Life Insurance
Domestic partner meets criteria; affidavit is approved	<ul style="list-style-type: none"> ▪ Add domestic partner, children as applicable ▪ Change tier or cancel coverage 	No change allowed	Can add domestic partner, children to life insurance as applicable
Divorce, annulment or legal separation <i>Note:</i> The effective date of the loss of benefits is retroactive to the last day of the month in which the divorce or legal separation occurred.	<ul style="list-style-type: none"> ▪ Add coverage, including children, if other coverage is lost ▪ Cancel spouse's coverage ▪ Change coverage tier 	Decrease coverage	<ul style="list-style-type: none"> ▪ Can cancel spouse's life coverage ▪ Increase or decrease personal supplemental life coverage
Termination of domestic partnership <i>Note:</i> The effective date of the loss of benefits is retroactive to the last day of the month in which the domestic partnership terminates.	<ul style="list-style-type: none"> ▪ Add coverage, including children, if other coverage is lost ▪ Cancel domestic partner's coverage ▪ Change coverage tier 	No change allowed	<ul style="list-style-type: none"> ▪ Can cancel domestic partner's life coverage ▪ Increase or decrease personal supplemental life coverage
Death of spouse	<ul style="list-style-type: none"> ▪ Add coverage, including children, if other coverage is lost ▪ Cancel spouse's coverage ▪ Change coverage tier ▪ 	Decrease coverage	<ul style="list-style-type: none"> ▪ Can cancel spouse's life coverage ▪ Increase or decrease personal supplemental life coverage

Qualifying Event	Medical, Dental and Vision Plans	Flexible Spending Accounts	Life Insurance
Death of domestic partner	<ul style="list-style-type: none"> ▪ Add coverage, including children, if other coverage is lost ▪ Cancel domestic partner's coverage ▪ Change coverage tier 	No change allowed	<ul style="list-style-type: none"> ▪ No change allowed for LTD ▪ Can cancel domestic partner's life coverage ▪ Increase or decrease personal supplemental life coverage
Increase or Decrease in Number of Family Members			
Birth, adoption or placement for adoption, custody, legal guardianship <i>Note:</i> Your newborn (or enrolled dependent's newborn) automatically will be covered for the first 31 days; you must alert the City within 60 days for benefits to continue.	<ul style="list-style-type: none"> ▪ Add new children ▪ Add Spouse or Domestic Partner (If not already enrolled) ▪ Change coverage tier 	Increase coverage	<ul style="list-style-type: none"> ▪ Can decrease supplemental life insurance coverage at any time, for any reason ▪ Can increase supplemental life coverage to the guarantee issue amount, only if you have not previously been denied and your coverage is not already at the maximum
Child reaches Plan's age limit, or death of covered child	<ul style="list-style-type: none"> ▪ Cancel child's coverage only ▪ Change coverage tier 	Decrease coverage	<ul style="list-style-type: none"> ▪ Can cancel child's life insurance coverage
Change in Work Status			

Qualifying Event	Medical, Dental and Vision Plans	Flexible Spending Accounts	Life Insurance
Change in hours to become eligible for benefits (full-time, part-time)	Elect new plans	Elect new plans	Elect new plans
Change in hours that affects percentage level of contribution for benefits	<ul style="list-style-type: none"> ▪ <i>If your contribution increases:</i> you can cancel coverage (if you can provide proof of other coverage) or drop dependents from your coverage ▪ <i>If your contribution decreases:</i> you can elect coverage and/or add dependents to your coverage 	No changes allowed	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life ▪ You may apply to increase or decrease Supplemental Life at any time
Change in hours that causes employee to become ineligible for benefits	Coverage ends, subject to your rights under the Affordable Care Act (ACA) (COBRA continuation is offered for Medical, Dental, Vision)	Coverage ends (COBRA continuation is offered for HFSA)	Coverage ends
Change in Employment of Covered Family Member			
New job – gain coverage or eligibility	Cancel coverage for those enrolling in new/other plan	Decrease coverage	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life ▪ You may apply to increase or decrease Supplemental Life at any time
Job loss – loss of coverage	<ul style="list-style-type: none"> ▪ Elect coverage/add eligible family members ▪ Change coverage tier 	Increase coverage	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life ▪ You may apply to increase or decrease Supplemental Life at any time
Other Plan Open Enrollment for Eligible Family Member			

Qualifying Event	Medical, Dental and Vision Plans	Flexible Spending Accounts	Life Insurance
Spouse's or domestic partner's annual enrollment for health coverage (with different coverage periods from this plan)	<ul style="list-style-type: none"> ▪ Elect new coverage tier ▪ Cancel coverage for those enrolling in new plan 	No change allowed	No change allowed
Change in Residence/Worksite			
Move into or out of medical network area (if enrolled in Kaiser HMO)	<ul style="list-style-type: none"> ▪ Elect new coverage option (same enrollment category) ▪ Cancel coverage, if currently out of network area 	No change allowed	No change allowed
Enrollment in Government Program			
Medicare, Medicaid, CHIP, TRICARE	Add or cancel coverage for person affected	No change	No allowable change
Retiree is eligible for a Special Enrollment Period, or seeks to enroll in a Qualified Health Plan through a Marketplace during the Marketplace's annual open enrollment period.	Retiree may revoke coverage through the City	N/A	N/A
Leave of Absence – FMLA Rules Apply			
Begin leave (unpaid)	Continue or cancel coverage	Continue or cancel coverage	City-paid coverage continues
Return from leave (unpaid)	Reinstate prior coverage	Reinstate prior coverage	Reinstate prior coverage
Cost Change			

Qualifying Event	Medical, Dental and Vision Plans	Flexible Spending Accounts	Life Insurance
Significant cost increase	<ul style="list-style-type: none"> ▪ Continue current coverage ▪ May choose another similar plan with lower cost ▪ Decrease coverage ▪ Cancel coverage if no similar plan 	DFSA changes are allowed	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life ▪ You may apply to increase or decrease Supplemental Life at any time
Significant cost decrease	<ul style="list-style-type: none"> ▪ Continue current coverage ▪ Choose more expensive plan ▪ If no prior coverage, may choose plan ▪ Change coverage level 	DFSA changes are allowed	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life ▪ You may apply to increase or decrease Supplemental Life at any time
Minor cost increase or decrease	<ul style="list-style-type: none"> ▪ Automatic increase or decrease ▪ No change of enrollment category allowed 	No change allowed	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life ▪ You may apply to increase or decrease Supplemental Life at any time
Coverage Change			
Significant loss or curtailment of coverage	<ul style="list-style-type: none"> ▪ Continue current coverage ▪ For loss of coverage, may choose another similar plan or cancel coverage if no similar plan ▪ For curtailment of coverage, may choose another similar plan 	DFSA changes are allowed	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life or Basic LTD ▪ You may apply to increase or decrease Supplemental Life or Buy-up LTD at any time
Addition or improvement of plan	<ul style="list-style-type: none"> ▪ Continue current coverage ▪ Choose new or improved plan ▪ If no prior coverage, may choose new or improved plan 	DFSA changes are allowed	<ul style="list-style-type: none"> ▪ No changes allowed for Basic Life or Basic LTD ▪ You may apply to increase or decrease Supplemental Life or Buy-up LTD at any time
IMPORTANT NOTE FOR RETIREES:			

Qualifying Event	Medical, Dental and Vision Plans	Flexible Spending Accounts	Life Insurance
<p>If you are a retiree and experience a qualifying family status change during the year, you must complete a City of Portland Notice of Change in Family Status form. Please contact the Health & Financial Benefits Office at 503-823-6136 to provide notice and obtain the form. Documentation must be returned to the Health & Financial Benefits Office within 60 days of the event.</p>			

Special Situations

In the event of a **Qualified Medical Child Support Order (QMCSO)**, you may add coverage for a child or cancel coverage for a child as appropriate. A QMCSO is a judgment, decree, order or state administrative order—resulting from a divorce, legal separation, annulment or change in legal custody—that requires the Plan Administrator to provide health coverage for your child. When a medical child support order is determined to be “qualified,” the child’s coverage will be effective on the first day of the month following the determination.

Effective Dates of Mid-Year Changes

Coverage for newly eligible dependents becomes effective the first of the month following or coinciding with the later of: (1) the effective date of your coverage; (2) the date the individual becomes a dependent; or (3) the date you submit completed enrollment forms and all required documentation to the City’s Health & Financial Benefits Office. If you do not return a completed City of Portland Notice of Change in Family Status form to add dependents within 60 days of the status change or do not provide documentation after enrolling the dependent online, then the dependent cannot be added until the next annual enrollment period.

When Coverage Ends

For Employees

Coverage will end automatically on the earliest of the following:

- The last day of the last period for which you make a required premium contribution
- The date the group policy terminates
- The date you (or your dependent) is no longer eligible
- The last day of the month in which:
 - Your unpaid military leave begins (following a 31-day period in which coverage continues as if you were still actively employed)
 - Your approved FMLA leave ends and you have not returned to work for the City
 - Your Workers’ Compensation or service-connected illness or injury leave ends and you have not returned to work for the City
 - Your employment ends.
- Your termination date for Flexible Spending Accounts (FSA)

In addition, coverage will end as outlined below.

Healthcare coverage will end on the last day of the month in which you have not been paid a minimum of 80 benefit-eligible hours or you do not pay the required employee premiums.

Life Insurance and Supplemental Life Insurance coverage ends the last day of the month in which you terminate employment. There is no City sponsored extension of this coverage.

Group life insurance can be converted to an individual policy (not rate guarantee) and up to \$200,000 (employee) and \$30,000 (spouse/partner) of Supplemental Life Insurance can be ported (paid at the same rate as City employees).

Reinstatement of Coverage

If your coverage has been terminated due to loss of eligibility (excluding termination of employment), coverage can be resumed without meeting the eligibility waiting period, provided you return to a benefits-eligible status within 12 consecutive months after the date coverage stopped. If you are eligible for reinstatement, City contributions become effective on the first of the month following the month in which you have been paid a minimum of 80 benefit-eligible hours.

If your employment has been terminated and you are rehired in the same plan year, your previous plans will be reinstated. If you have experienced a qualifying life event while ineligible for benefits, you can add beneficiaries at that time. If you have been rehired after annual open enrollment, you are able to change medical and/or dental plans and elect Healthcare FSA and Dependent Care FSA. Employees who have terminated employment, and are rehired within the same plan year cannot change plans, only add or drop dependents or increase/decrease FSA Healthcare FSA and/or Dependent Care FSA plans, if a qualifying life event applies.

For Retirees or Other Self-Pay Continuation Participants (including COBRA)

Coverage will end automatically on the earliest of the following:

- The last day of the last period for which you make a required premium contribution
- The date the group policy terminates (note that COBRA continuation coverage continues as long as the City offers any group health policy)
- The date you (or your dependent) is no longer eligible
- When you become eligible for Medicare
- When your COBRA eligibility period ends

For Your Dependents

Your dependents' coverage will end on the last day of the month in which they no longer meet the definition of a dependent. This includes:

- Following divorce or legal separation from your spouse
- Termination of your declared domestic partnership
- When your eligible child reaches age 26
- When your incapacitated child is no longer considered disabled under the Social Security Act
- If you or your spouse/domestic partner no longer has legal custody or is no longer legal guardian

Also, coverage for your dependent child's child (your grandchild) will end if the child's parent is no longer considered your eligible dependent and/or both your child and grandchild no longer live with you.

You will be required to pay the cost of premiums or claims incurred by your dependents after the date benefits *should have* ended. If you report a change in dependent's status within 60 days, as required, your dependent may be eligible for COBRA continuation coverage. See the *COBRA Coverage* section for more details.

HIPAA

The Plan is in compliance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Leaves of Absence

In certain leave situations you may continue to participate in some or all of your benefits through the City. The City's health plans comply with the health continuation provisions of the federal Family and Medical Leave Act of 1993 (FMLA), Oregon Family Leave Act (OFLA), and the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA). **Leaves of absence do not apply to retirees or other self-pay participants (including COBRA).**

Family and Medical Leave Act (FMLA)

The Family and Medical Leave Act (FMLA) provides up to 12 weeks per calendar year of protected leave if you need to take time off from work due to a serious medical condition of your own or that of a family member, for the birth, adoption or foster care placement of a child, or for the military service of family members. FMLA law primarily does three things:

1. Protects your job while you are off work, so that your job or a similar job will be available when you can return to it (as long as you are able to return to work before you exhaust your FMLA leave).
2. Protects your time off from being held against you in employment actions such as hiring, promotions or discipline.
3. Requires employers to continue your health benefits in the same manner as it did when you were working.

The following rules apply to FMLA leaves:

- Although Family Leave is unpaid, employees are entitled to use their accrued paid vacation, sick or other paid leave to supplement any loss in pay.
- While on approved FMLA, any share of health plan premiums normally paid by you prior to leave must continue to be paid by you during the leave period.
 - As an alternative, you can pay any unpaid portion of your premium share upon your return to work
- If you and/or your enrolled dependents have other coverage and choose not to retain the City's group health plan coverage during FMLA leave, you and/or your enrolled dependents will be eligible to be reinstated in the same plan(s) as before the leave on the date you return from FMLA leave. Contact your Benefits Office, 503-823-6031, if you require more information about qualifying health plan coverage changes.

- If you do not return to work after the approved FMLA period of leave, reimbursement of all the benefit payments the City made on your behalf during the leave will be requested (unless there is a continuation, recurrence, or onset of a serious health condition).

Your rights under this provision are determined by the Family and Medical Leave Act of 1993 and its regulations, as amended.

Oregon Family Leave Act (OFLA)

The Oregon Family Leave Act (OFLA) provides protected leave similar to FMLA in the event you need to take some time off from work due to a serious medical condition of your own or that of a family member, for the birth, adoption or foster care placement of a child, or for the military service of family members. Leave taken under FMLA will count as OFLA leave provided you are also eligible for OFLA leave. OFLA is different from FMLA in the following ways:

- OFLA has an expanded list of “family members” compared to FMLA. OFLA also extends to a child age 18 or older (if the purpose of the leave is due to the child’s own serious health condition), grandparents and grandchildren, parents-in-law, same-gender domestic partners, and children and parents of same-gender domestic partners.
- OFLA has sick child leave (for a child’s non-serious health condition requiring home care, or care of a child whose school or childcare provider is closed due to a statewide declared public health emergency). A child must be under the age of 18, or an adult dependent child incapable of self-care because of a mental or physical disability, for the purposes of sick child leave.
- OFLA has an additional allotment of leave for pregnancy disability (a form of a serious health condition leave) and for sick child leave when following 12 weeks of parental leave.
- OFLA has bereavement leave which is leave to make funeral arrangements, attend the funeral, or to grieve a family member who has passed away. This leave is limited to two weeks and must be completed within 60 days of the date when the employee learned of the death. Bereavement leave will count toward the total amount of OFLA eligible leave.

Your rights under this provision are determined by the Oregon Family Leave Act and its regulations, as amended.

Please contact your bureau Family Medical Leave Coordinator for assistance and questions about eligibility; the information described here is not a full description of FMLA, OFLA and/or its complex rules.

City Paid Parental Leave

City Paid Parental Leave is leave taken to bond and care for a newborn child or newly adopted child. City Paid Parental Leave may also be taken for new Foster Care placement of a child. All regular, probationary, limited duration, or temporary employees in budgeted positions, as well as Bureau Directors, employees in elected official offices, and employees in other classifications designated as “at will”, are eligible for paid parental leave after 180 consecutive calendar days of employment.

Eligible employees may receive up to a maximum of one continuous period of paid parental leave, not to exceed 6 calendar weeks, per event. An eligible employee may receive paid parental leave for only one event per calendar year. The Director of Human Resources may make an exception and allow additional paid parental leave if two qualifying events occur in the same calendar year, or when extenuating circumstances exist.

If an employee qualifies for FMLA, OFLA leaves, and/or parental leave under a collective bargaining agreement, City Paid Parental Leave under this rule must run concurrently with said leaves and must be

used during the approved FMLA and/or OFLA parental leave. Parental leave must be taken within 12 months of the birth, adoption, or Foster Care placement of the child. Additional guidance may be found within the City's Administrative Rule, 6.05 Family Medical Leave.

Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA)

If you leave your job to perform military service, you can elect to continue your existing health benefits for yourself and your covered dependents for up to 24 months while in the military. If you do not elect to continue coverage during military service, you have the right to be reinstated in the City's health plan upon reemployment, generally without any waiting periods or exclusions except for service-connected illnesses or injuries (which are covered under military coverage).

The following rules apply to military leaves:

- Employees on unpaid military leave of 31 days or more can elect to continue medical/vision and dental benefits similar to COBRA continuation coverage for themselves if they are already enrolled in City medical/vision and/or dental coverage. Continuation coverage would be in addition to military coverage. Upon reemployment, the City will reinstate your coverage without imposing any exclusion or waiting periods that would not have been imposed had the coverage not been terminated.

The City will pay the cost of continuing to provide health insurance coverage similar to COBRA continuation coverage for up to 24 months for your dependents and will waive the 2% administrative fee for your dependents when you are called to active duty for a minimum of 31 days (training periods do not qualify) at the same level and cost provided while you were at work. Your dependents who have dual coverage through the City or a spouse/domestic partner's employer are not eligible for this benefit.

- For military leave of less than 31 days, your City-paid coverage will continue.

Coverage Continuation Options

You and your eligible dependents may elect a temporary continuation of coverage for medical, vision, dental, Employee Assistance Program, and the Healthcare FSA under certain circumstances, when coverage would otherwise end. Options include:

- Workers' Compensation/Industrial Accident Leave
- Legally Separated, Divorced or Widowed Spouses, or Registered Domestic Partners Over 55
- Disabled Employees and Retirees
- COBRA continuation coverage when employment or eligibility ends

Continuation of Coverage: Workers' Compensation/Industrial Accident Leave

You can continue benefits during a Workers' Compensation or Industrial Accident Leave, in accordance with Oregon statutes, the applicable Labor Agreement and/or Administrative Rule 6.13; however, you must pay any applicable employee premium share contributions in order to continue coverage, even while in an unpaid status.

Continuation of Coverage: Legally Separated, Divorced or Widowed Spouses, or Registered Domestic Partners Age 55 or Older

Under Oregon law (ORS 743.600-743.602), if you are a spouse or registered domestic partner who is age 55 or older and your eligibility for group health plan coverage has ended due to legal separation, termination of marriage or the member's death, you may be entitled to continue your plan coverage (including coverage for dependent children) until one of the following events occurs:

- The date you become covered under any other group health plan, regardless if the other plan has an exclusion or limitation period.
- The date you become eligible for federal Medicare coverage, whether or not you enroll in Medicare
- The last day of the month that premiums were paid to the City in the event of non-payment of premiums
- The date the plan terminates or the date the City of Portland terminates participation under this plan
- A dependent child may remain on the plan with you until the child no longer meets the plan's definition of a dependent child
- The date the member remarries or registers another domestic partnership

Oregon continued coverage is available only if you (spouse/domestic partner age 55 or older) notify the Plan Administrator in writing of the legal separation, termination of marriage or your spouse's death within:

- Thirty (30) days of the date of the member's death;
- Sixty (60) days of the date of legal separation; or
- Sixty (60) days of the date of entry of the divorce decree.

Coverage under this law will be subject to all other regulations governing COBRA administration (see the *COBRA Coverage* section), but is not considered a second qualifying event.

Continuation of Coverage: Retirees and Other Self-Pay Participants

Disabled employees, retirees, and their eligible dependents may qualify to continue benefits. Continuation of Coverage is paid entirely by the disabled employee, retiree and/or their eligible dependents. Where collective bargaining agreement language deviates from this document, the collective bargaining agreement language will be the governing language. You and/or your dependents will be permitted to continue the same coverage you or your dependents had on the day before the qualifying event occurred, unless you move out of that plan's coverage area or the plan is no longer available. You and/or your dependents cannot change coverage options until the next annual enrollment period.

There are three group health components to the City's retiree/disability continuation coverage:

1. Medical/Vision
2. Dental
3. Employee Assistance Program (EAP)

There may be other coverage options for you and your family. For example, you may choose to buy coverage through the Health Insurance Marketplace (for information, see the *Health Insurance Marketplace* section of the SPD or visit healthcare.gov); or you may be eligible for a special enrollment

opportunity through another group health plan, like your spouse's/domestic partner's plan, if you request enrollment within the required timeframe (typically 30 days).

Eligibility

To be eligible for disabled employee or retiree continuation of coverage, you must meet both of the following conditions:

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

Special Rules – Retirees and Disabled Employees

Retirees and disabled members not eligible for Medicare and their non-Medicare-eligible, covered dependents are able to continue on the City's health care plans for active employees by timely self-paying the monthly premium. Once a retiree/disabled member and/or dependent becomes eligible for Medicare and/or attains age 65, they are no longer eligible for the City active employee medical, vision, or dental plans. **Retirees, disabled employees and/or their dependents who are Medicare-eligible and/or attain age 65 are eligible for coverage under the Kaiser Medicare Advantage Supplement plan.**

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 on the active employee plans by self-paying the monthly premiums. If the individual becomes entitled to Medicare later (based on spouse's/domestic partner's or ex-spouse's/domestic partner's Social Security eligibility), they will no longer be eligible for the non-Medicare plans including vision and dental. **Note:** Dental plan eligibility ends at age 65 (regardless of Medicare eligibility).

Termination of Coverage

If disabled members or retirees elect to terminate coverage under City plans prior to age 65, they can *only* return to the City's medical and dental plans in which they were previously enrolled if they are not Medicare-eligible and they maintain continuous medical and dental coverage between the time they leave the City plans to the date they want to return. This includes:

- Other group (employer sponsored) coverage, and
- Individual plans purchased through the federal exchange.
- The option to return from an individual plan to the City's plans is limited to one time per participant.

Continuation of Coverage During Strike or Lockout

Important Note: The following language is required to be included as part of this SPD because the CityNet PPO plan is an insured health plan—but it does not apply to PPA employees as PPA members are governed under ORS 243.736.

If employed under a collective bargaining agreement and involved in a work stoppage because of a strike or lockout, a subscriber may continue coverage for up to 6 months. The subscriber must pay the full premiums, including any part usually paid by the City, directly to the union or trust, and the union or trust must continue to pay Moda Health, the plan administrator, the premiums when due.

Continuation of coverage during a strike or lockout will not occur if:

- Fewer than 75% of those normally enrolled choose to continue their coverage

- A subscriber accepts full-time employment with another employer
- A subscriber otherwise loses eligibility under the Plan

Continuation of Coverage: COBRA

Under certain circumstances, you (including retirees) and your covered dependents may continue your health care coverage after the date it would otherwise end. The law that allows you to do so is called COBRA, which stands for “Consolidated Omnibus Budget Reconciliation Act of 1985.”

Through COBRA, you and/or your dependents must be given the opportunity to continue health insurance when there is a qualifying event that would result in loss of coverage under the plan. You and/or your dependents will be permitted to continue the same coverage you or your dependents had on the day before the qualifying event occurred, unless you move out of that plan’s coverage area or the plan is no longer available. You and/or your dependents cannot change coverage options until the next annual enrollment period.

There are four group health components to the City’s COBRA continuation coverage:

1. Medical/vision
2. Dental
3. Employee Assistance Program (EAP)
4. Healthcare FSA

There may be other coverage options for you and your family. For example, you may choose to buy coverage through the Health Insurance Marketplace (for information, see the *Health Insurance Marketplace* section of the SPD or visit healthcare.gov); or you may be eligible for a special enrollment opportunity through another group health plan, like your spouse’s/domestic partner’s plan, if you request enrollment within the required timeframe (typically 30 days).

*Retirees and dependents are eligible for limited Healthcare FSA continuation coverage.

Did You Know?

If you have a Healthcare FSA balance when enrolling for COBRA... Your “under spent” account (the balance of your total annual election minus reimbursements to date) will continue as it otherwise would. COBRA continuation coverage will terminate at the end of the plan year and qualified beneficiaries may not enroll in the Healthcare FSA in subsequent years.

Who Is Eligible?

Only a “qualified beneficiary” (as defined by federal law) may elect to continue health insurance coverage. A qualified beneficiary may include the following individuals who were covered by the plan on the day the qualifying event occurred: you (active or retired employee), your spouse, and your children. **Note:** Domestic partner may only continue coverage as part of the family unit; domestic partners do not have an independent right to continue coverage.

When COBRA Coverage Ends

This chart shows the reasons that coverage would end for you or your covered family member. For each of those reasons, COBRA specifies the length of time that a former covered person may continue his or her health plan coverage. However, if a *second* qualifying event occurs within the 18- or 29-month continuation period, the COBRA continuation period for the medical, vision, or dental—but not the Healthcare FSA—may be extended for up to 36 months from the first COBRA event. You must notify the Health & Financial Benefits Office of the second qualifying event within 60 days; otherwise, no extension will be granted.

Reason Coverage Ended ("COBRA Qualifying Event")	Maximum COBRA Continuation Period*		
	You	Your Covered Spouse/Domestic Partner	Your Covered Child
You lose coverage because of reduced work hours	18 months	18 months	18 months
Your employment ends for any reason other than gross misconduct	18 months	18 months	18 months
You or your covered family member become eligible for Social Security disability benefits when you lose coverage under the Plan	29 months	29 months	29 months
You die	N/A	36 months	36 months
You divorce	N/A	36 months	36 months
You become entitled to Medicare	N/A	36 months** 1	36 months ** 1
Your child is no longer eligible	N/A	N/A	36 months
Your leave exceeds the maximum leave covered by FMLA	18 months***	18 months***	18 months***

* The maximum COBRA continuation periods in this chart apply to the medical, vision, EAP and dental plans only. COBRA coverage for Healthcare FSA may be continued only through the end of the plan year.

** If the employee became entitled to Medicare benefits less than 18 months before the COBRA qualifying event, COBRA coverage for qualified beneficiaries can continue up to 36 months *after the date of Medicare entitlement*. If an employee becomes entitled to Medicare two months before a qualifying event, his/her qualified beneficiaries would only be able to continue COBRA coverage for 34 months (36 months minus 2 months). This applies when coverage is lost due to termination, reduction of hours, leave of absence or moving to a non-benefits-eligible job status.

*** Unless you would otherwise be eligible for the additional 11 months for disability.

¹ Domestic partners are excluded from this 36-month extension.

Coverage will be terminated before this maximum period if any of the following occurs:

- Any required premium is not paid in full on time.
- A qualified beneficiary first becomes covered under another group health plan. **In this case, the qualified beneficiary must notify the Health & Financial Benefits Office within 30 days of eligibility and enroll at the first eligibility date for such other coverage.**
- A qualified beneficiary first becomes entitled to Medicare benefits (under Part A, Part B, or both) after electing continuation coverage. The qualified beneficiary must notify the Health & Financial Benefits Office within 30 days of entitlement to Medicare.
- During a disability extension period, the Social Security Administration makes a final determination that the disabled qualified beneficiary is no longer disabled (COBRA coverage for all qualified beneficiaries, not just the disabled qualified beneficiary, will terminate). In this case, the qualified beneficiary must notify the Health & Financial Benefits Office within 30 days after the date of the Social Security final determination.
- The City ceases to provide any group health plan for its employees.

- Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

Extending COBRA Coverage

Disability Extension

You and your qualified beneficiaries may be eligible to extend COBRA coverage for 11 additional months if any of you are determined under the Social Security Act (Title II or XVI) to be disabled. The extension is available to you and all of your dependents who are receiving COBRA continuation coverage as a result of the covered employee's termination, reduction in hours, leave of absence or change to a non-benefits eligible position.

The disability must have started on or before the 60th day of COBRA continuation coverage, and must last at least until the end of the 18-month period of coverage. Notice to the Health & Financial Benefits Office must be provided—with the Social Security determination letter—within 60 days after the determination is made and before the 18-month COBRA period ends. **Note:** If notice to the Health & Financial Benefits Office is not received within this timeframe, there will be no disability extension of COBRA coverage.

To qualify for the disability extension, all of the following requirements must be satisfied:

- Inform the Health & Financial Benefits Office within 60 days after the date of the disability determination; and
- If applicable, inform the Health & Financial Benefits Office within 30 days after the date of any final determination that the covered employee or covered family member is not disabled.

Second Qualifying Event

If, as a result of your termination of employment or reduction in work hours, your dependent(s) have elected COBRA continuation coverage and one or more dependents experience another COBRA qualifying event, the affected dependent(s) may elect to extend their COBRA continuation coverage for an additional 18 months (seven months if the secondary event occurs within the Disability extension period). The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. The second qualifying event must occur before the end of the initial 18 months of COBRA continuation coverage, or within the disability extension period discussed below.

Note: Under no circumstances will COBRA continuation coverage be available for more than 36 months from the initial qualifying event.

Secondary qualifying events are:

- Death of a covered employee
- Divorce or legal separation from a covered employee
- Covered employee becomes entitled to Medicare benefits (Part A, Part B or both)
- For a dependent child, failure to continue to qualify as a dependent under the plan

Electing COBRA, Retiree or Other Self-Pay Continuation Coverage

When you or your Bureau/Office notifies the Health & Financial Benefits Office of a qualifying event, you will be sent the applicable package. **To elect COBRA**, complete the COBRA Election Form included in the package. The completed and signed Election Form must be received by the Health & Financial Benefits Office before the deadline or you will lose your right to elect COBRA coverage. **To elect retiree or other self-pay continuation coverage**, complete the appropriate Election Form included in the

package. The completed and signed Election Form must be received by the Health & Financial Benefits Office before the deadline or you will lose your right to elect disabled or retiree coverage.

Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee’s spouse/domestic partner may elect continuation coverage even if the employee does not. This is called an independent election right.

Did You Know?

Any qualified beneficiary for whom COBRA, retiree or other self-pay continuation coverage is not elected within the 60-day election period will lose his or her right to elect continuation coverage in the future.

Cost

When you are no longer an active employee—you are retired, or on COBRA or another self-pay continuation coverage—you are liable for the entire cost of coverage. (For COBRA continuation, you pay the full cost during the applicable 18-, 29-, or 36-month period, measured from the date that coverage would otherwise end due to the qualifying event.) Retirees and participants with self-pay continuation coverage will pay 100% of the cost of active coverage; participants on COBRA will pay 100% of the full cost of active coverage. In the case of an extension of continuation coverage due to a disability, your cost may be 150% of the cost of coverage.

Due to the required 60-day benefits election period, it is likely that you will be responsible for retroactive premiums. These premiums must be paid in a lump sum within 45 days after electing retiree or continuation coverage in order for the coverage to be effective.

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

PPA COBRA Rates			
Total Monthly Cost	Employee Only	Employee + 1	Family
CityNet, VSP Vision	\$683.37	\$1,323.15	\$1,770.45
CityNet, VSP Buy-Up	\$693.59	\$1,341.71	\$1,795.20
Kaiser Medical, Vision	\$592.84	\$1,132.02	\$1,671.22
CityHDP, VSP Vision	\$511.15	\$975.74	\$1,300.58
CityHDP, VSP Buy-Up	\$521.37	\$944.30	\$1,325.33
Delta Core Dental Plan	\$57.42	\$99.20	\$176.23
Delta Dental Buy-Up	\$66.30	\$114.57	\$203.55
Kaiser Dental	\$63.70	\$127.36	\$191.06
Employee Assistance Program (EAP)	\$6.40 per month (same for all tiers)		

When Payment Is Due

If your first full payment is not received within the first 45 days of your retiree or continuation coverage, you will lose coverage and the right to re-elect it.

Monthly payments are required to continue coverage; the amount will be provided on your election notice, and it is your responsibility to provide timely payments. **Payment is due on the first day of the month.** There is a grace period of 30 days after the first day of every month. *However, if your payment is received after the first day of the month (within the 30-day grace period), your coverage will be temporarily*

suspended until your payment is received. Any claim you submit for benefits may have to be re-submitted after your coverage is reinstated following receipt of your payment.

If you fail to make a payment before the end of the grace period for that month, you will lose coverage and the right to re-elect it.

COBRA Notice Procedures

The Program's Retiree/COBRA Administrator will notify you by mail (at the address you have on file with the City) of your right to choose COBRA coverage when your COBRA event is a reduction in hours or termination of employment (including retirement and in the event of your self-pay continuation coverage). The notice will include an Election Form and give you instructions on how to continue your health plan coverage. **Note:** When you retire, you automatically will receive a COBRA notice; you may also have the opportunity to enroll in retiree medical coverage instead (if you are eligible).

If your covered family members lose coverage due to divorce or loss of dependent status, you or your covered family member must notify the City through the BenefitsOnline system or in writing to the Health & Financial Benefits Office on the City's Change in Family Status Change Form. Written notices must be mailed or hand-delivered to:

COBRA Administrator
City of Portland
BHR/Health & Financial Benefits Office
1120 SW Fifth Avenue, Room 987
Portland, OR 97204

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

Any notice you provide must include:

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

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

Any notice of **disability** that you provide must include:

- The name and address of the disabled qualified beneficiary;
- The date the qualified beneficiary became disabled;
- The names and addresses of all qualified beneficiaries who are still receiving COBRA coverage;
- The date the Social Security Administration made its determination;

- A copy of the Social Security Administration’s determination; and
- A statement whether the Social Security Administration has subsequently determined the disabled qualified beneficiary is no longer disabled.

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

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

Health Insurance Marketplace

Another option for medical coverage is through the Health Insurance Marketplace, or “exchange.” The exchange allows people without medical insurance to shop for and purchase health insurance coverage for themselves and their dependents. Using the website, you can compare all of your options and costs side by side and see if you qualify for financial help. All of the plans offered through the exchange must meet certain rules relating to affordability, required minimum benefits and market standards. Through the exchange:

- You can choose from four plan levels: Bronze, Silver, Gold and Platinum. They provide different levels of coverage to fit different needs.
- You can choose from a variety of insurance companies. Shopping through the exchange allows you to see several options and associated costs at one time.
- You can fill out an application for financial help.

Many states offer their own exchange—you can find out more about the Washington state marketplace at www.wahbexchange.org. For Oregon and other states that don’t offer an exchange, you have access to a health care marketplace offered by the federal government. More details can be found at www.healthcare.gov.

If you are enrolled in one of the City’s medical plans, you are not eligible for the federal care exchange.

Medical Plan Options

This section describes the medical coverage available to you and your eligible dependents. The plans described are effective July 1, 2021. (To see who is eligible for coverage, go to the *Who Is Eligible?* section.) This important benefit helps protect you from the high and often unexpected cost of medical bills when you or a covered dependent is sick or injured. The Plan also covers preventive care and emergency services to help you and your dependents maintain your health.

You are offered three medical plans, and vision coverage is dependent on the medical plan you choose. You may be eligible to opt out of City medical and vision coverage to receive Opt-Out Dollars.

IMPORTANT NOTE FOR RETIREES/COBRA and Other Self-Pay Participants:

You are not eligible for the medical opt-out dollars.

Please carefully review this section so you understand how your medical benefits work.

Coverage Options

You have three options for medical coverage:

- CityNet Preferred Provider (PPO) Medical Plan administered by Moda Health Plan, Inc..
- CityHDP Medical Plan (High Deductible Health Plan) administered by Moda Health Plan, Inc.
- Kaiser HMO Medical Plan through Kaiser Permanente

Good news! Preventive care (like an annual physical, age-appropriate screenings, etc.) that you receive from an in-network doctor is covered 100%, no matter which medical plan you enroll in.

NOTE FOR RETIREES:

Assuming you are an eligible retiree (not eligible for Medicare at retirement), you and your non-Medicare eligible, covered dependents may continue on the City's health care plans for active employees *as long* as you remain eligible and continue to pay the monthly premium.

Once you (or your dependents) **become eligible for Medicare**, your medical, dental and vision coverage will end. At that time, **you may participate in the Kaiser Senior Advantage Plan**. See the *Kaiser Permanente Senior Advantage Benefit Summary* for the details.

Preventive Care Initiative for all City Health Care Plans

NOTICE REGARDING WELLNESS PROGRAM

The City of Portland Preventive Care Initiative is a voluntary wellness program available to all benefit eligible employees. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the Preventive Care Initiative program you will be asked to complete a preventive exam; which may include a blood test for cholesterol, diabetes, triglycerides, among others. Employees must

receive a preventive exam once in a 2 calendar year cycle or have received other qualifying care such as prenatal and maternity care within the last 2 years, have been inpatient within a hospital, or have sought regular medical care to address a chronic condition to earn the incentive. For July 2022, Moda and Kaiser will look back to calendar year 2020 and 2021 for each participating employee. New employees will have one complete calendar year, regardless of hire date, to meet the Preventive Care Standard. You may also be asked to provide permission for your chosen health plan to send the City of Portland the information it needs to administer the program. Please see an example of the authorization below.

Kaiser Permanente will not share whether you met the Preventive Care Initiative Standard with the City unless you submit a signed paper acknowledgement form, or you go online and confirm your acknowledgement electronically. If the City is unable to confirm your participation, your premium share may be affected.

You are not required to complete a preventive examination. However, employees who choose to participate in the wellness program will receive the incentive. Full-time employees who meet the standard will continue to pay 5% premium share contribution each fiscal year. Although you are not required to complete the preventive exam which may include biometric screening, only full-time employees who do so will continue to pay 5% premium share during the plan year. If you do not meet the standard, your premium share will be 10% for each fiscal year that you have not completed a preventive exam with biometric screening once in a 2 calendar year cycle.

Because part-time employees already pay a greater share of the premium contribution for their coverage, the 5% difference will be added to their monthly premium share amount. The percentages of premium share for part-time employees are different based on union status and standard hour designations. As an example, if you are a non-represented employee with a standard hour's designation of 30 hours per week; you pay a 25% premium share of your medical, dental and vision costs. Should you choose not to participate in the Preventive Care Initiative wellness program as described; your premium share would go from 25% to 30%.

If you feel you are unable to participate in a preventive exam which may include biometric screening once in a 2 calendar year cycle to earn the incentive, you may be entitled to a reasonable accommodation or an alternative standard. You may request a reasonable accommodation or an alternative standard by contacting The Health & Financial Benefits Office at 503-823-6031. Waiting until the last minute to schedule an exam will not be considered for exception or reasonable accommodation.

The information from your preventive exam which may include biometric screening will be used to provide **you and your provider** with information to help understand your current health and potential risks, and may also be used to offer you other services, such as health coaching, health education and/or participation in Healthy Foundations, a chronic disease management program.

PCI Non-Compliant Rates

Cost per pay period	Employee Only	Employee + 1	Family
CityNet, VSP and Delta Dental	\$37.04	\$71.11	\$97.33
CityNet, VSP and Kaiser Dental	\$37.35	\$75.52	\$98.07
CityHDP, VSP and Delta Dental	\$2.87	\$4.96	\$8.81
CityHDP, VSP and Kaiser Dental	\$3.18	\$6.37	\$9.55
Kaiser Medical, Vision, Dental	\$32.82	\$62.97	\$93.11
Kaiser Medical, Vision, Delta Dental	\$32.51	\$61.56	\$92.32
Delta Dental Buy-Up (add this to your total cost)	\$4.44	\$7.69	\$13.66
VSP Buy-Up (add this to your total cost)	\$5.11	\$9.28	\$12.38

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and the City of Portland may use **aggregate** information it collects to design a program based on identified health risks in the workplace, the City of Portland Preventive Care Initiative will never disclose any of your personal information either publicly or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. **Medical information that personally identifies you will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.** In fact, the only information the City will receive in connection to you personally will be your Name, date of birth and last four of your social security number to ensure the benefits administrative annual enrollment software displays the correct premium share values during annual enrollment.

Sample Report on Individuals Meeting the Standard:

Last Name	First Name	DOB	Last Four SSN
Doe	Jane	01/10/1950	1234
Smith	John	04/15/1970	5678

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information are your doctor, nurse or nurse practitioner, physician's assistant, or a health coach in order to provide you with services under the wellness program.

In addition, any medical information obtained through your own self-disclosure in connection with the wellness program (example: for an accommodation) will be maintained separate from your personnel records, information stored electronically will be secured, and no information you provide as part of the wellness program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Health & Financial Benefits Office at 503-823-6031.

- **To complete the City of Portland HIPAA Authorization, you can fill out the online form by clicking the following link: [Kaiser HIPAA Authorization](#). You may also complete the authorization, and scan it in an email to benefits@portlandoregon.gov. The authorization is located at the end of this booklet.**
- **You may, as part of the Annual Enrollment process, complete the authorization online. When you log into your Benefits portal during annual enrollment to elect your FSA, change your coverage or dependents the authorization will be available to you. You may access the portal at: www.portlandoregon.gov/benefits.**

Non-Represented employees, members of the PPA, PPCOA, Housing, BOEC, PTE-17, PCL, Recreation, DCTU and PFFA unions are subject to the provisions of the Preventive Care Initiative as outlined in this document, the Summary Plan Description (Employee Handbook) and completed Collective Bargaining Agreements.

City of Portland HIPAA Authorization - EXAMPLE

This example acknowledgement explains the City's application of protected health information (PHI) in the administration of an employee wellness program.

You can keep the amount taken from your paycheck at the lowest rate if you go to a health care provider and get a checkup. A checkup is a preventive exam. To make sure the City of Portland knows you have gone to a health care provider and gotten a checkup, Kaiser Permanente needs your permission to send your name back to the City.

The City won't get any information about your appointment, except that you had one.

- If you get a checkup, Kaiser Permanente will send you a notice in the mail and send your name, date of birth (DOB) and last four numbers of your SSN to the City.
- If you have not had the required checkup, Kaiser Permanente will send you reminders and help you make an appointment.

Kaiser Permanente will only report your name, DOB and last four numbers of your SSN back to the City.

By signing this form, you acknowledge that you have read this statement and agree to let Kaiser Permanente report your name, DOB and the last four numbers of your SSN back to the City. If you choose not to sign this form, you will not be enrolled in the Preventive Care Initiative and will not qualify for the lowest premium contribution.

Yes, I agree to allow Kaiser Permanente to report my name, DOB and last four numbers of my SSN back to the City as part of the Preventive Care Initiative.

No, I do not agree to allow Kaiser Permanente to report my name, DOB and last four numbers of my SSN back to the City as part of the Preventive Care Initiative. I understand that I will not pay the lowest

premium contribution. I further understand that I will not be denied treatment, payment of claims, enrollment, or eligibility for benefits based on my participation in the Preventive Care Initiative.

This Health Insurance Portability and Accountability Act (HIPAA) Authorization form (Authorization) explains how your health plan and the City may use your protected health information as part of your wellness program, the Preventive Care Initiative.

This Authorization is valid for 12 months for residents of Washington and 24 months for residents of Oregon as determined by the date you sign this form. You may cancel this Authorization at any time by submitting a new Authorization form to the City Benefits Office or by submitting the form electronically through the online portal at portlandoregon.gov/benefits. Your cancellation will not affect information (your name) that was accessed or shared before your request was submitted. Once this information (your name) is accessed or shared for the limited purposes described above, it may no longer be protected under HIPAA.

City of Portland Preventive Care Initiative — Preventive Care Standard

The Preventive Care Standard is defined as a preventive health care screening (checkup) with a health care provider once every 2 calendar years.

To participate in the Preventive Care Initiative, you must agree to allow Kaiser Permanente to share your name, DOB and last four numbers of your SSN with the City as stated in the Authorization. Employees who do not agree to participate and do not sign the Authorization will not get the lowest premium contribution.

For additional information, please see the Employee Benefit Handbook at portlandoregon.gov/bhr/27553.

Kaiser Permanente will:

- Include your name, DOB and last four numbers of your SSN on a report to the City if you met the Preventive Care Standard (got a checkup)
- Send notices to you if you met the Preventive Care Standard (got a checkup)
- Send notices to you if you signed the Authorization and have not met the Preventive Care Standard

Medical Opt-Out Dollars

If you have proof of enrollment in a group medical plan through your spouse or domestic partner under another employer's group medical plan or the City's medical plan, you may opt out of the City's medical/vision coverage. In exchange for opting out, you can receive Opt-Out Dollars in the form of taxable pay added to your paycheck the first and second pay periods of each month for the plan year (or remainder of the plan year, if enrolling mid-year). As an alternative, you can choose to use your Opt-Out Dollars to fund all or part of your flexible spending accounts (HFSA and/or DFSA). You should consider opt-out when having double coverage means you pay 2 separate premium shares and do not have consistent medical costs each month that are equal to or more than the additional premium share you pay

The amount of your Opt-Out Dollars will depend on the coverage tier level of you and your dependents. The City will provide the following Opt-Out Dollars:

Coverage Tier Level	Semi-Monthly Opt-Out Dollars* (Taxable Pay)
Full-time Employee	\$25
Full-time Employee +1	\$45
Full-time Employee + Family	\$62.50

*These amounts will be prorated for part-time employees according to their regularly scheduled hours and/or labor agreement.

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

No Dental Premiums—If You Opt Out of Medical Coverage

The City will pay the monthly premium for core dental coverage for full-time employees and any eligible dependents who opt-out of medical coverage. You also may choose to opt out of City dental coverage, but you will not receive additional Opt-Out Dollars.

Choosing a Medical Plan

Healthcare choices can be difficult decisions, and understanding what plan is best for you and your family is important. Below are some important questions to consider when making your annual enrollment elections for the 2021-22 plan year.

1. How much is your monthly premium share? Is this important to you?

Your premium share is what you, the employee, pay on a pre-tax basis out of your paycheck. Depending on your plan elections you can expect to pay anywhere from \$0 to \$60 per pay check, depending on your elections and family status.

Unfortunately, lower premium doesn't always mean lower medical costs overall and it is likely only one of the expenses you will have if you are needing to seek services. Make sure to review the plan comparisons as well as the chart below to see what plans may best fit your needs!

2. What medical needs to you anticipate to have in this coming year?

Think about how often you will need to see the doctor, or if you will need to see a doctor at all this year. There are things that are unpredictable but think about how often you regularly see a doctor. Do you only go for preventive care? Do you need to see a specialist for a chronic condition? Comparing out of pocket costs can help you make that decision.

If you know that you are going to be seeking regular services, set aside pre-tax dollars into a Healthcare FSA, to help you offset the out of pocket cost, and offset your taxable income!

3. How much will you pay out-of-pocket for services?

Cost-sharing is a term we use to talk about how much it costs when you get medical care, or pick up a prescription. Cost-sharing includes deductibles, copayments, coinsurance and out-of-pocket

maximums. These plan features are a frequent point of confusion. Review the definitions of these cost-sharing terms, so that you can better understand what you will pay for services.

4. Do you take regular prescriptions?

If you take any prescriptions on a regular basis, check to see if the plans you are considering have your drugs listed on their formulary. A formulary is a list of all drugs covered by an insurance company. It is important to make sure that your medications are listed, so you can save on costs!

5. Is your doctor included in-network and do they cover the services you want to get?

All the City's plans use different networks of doctors and medical facilities/hospitals. If you visit a provider who is not in the network, you pay a higher deductible and coinsurance. It is really important the doctors you want to see are in your plans network. The CityNet and the CityHD plans, use the Connexus Network, and the Kaiser plan uses the Kaiser Network.

Finally, use the table on the chart on the next page, to help answer some questions that may help you decide what health plan is best for you!

Need help making your plan selections? See chart below for things to consider			
<i>If you want to...</i>	CityNet Medical Plan	High-Deductible (CityHD) Health Plan	Kaiser Permanente NW Medical Plan
Self-select providers or specialists (e.g. orthopedist, physical therapist, chiropractors) without a referral from a primary care physician	X	X	
Pay an exact copay (just a specific dollar amount) when you get routine care (e.g. office visit, x-ray, counseling)			X
Reduce how much is taken from your paycheck (e.g. 5% premium share) but pay higher deductible costs when services are received		X	
Access in-network services from alternative care providers to broad hospital networks in the Portland Metro Area (Legacy, OHSU, Portland Adventist, Providence)	X	X	
Limit what you pay for required services, surgery or inpatient hospital care to less than \$600 per person			X
Limit what you pay for medical services, surgery or inpatient hospital care to less than \$1,000 per person	X		
Cap your cost of generic, brand or specialty prescriptions	X		
Enroll in Healthy Foundations for added support for risk factors or chronic disease	X		
Work with your primary care physician to manage your care and provide access to specialists			X

Medical Plan Comparison

Use the chart on the following pages to help you determine which medical plan is best for you and your family. If you elect the CityNet or CityHDP medical plan, you will automatically be enrolled in vision coverage through Vision Service Plan (VSP). If you elect the Kaiser NW HMO medical plan, Kaiser will provide vision benefits. This chart shows what *you pay* for in-network services unless otherwise stated.

IMPORTANT TERMS TO KNOW:

These are the basic components of a medical plan. For more details, view the Medical Plan Coverage chart.

Copayment or copay: A copayment, or copay, is a pre-determined, flat dollar amount you pay a provider for certain services or procedures. Depending on the plan you choose, copays may apply to emergency and urgent care, in-network office visits, and some prescription medications.

Coinsurance: The portion of each allowable charge that you must pay; usually expressed as a percentage of the total cost of a service. It is sometimes called a “co-share” because you pay part of the charge and the plan pays the rest—you and the plan share in the cost of services. Typically, you are

required to meet your annual deductible first, then share the cost of services with the plan through coinsurance.

Annual deductible: A specific dollar amount of eligible expenses you pay each year before the CityNet or CityHDP medical plan begins paying benefits for your care. That means you pay the full cost of services or procedures (that are subject to the deductible) until you reach the deductible amount. *For the CityHDP plan, preventive care and some maintenance medications may be covered without meeting the deductible first. All other services will be subject to the deductible and applicable co-insurance.* Check the Medical Plan Comparison chart for the details. Remember, you can use money from your Medical Expense Reimbursement Plan (Healthcare FSA) for eligible out-of-pocket expenses, and may include the deductible under the CityHDP plan, provided you do not contribute to and/or use a separate health savings account.

Out-of-pocket maximum: The maximum amount you pay for covered services out of your own pocket during the plan year. When you reach the out-of-pocket maximum amount, the plan will pay 100% of eligible charges for the remainder of the year. All covered medical expenses, including deductible, coinsurance and copayments count toward the out-of-pocket maximum.

Medical Plan Comparison

Use the chart on the following pages to help you determine which medical plan is best for you and your family. If you elect the CityNet PPO or the CityHDP medical plan, you will automatically be enrolled in basic vision coverage through Vision Service Plan (VSP). If you elect the Kaiser HMO medical plan, Kaiser will provide vision benefits. This chart shows what *you pay* for in-network services unless otherwise stated.

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
General Information			
Network	The CityNet PPO Plan's network is the Connexus Network. During the year you can go in-network or out-of-network as you choose. When you go in-network, you will have fewer out-of-pocket expenses. Only in-network services are represented in this table	CityHDP is a High Deductible Health Plan. In-network services are covered within the Connexus Network. During the year you can go in-network or out-of-network as you choose. When you go in-network, you will have fewer out-of-pocket expenses. Only in-network services are represented in this table	You must use Kaiser providers
Maximum Plan Allowance (MPA)	After the deductible, the plan pays benefits based on negotiated rates	After the deductible, the plan pays benefits based on negotiated rates	Not applicable
Plan Year Deductible	\$150/person; \$450/family maximum	\$1,600/person; \$3,200/family maximum	None
	Notes: CityNet and City HDP in-network expenses apply to the in-network deductible. Out-of-network expenses apply to the out-of-network deductible; there is no cross-over. Charges over MPA are not applied to deductible.		

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
Out-of-Pocket Maximum	\$1,000/person; \$2,500/family maximum (excludes out-of-network expenses)	\$3,500/person; \$7,000/family maximum (excludes out-of-network expenses)	\$600/person; \$1,200/family maximum per plan year*
	Note: Charges over MPA do not apply to annual out of pocket maximum.		
Lifetime Maximum Benefits	No lifetime maximum benefit limit		
Prior Authorization	Required for hospitalization and certain other services. See <i>Services Requiring Prior Authorization</i> .		Handled by Kaiser physician
For the following treatments and services, you pay:			
Physician Services			
Office Visit (for primary care, lab work, allergy shots, kidney dialysis, prenatal visits and other medically necessary exams)	20% up to plan year out-of-pocket maximum, after you meet deductible	<ul style="list-style-type: none"> ▪ \$10 copay (except prenatal visits, which are not subject to the office visit copay) ▪ You pay \$0 for lab and x-ray, allergy shots and other injections 	
Specialist Office Visit	20% up to plan year out-of-pocket maximum, after you meet deductible	\$20 copay	
Pregnancy	20% up to plan year out-of-pocket maximum, after you meet deductible	\$0 (Copays for prenatal office visits are waived)	
Urgent Care	20% up to plan year out-of-pocket maximum, after you meet deductible	\$20 copay	
Telehealth/Virtual Visits	20% up to plan year out-of-pocket maximum, after you meet deductible (only for OHSU telehealth visits through members myModa account)	\$0 copay	
Preventive Care (including, but not limited to: routine visits, lab work, diagnostic medical procedures, immunizations, health/education or tobacco cessation counseling, screenings, etc.)			
Wellness – Routine Physical Exams and	\$0 (Plan pays 100%)		\$0 (Plan pays 100%)

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
<p>Immunizations (except for travel-related immunizations)</p> <p>Note: Non-routine lab work and/or tests and other medically necessary exams are not covered at 100%, but will be covered at regular benefit levels.</p> <p>Preventive services are covered as required under the Affordable Care Act.</p>	<p>Preventive care is subject to these limits:</p> <p>Routine physical exam maximum:</p> <ul style="list-style-type: none"> ▪ Newborn: 2 hospital exams ▪ Infant: 6 exams in first 12 months ▪ Ages 1 – 4: 7 exams ▪ Ages 5 and older: 1 exam per plan year ▪ Routine vision screening for age 3 to 5 ▪ Newborn hearing screening <p>Cancer screenings:</p> <ul style="list-style-type: none"> ▪ Breast Cancer – Mammogram maximum: <ul style="list-style-type: none"> ○ Ages 35 – 39: 1 ○ Ages 40+: 1 per 12 months (365 days) ○ At any age when high risk and deemed necessary by physician ▪ Cervical Cancer – Pap Smear maximum: 1 per 12 months or at any time when high risk and deemed necessary by physician <ul style="list-style-type: none"> ○ Women should begin screenings within 3 years of sexual activity or age 21, whichever is earlier. ▪ Prostate Cancer – PSA (no maximum; frequency at recommendation of treating provider) ▪ Colorectal cancer screening <ul style="list-style-type: none"> ○ Including hospital, sedation and related tissue pathology charges ○ Post-op office visits are covered at regular copays ○ Maximums: <ul style="list-style-type: none"> – Age 50+: 1 sigmoidoscopy every 5 years OR 1 colonoscopy, including polyp removal, every 10 years (procedures will be covered when deemed necessary by a physician because of high risk or family history) – Age 50+: 1 fecal occult blood test per 12 months – Age 50+: 1 double contrast barium every 5 years (does not prohibit a member from receiving a colonoscopy in addition to or in lieu of a double contrast barium, if needed) 		<p>Please talk with your primary care physician about the tests and/or care recommended for you.</p>
Outpatient Services			
Diagnostic X-rays (including ultrasound and other radiology services)	20% up to plan year out-of-pocket maximum, after you meet deductible		\$0 (Plan pays 100%)
Advanced Imaging (including CT Scans, MRIs and PET Scans)	20% up to plan year out-of-pocket maximum, after you meet deductible		\$50 copay

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
Outpatient Hospital (including in-hospital diagnostic x-rays and lab work, surgery, anesthesia and miscellaneous services)	20% up to plan year out-of-pocket maximum, after you meet deductible		\$0 (Plan pays 100%)
Inpatient Hospital Services			
Inpatient Hospital (including semi-private room and board, in-hospital diagnostic x-rays and lab work, surgery, anesthesia and miscellaneous services)	20% up to plan year out-of-pocket maximum, after you meet deductible		\$0 (Plan pays 100%)
Emergency Services			
Emergency Room (copay waived if admitted as inpatient following emergency)	\$50 copay, then 20% up to plan year out-of-pocket maximum (not subject to deductible)	20% up to in-network plan year out-of-pocket maximum, after you have met the deductible plus amount in excess of MPA (not subject to deductible)	\$75 copay

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
Extended Care Services			
Skilled Nursing Facility	20% up to plan year out-of-pocket maximum, after you meet deductible (limited to 30 days per plan year)		\$0 (Plan pays 100%), limited to 100 days'/calendar year

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
Home Health Care	20% up to plan year out-of-pocket maximum, after you meet deductible (limited to 60 visits per plan year)		\$0 (Plan pays 100%) for part-time care, limited to 130 days'/calendar year for prescribed home health services
Hospice	20% up to plan year out-of-pocket maximum, after you meet deductible		\$0 (Plan pays 100%)
Other Services			
Ambulance	20% of MPA, up to plan year out-of-pocket maximum, no deductible	20% of MPA, up to plan year out-of-pocket maximum, after you meet the deductible	\$75 copay
Durable Medical Equipment	20% up to plan year out-of-pocket maximum, after you meet deductible Note: Pre-authorization required if rental exceeds 30 days or cost exceeds \$500.		20% coinsurance (includes external prosthetics and orthotic devices) Requires prior or concurrent authorization.
Alternative Care (includes spinal manipulation, acupuncture, and naturopathic services)	20% up to plan year out-of-pocket maximum, after you meet deductible Notes: 35-visit annual maximum for chiropractic care. CityNet PPO and HDP plan members must use Connexus network providers to receive in-network benefits.		Self-referred chiropractic, acupuncture and naturopathic services are <i>not covered</i> ; you pay 100% of the cost.
Physical Therapy	20% up to plan year out-of-pocket maximum, after you meet deductible		\$20 copay (limited to 20 visits per therapy, per calendar year)
Infusion Therapy	Some medications may require use of an authorized provider to be eligible for coverage. Some medications are not covered in an outpatient hospital setting. Prior authorization required.		20% for inpatient infused medications
Refractive Eye Surgery	Not covered	Not covered	Not covered
Hearing Aids ▪ For members under age 26	20% after you meet deductible, one per ear every 36 months (Includes bone conduction sound processors)		20%, one per ear every 4 years per member who is >18, or enrollees age <19 to 25 enrolled in an accredited institution. Cleaners, moisture guards and assistive listening devices are not covered.

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
<ul style="list-style-type: none"> For adults age 26 and older 	40% plus amount in excess of MPA (no deductible for CityNet); plan pays up to \$1,200 per ear; new hearing aid covered once every 36 months if medically necessary		No coverage
TMJ Treatment	Non-surgical benefit subject to deductible, then you pay 20% up to plan year out-of-pocket maximum.	Non-surgical and surgical benefit 20% up to plan year out-of-pocket maximum, after you meet deductible. Combined maximum lifetime benefit of \$3,000.	\$20 copay
TMJ Surgical Treatment	1 st surgery is covered at 20% up to the plan year out-of-pocket maximum, after you meet the deductible Second surgical appliance subject to prior authorization. Maximum lifetime benefit of \$3,000.		\$0 (Plan pays 100%) <i>If medically necessary</i>
Behavioral Health and Mental Health Treatment Note: Prior authorization is required for all inpatient, partial hospitalization and residential treatment programs.	Outpatient Office visits: \$0 copay Inpatient: 20% up to plan year out-of-pocket maximum, after you meet deductible Note: Intensive outpatient treatment requires prior authorization		<ul style="list-style-type: none"> Outpatient and/or day treatment setting: \$0 copay Inpatient hospital and residential services: \$0 (Plan pays 100%)
Chemical Dependency Treatment Note: Prior authorization is required for all inpatient, partial hospitalization and residential treatment programs	Outpatient Treatment: 20% up to plan year out-of-pocket maximum, after you meet deductible Inpatient and residential treatment programs: After meeting the \$250 deductible, cost of co-insurance is waived for members	20% up to plan year out-of-pocket maximum, after you meet deductible	<ul style="list-style-type: none"> Outpatient and/or day treatment setting: \$10 copay Inpatient hospital and residential services: \$0 (Plan pays 100%)
Sterilization, Contraceptive Implants (e.g., IUD and Norplant)	\$0 (Plan pays 100%) if provided by an in-network provider		<ul style="list-style-type: none"> Sterilization: \$10 copay Implants: Rx copay varies

Medical Plan Feature	CityNet Medical Plan	City HDP	Kaiser HMO Medical Plan
	In-Network	In-Network	
Infertility Treatment	Not covered		50% covered. Member responsible for non-covered services.
Prescription Medication Coverage			
Prescription Medications Express Scripts Retail and Mail-Order Specialty Pharmacy: Accredo 30-day supply for acute and/or new medications up to a 90-day subject to co-insurance/maximum as shown.	In-network pharmacy : <ul style="list-style-type: none"> ▪ <i>Generic:</i> 10% of medication cost ▪ <i>Preferred:</i> 20% of medication cost ▪ <i>Non-preferred medication (generic or brand):</i> 30% of medication cost Retail and Mail-Order Pharmacy: Express Scripts Subject to \$5 minimum, \$35 maximum copay. For prescriptions between 31-90-days supply. Subject to \$5 minimum, \$50 maximum copay	In-network pharmacy: <ul style="list-style-type: none"> ▪ <i>Generic:</i> 10% of medication cost ▪ <i>Preferred:</i> 20% of medication cost ▪ <i>Non-preferred medication (generic or brand):</i> 30% of medication cost Retail and Mail-Order Pharmacy: Express Scripts Subject to \$0 minimum, \$150 maximum copay. For prescriptions between 31-90-days supply. Subject to \$0 minimum, \$300 maximum copay after deductible is met and includes specialty medications purchased at retail pharmacy (with prior authorization). Certain maintenance medications on the Express Scripts Preventive Plus Medications list are covered at the stated benefit level before meeting the annual deductible.	Kaiser pharmacy: <ul style="list-style-type: none"> ▪ \$15 copay per prescription (non-formulary medications are not covered unless medically necessary) ▪ 20% coinsurance for outpatient administered medications Non-Kaiser pharmacy: Not covered Mail order: \$30 copay for formulary maintenance medications. Mail delivery cannot be provided to members who permanently reside outside of Oregon and Washington.
	Be sure to go online at www.express-scripts.com to compare pricing and pharmacy availability.		

Express Scripts SaveOn Program:

Certain specialty pharmacy drugs are considered non-essential health benefits and fall outside the out-of-pocket limits. The cost of these drugs (though reimbursed by the manufacturer at no cost to you) *will not be applied towards satisfying your out-of-pocket maximums.*

Eligible CityNet participants who do not enroll in the program, you will be subject to a higher copay which is not applied to your annual Out of Pocket Maximum. This program does not apply to participants in the CityHD medical plan.

Mental Health/Substance Abuse Prescription Plan Comparison

Medical Plan Feature	CityNet Medical Plan	CityHDP	Kaiser NW Medical Plan
	In-Network	In-Network	
Prescriptions related to Mental Health/Substance Abuse (Generic and Preferred brand medications)	\$15 copay – Retail/Mail Order 30-Day	\$15 copay – Retail/Mail Order 30-Day After Deductible	\$15 copay – Retail/Mail Order 30-Day
	\$30 copay – Retail/Mail Order 90-day	\$30 copay – Retail/Mail Order 90-day After Deductible	\$30 copay – Retail/Mail Order 90-day

Kaiser Permanente Senior Advantage Benefit Summary

The following chart outlines the key features of the Kaiser Medicare Advantage Plan **for retirees who are age 65 or older and/or eligible for Medicare.** If you choose to continue coverage, this “Medicare supplement” plan will pay benefits as shown below. For more details, please contact Kaiser at **503-813-2000.**

Medical Plan Feature	Kaiser Senior Advantage Plan for Medicare-eligible Retirees
General Information	
Network	You must use Kaiser providers
Annual Deductible	None
Annual Individual Out-of-Pocket Maximum	\$1,000
Lifetime Maximum Benefit	No maximum
Benefit (when provided, proscribed or authorized by a Kaiser Permanente plan physician)	Chart shows what you pay:
Office visits and outpatient services:	
Routine preventive physical exam	\$0
Primary care visit	\$15

Medical Plan Feature	Kaiser Senior Advantage Plan for Medicare-eligible Retirees
Specialty care visit	\$15
Prenatal care visit	\$0
Routine eye exam	\$15
Allergy shots and other injections	\$0
Immunizations	\$0
Rehabilitative therapies	\$15
Outpatient surgery	\$15
Inpatient services:	
Inpatient hospital services	\$200 per admission
Emergency/urgent services:	
Ambulance services (per one-way trip)	\$50
Urgent care visit	\$15
Emergency department visit	\$50 (waived if admitted)
Chemical dependency services:	
Outpatient services/day treatment	\$15 per day for day treatment
Inpatient hospital	\$200 per admission
Residential (partial hospitalization)	Half of inpatient hospital (\$100 per admission)
Mental health services:	
Outpatient services/day treatment	\$15 per day for day treatment
Inpatient hospital	\$200 per admission
Residential (partial hospitalization)	Half of inpatient hospital (\$100 per admission)
Other outpatient services and supplies:	
Outpatient durable medical equipment (DME), external prosthetics and orthotics	20% coinsurance
Diabetes self-monitoring, training and supplies	\$0
Outpatient laboratory, x-ray, imaging, and special diagnostic procedures	\$0
Outpatient prescription medications, supplies and supplements	
<ul style="list-style-type: none"> ▪ Medicare – Part B ▪ Medicare – Part D 	<ul style="list-style-type: none"> ▪ \$0 ▪ 40% up to a maximum of \$150 per prescription
Miscellaneous services:	
Home health care	\$0 within service area
Skilled nursing facility care (up to 100 days per Medicare Benefit Period)	\$0

Medical Plan Feature	Kaiser Senior Advantage Plan for Medicare-eligible Retirees
Prescription eyeglasses and contact lenses	Balance after \$100 allowance once in a 2 calendar year period.
Hearing aids	Not covered
Additional travel benefits for services at participating Medicare, non-Kaiser providers Note: Kaiser pays 80% up to a maximum benefit of \$1,000 per year.	20% of Medicare-allowable charges. You pay 100% after Kaiser pays maximum benefit of \$1,000 per year.
Health fitness program	\$0 for basic fitness facility membership at affiliated facilities.

Medically Necessary Care

Medically Necessary means healthcare services, medications, supplies or interventions that a treating licensed healthcare provider recommends and all of the following are met:

1. It is consistent with the symptoms or diagnosis of a member's condition and appropriate considering the potential benefit and harm to the patient
2. The service, medication, supply or intervention is known to be effective in improving health outcomes
3. The service, medication, supply or intervention is cost effective compared to the alternative intervention, including no intervention

The fact that a professional provider may prescribe, order, recommend, or approve a service or supply does not, in itself, make the charge a covered expense.

The claims administrator (Moda Health or Kaiser) may require proof that services, interventions, supplies or medications (including court-ordered care) are medically necessary. No benefits will be provided if the proof is not received or is not acceptable or if the service, supply or medication dose is not medically necessary. Claims processing may be delayed if proof of medically necessary is required but not provided by the health service provider. Medically necessary does not include custodial care.

CityNet PPO Medical Plan

The City offers a CityNet PPO medical plan and CityHDP medical plan for benefits-eligible PPA employees and non-Medicare eligible retirees. The plans are self-insured, which means the plans are not insured by an insurance company; rather, the City pays the claim costs over and above what you pay. An administrator (Moda Health) handles claims and provides customer service for these plans, but the City writes the checks. The CityNet medical plan offers a broad range of medical coverage as well as a choice of preferred provider networks.

Did You Know?

As an enrolled participant in the CityNet PPO medical plan, you are considered a "member." References in this section to "you" or "member" or "covered participant" all refer to eligible individuals who are enrolled and participate in the CityNet PPO plan.

CityNet PPO Network

Moda Health is the claims administrator for the CityNet PPO medical plan. The plan offers you the Connexus network. This is a group of health care providers (doctors, hospitals, and clinics, called “providers” because they provide care) that have a network contract with Moda Health. When you use health care providers in the Connexus network—known as “in-network” providers—you receive the medical plan’s highest level of benefit for your care and keep more money in your pocket.

Connexus network providers file claims for you and receive their payment directly from the plan. You pay an in-network provider your share of the cost of coverage (your coinsurance amount after you’ve met the deductible, for example). Charges from Connexus network providers are never more than the plan’s “maximum plan allowance” (MPA).

Understanding Networks

Each health insurance company—like Moda Health, the plan administrator—sets up a plan network, a select group of physicians, hospitals and other medical care professionals who agree to deliver medical services to its members at lower, negotiated rates. When you join a medical plan, you’re considered a member and you have full access to that plan’s network.

Doctors can choose to participate in several networks at the same time. The contract is between the provider and the network, and the contract can terminate mid-year. It is always a good idea to verify your provider’s participation in the Connexus Network each time you seek services.

In-Network Care: Connexus Network

Under the CityNet PPO Medical Plan, you must choose Connexus network providers to receive the in-network level of coverage. The Connexus Network includes physicians, hospitals and other providers associated with the Providence Health System, Legacy Health System, Portland Adventist Hospital, OHSU Hospital and OHSU physicians.

If you have covered children who live outside of the network area, they can still receive care at the in-network level of benefits through a separate network called First Health. See the *Special Circumstances* section of this SPD for more details.

In Oregon, the Connexus Network is available in the following counties:

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

In SW Washington, the Connexus Network is available in the following counties:

Benton	Klickitat
Clark	Pacific
Columbia	Skamania
Cowlitz	Wahkiakum
Franklin	Walla Walla

In Idaho, the Connexus Network is available in the following counties:

Ada	Owyhee
Boise	Payette
Canyon	Twin Falls
Elmore	Valley
Gem	Washington

Traveling or Retired? Out-of-Area Dependent? You can still get in-network benefits.

When traveling outside of the Connexus Network area, you will want to seek services from the First Health network of providers for emergency/urgent care. If you use the First Health network, discounted in-network reimbursement will apply. To find providers, go to www.modahealth.com and click on “Find Care”. Once you have clicked on “Find Care” you will enter your subscriber ID. Under “What type of care can we help you find?” you will see the question, “Are you traveling and need to find a medical provider? Search the **Moda’s Travel Network** to find the care nearest you”. Once you click the link available online, it will take you to the First Health Provider Search. While it is important to seek emergency services when an emergency occurs, many less costly options exist for non-emergent care through urgent care clinics or other retail clinics.

Retirees living outside of the Connexus network area may sign up for the PHCS network. Do this by contacting the COBRA/Retiree Administrator at **503-823-6136** if you live (or move) outside of the Connexus network area. You will need to choose a provider at www.multiplan.com; search in the PHCS (PPO) network.

Special Circumstances: In-network Care Outside the Network Area

In certain circumstances, covered individuals living outside of the Connexus network area may receive network care.

- **Retirees who live outside of the Connexus network area may instead choose to use the PHCS PPO network.** The PHCS network is a national network. When you choose this network, the plan provisions generally match the in-network benefits shown in the Medical Plan Comparison chart.
- If, as an active employee, you have **covered dependents living outside of the Connexus network area**, your covered dependent child(ren) **can participate in the First Health network.** (An example would be if your child is away at college.) Using providers in the First Health network, your dependents would be subject to the in-network provisions shown in the Medical Plan Comparison chart.

Special Circumstances: Surprise Billing

When receiving care at an in-network facility ask to receive services performed by in-network providers to ensure the highest benefit level. When you are at an in-network facility and are not able to choose the provider, in-network cost sharing will apply to services performed at the facility by out-of-network providers, and the provider cannot charge you the difference between the maximum plan allowance and bill charged.

If you choose to receive services from an out-of-network provider, benefits will be at the out-of-network level and you will have to pay any amount over the maximum plan allowance.

Out-of-Network Care

When you use health care providers that *are not* in the Connexus network or another qualifying network as described within this handbook, your benefit from the medical plan is lower and your deductible is much higher. In most cases you must pay the provider all charges at the time of your treatment, and you then file a claim to be reimbursed the out-of-network benefit. If the provider's charges are in excess of the maximum plan allowance—as determined by Moda Health—you are responsible for paying those excess charges.

Out-of-Network Provisions:	
Annual Deductible:	\$450/Person, \$1,350/Family
Annual Out-of-Pocket Maximum:	\$3,600/Person, \$9,000/family
Co-Insurance:	40% coinsurance on all covered services.
Lifetime Maximum:	None

Alternative Care Providers

Only Connexus network providers are considered in-network for reimbursement of alternative care claims. The network of alternative care providers (including chiropractors, naturopaths, licensed massage therapists and acupuncturists) provides medically necessary alternative services within the scope of their licenses at discounted rates.

Therapeutic massage therapy is not covered, but medically necessary manual therapy (received in conjunction with other medically necessary services including physical therapy and alternative care treatments such as chiropractic/acupuncture/naturopathic services) are covered.

Services provided by a *non*-Connexus alternative care provider will be paid at the out-of-network benefit level. ***Only medically necessary care anticipated to improve one's medical condition is eligible for reimbursement. Maintenance care does not qualify for reimbursement.***

Please note that alternative care providers in the PHCS network will be considered in-network for retirees living outside the Connexus area; alternative care providers in the First Health network will be considered in-network for covered dependents living outside the Connexus area.

Spinal manipulation treatment must be prior authorized through Moda Health if treatment will extend beyond 20 visits. A 35-visit annual maximum applies.

Frequently Asked Questions About the Network

- 1. How do I verify whether a medical provider I am interested in seeing is in the preferred provider network?** To confirm if a provider is in the Connexus network, go to www.modahealth.com.
Always check the online directories or call Moda Health prior to seeking non-emergency services.
- 2. Will I be required to use network providers?** No. However, you will receive increased benefits, save money, and moderate future rate increases by helping the plan reduce its costs when you use network providers.

3. **How will I be covered when I'm traveling outside of the Connexus network service area?** If your primary network is the Connexus network and you are traveling outside of the service area, Emergency Room claims will be covered at the in-network benefit level. If the ER is not part of the First Health network, charges over MPA may be charged directly to you. Urgent care claims will be covered as in-network when a First Health provider is used; otherwise your out-of-network benefit level will apply and charges over MPA may be charged directly to you.
4. **How will I be covered when I'm traveling outside of the country?** When you have an emergency outside of the country, the plan will pay at the in-network benefit level, up to MPA limits. ER visits will require a \$50 copay (waived if you are admitted). Additional services will be subject to coinsurance (plan pays 80%, you pay 20%). You will need to pay the providers directly and submit your itemized bills with a claim form to Moda Health when you return. If you see a physician outside of the country for non-emergency care, you will be subject to the out-of-network deductible and coinsurance.

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

Does the Network Really Matter?

Yes. Using in-network providers and facilities can have a big effect on your bank account. Let's say you have met your in and out-of-network deductibles and need to go to the doctor. The normal charge for the service is \$100.

- At a *network* doctor: the actual charge may be reduced by 30% (due to the special negotiated rates), down to \$70. You pay 20% of \$70, so your cost would be **\$14**. The plan pays 80% of \$70, so the City's cost is \$56. Without the provider-negotiated rate, you would have paid \$20 and the City would have paid \$80.
- At an *out-of-network* doctor: the charge would remain \$100. You would pay 40%, so your cost would be **at least \$40**.

Just by using in-network providers and facilities—to get the same services you'd receive somewhere else—you can save yourself a significant amount of money (depending on the service)!

CityNet PPO Medical Plan: More Details

Annual Deductible

The medical plan applies a deductible each plan year to many types of care. The annual deductible is a specific dollar amount of eligible expenses you pay in a year before the plan begins paying benefits for that care. That means you pay the full cost of services (that are subject to the deductible) until you have spent the deductible amount. At that point, the plan begins sharing costs with you.

Reaching the annual deductible is often referred to as "meeting your deductible" or "satisfying your deductible." Once you've reached your deductible, the plan will share the cost of eligible, covered services with you in the form of coinsurance. **Note:** The deductible is lower when you use in-network PPO providers. To be sure your provider is in the network, go to www.modahealth.com and search the Connexus network.

The deductible is applied each plan year (July 1 through June 30). However, **expenses incurred and applied to the deductible during the last three months of the plan year (April, May and June) will**

also count towards meeting the following year’s annual deductible. See the *Medical Plan Comparison* chart for details concerning copays and coinsurance amounts for various services.

For the CityNet Medical Plan, the following chart helps explain how the in-network deductible, coinsurance and claims payment process is designed. This example does not take into account any prescriptions costs that are also calculated toward your out-of-pocket maximum and is intended as a high level example. This is generally not representative of a typical year for a family:

	Allowed	Deductible Paid	Co-insurance	Total Out-of-Pocket Max
Employee	\$13,200	\$150	\$850 (20% of the remaining cost is \$2,610 but you only pay up to your out-of-pocket maximum)	\$150+\$850=\$1,000
Spouse	\$10,000	\$150	\$850 (20% of the remaining cost is \$1,970 but you only pay up to your out-of-pocket maximum)	\$150+\$850=\$1,000
Child	\$2,000	\$150	\$350 (20% of the remaining cost is \$370 but you only pay up to your family out-of-pocket maximum)	\$150+370=500
Total		\$450		\$2,500 (includes deductible)

Separate annual deductibles apply to in-network and out-of-network care.

Did You Know?

Preventive care is covered 100% in-network (no deductible) when you follow the schedule shown in the Medical Plan Coverage chart. Before you receive services, follow these steps to get the most from your plan:

- When making an appointment, double check when your last routine exam occurred to ensure you are eligible for the service at the 100% benefit level.
- Go to an in-network provider.
- Ensure your provider uses an in-network lab.

CityHDP High Deductible Medical Plan: More Details

Annual Deductible and Out-of-Pocket Maximums

The medical plan applies a deductible each plan year to many types of care. The annual deductible is a specific dollar amount of eligible expenses you pay in a year before the plan begins paying benefits for that care. Under a qualified high deductible health plan (HDHP), there are some differences in how the deductible and out-of-pocket maximums works.

- If enrolled as an Employee +1 or Family, you must reach the family deductible for coinsurance to kick-in and begin to pay
- If enrolled as an Employee +1 or Family, your out-of-pocket maximum has to be met at the family level, instead of at the individual level up to the family total

- All services, including pharmacy benefits, except preventive care and formulary preventive prescriptions, are subject to the deductible
- Employees cannot participate in a HealthCare FSA if contributing to a Health Savings Account. The employee can participate in a Limited Purpose Health Care FSA that provides for reimbursement of dental and vision qualified expenses.

Reaching the annual deductible is often referred to as “meeting your deductible” or “satisfying your deductible.” Once you’ve reached your deductible, the plan will share the cost of eligible, covered services with you in the form of coinsurance. **Note:** The deductible is lower when you use in-network PPO providers. To be sure your provider is in the network, go to www.modahealth.com and search the Connexus network.

To protect you and your family from catastrophic losses in a single year, the high deductible plan includes an annual out-of-pocket maximum. When qualified amounts you pay during the year reach your out-of-pocket maximum amount as described above, the medical plan’s benefit percentage increases to 100% for the rest of the plan year.

Some amounts you pay do not count toward your annual out-of-pocket maximum, including:

- Charges above the allowable amount, as determined by the Claims Administrator
- Charges for expenses not covered by the medical plan, such as for care that is not medically necessary
- Charges above the maximum plan allowance

Separate out-of-pocket maximums apply to in-network and out-of-network services

Out-of-Network Provisions, CityHDP Medical:	
Annual Deductible:	\$3,200/Person, \$6,400/Family
Annual Out-of-Pocket Maximum:	\$8,000/Person, \$16,000/family
Co-Insurance:	40% coinsurance on all covered services.
Lifetime Maximum:	None

For the CityHDP Medical Plan, the following chart helps explain how the in-network deductible, coinsurance and claims payment process is designed. This example does not take into account any prescriptions costs that are also calculated toward your out-of-pocket maximum and is intended as a high level example. This is generally not representative of a typical year for a family:

	Allowed	Deductible Paid	Co-insurance	Total Out-of-Pocket Max
Employee	\$13,200	\$3,200	\$2,000 (20% of remaining cost after deductible)	\$3,200 + \$2,000 = \$5,200
Spouse	\$10,000	\$0	\$1,800 (responsible for remaining cost up to out of pocket maximum)	\$1,800
Child	\$5,000	\$0	\$0	\$0
Total				\$7,000

Allowable Charges, Maximum Plan Allowance

In-network services: To reduce the cost of in-network care, the plan administrator (Moda Health) negotiates charges with providers in the Connexus network. (For out-of-area retirees, the network is PHCS; for dependent children of active employees who live outside of the network area, the network is First Health.) Benefits in the medical plan for in-network care are based on these negotiated (lower) charges, known as the plan’s “allowable amount.” Preferred or contracting providers who participate in the Connexus network in a particular area agree to charge no more than the allowable amount for services.

Out-of-network services: When you go to a provider who is not part of the Connexus network (or other applicable network), the amount the plan will pay for care is limited to what is considered a “maximum plan allowance” or MPA. The Medical Plan determines its MPA amount based on the Insurer’s determination of the charges for similar treatment from other similar providers in that area (usually driven by zip code). Generally, the plan will cover 60% of the MPA charges after you have satisfied the annual out-of-network deductible. But, charges from out-of-network providers may be more than the MPA. You are responsible for paying amounts above the MPA to these providers, and the excess amounts you pay do not apply to your deductible or out-of-pocket maximum.

Coinsurance

Once you meet your annual deductible, as described above, the CityHDP plan begins paying benefits—sharing the cost of eligible covered services with you. This is the plan’s benefit percentage, and it applies to your eligible expenses. The benefit percentage is known as coinsurance.

When the medical plan’s benefit percentage is less than 100%, you pay the remaining eligible expenses. The part you pay is known as your portion of the coinsurance, sometimes called your out-of-pocket amount.

Generally, the plan covers 80% of eligible reduced charges in-network (you pay 20%), and the plan covers 60% of MPA charges out-of-network (you pay 40% plus any amount billed over the MPA).

Out-of-Network Care

When you use health care providers that *are not* in the Connexus network or another qualifying network as described within this handbook, your benefit from the medical plan is lower and your deductible is much higher. In most cases you must pay the provider all charges at the time of your treatment, and you then file a claim to be reimbursed the out-of-network benefit. If the provider’s charges are in excess of the maximum plan allowance—as determined by Moda Health—you are responsible for paying those excess charges.

Out-of-Network Provisions:

Annual Deductible:	\$3,200/Person, \$6,400/Family
Annual Out-of-Pocket Maximum:	\$8,000/Person, \$16,000/family
Co-Insurance:	40% coinsurance on all covered services.
Lifetime Maximum:	None
*excludes in-network expenses	

Benefits for Special Medical Situations

The following chart highlights benefits available under the CityNet PPO plan in special medical situations. For more information, contact Moda Health directly to explore your options.

In this medical situation...	The CityNet PPO and CityHDP plan pays the following:
<p>You live in the network service area, but a specialist or type of treatment is not provided in your network service area</p>	<ul style="list-style-type: none"> ▪ You'll need to request prior authorization from Moda to see an out-of-network provider ▪ If approved, you meet the in-network deductible (if you haven't already), then you pay 20% coinsurance and any amounts over the MPA limits, and the plan pays 80% for medically necessary covered services ▪ Eligible charges are subject to the maximum plan allowance (MPA) limits. <p>Notes: Services provided through Shriner's hospital and discounted through Moda Health Supplemental contracts will be paid as in-network and accrue to in-network plan year maximums.</p>
<p>You live in the network service area, but your eligible dependent resides outside the network service area.</p>	<ul style="list-style-type: none"> ▪ All eligible services will be paid at the <i>in-network</i> benefit level ▪ If services are received from a First Health participating provider you will not be responsible for charges in excess of the contracted rate ▪ If services are received from a provider who does not participate in the First Health network, eligible services will be paid according to maximum plan allowance (MPA). Charges in excess of MPA will be your responsibility to pay. ▪ The in-network coinsurance will accumulate toward the in-network out-of-pocket maximum ▪ To receive in-network benefits, go to www.modahealth.com and click on "Find Care". Once you have clicked on "Find Care" you will enter your subscriber ID. Under "What type of care can we help you find?" you will see the question, "Are you traveling and need to find a medical provider? Search the Moda's Travel Network to find the care nearest you". Once you click the link available online, it will take you to the First Health Provider Search.
<p>Emergency care for CityNet PPO plan members</p> <p>Note: This section does not apply to urgent care.</p>	<p>Network providers: In-network benefit level applies after \$50 Emergency Room copay for an emergency. (Copay is waived if admitted; not subject to deductible.)</p> <p>Out-of-network providers: In-network benefit level, up to maximum plan allowance (MPA), after \$50 emergency room copay for an emergency. (Copay waived if admitted; not subject to deductible.) Charges in excess of MPA will be your responsibility to pay. In-network out of pocket maximum applies.</p>
<p>Out-of-network provider services are ordered by an in-network provider at an in-network participating hospital and/or urgent care center</p>	<p>After the in-network deductible is met, services by an out-of-network anesthesiologist, assistant surgeon, radiologist or pathologist, or supplies provided while a patient at a participating hospital and/or urgent care center will be covered at the in-network benefit level</p> <p>Surprise Billing: When you are at an in-network facility and are not able to choose the provider, in-network cost sharing will apply to services performed</p>

In this medical situation...	The CityNet PPO and CityHDP plan pays the following:
	<p>at the facility by out-of-network providers, and the provider cannot charge you the difference between the maximum plan allowance and bill charged.</p> <p>If you choose to receive services from an out-of-network provider, benefits will be at the out-of-network level and you will have to pay any amount over the maximum plan allowance.</p>
<p>You live outside the Connexus network service area</p>	<p>Although the City of Portland has worked to provide network access to all members, there may be employees who reside outside the network service area.</p> <p>You and your covered dependents living outside the area may use the First Health network for in-network benefits. If you do not see a Connexus or First Health network provider, eligible services will be paid according to maximum plan allowance (MPA) at the out-of-network benefit level. This means that charges in excess of the MPA will be your responsibility to pay.</p> <p>Retirees living outside the Connexus network area may choose the PHCS network for in-network benefits.</p> <p>For emergency situations, in-network benefits will apply and will be paid according to MPA. The information in this section does not apply to eligible dependents who reside outside the service area.</p>

CityNet PPO and CityHDP Plan Professional Providers

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

Note: For retirees living outside the Connexus network area, in-network providers would be those in the PHCS network; for covered dependents living outside the area, in-network providers would be those who are part of the First Health network.

What Is Covered: CityNet PPO and CityHDP Medical Plan Services

The medical plan pays benefits for eligible expenses only. Once you meet your annual deductible (when required), the plan applies its appropriate benefit percentage to your eligible expenses. (See the Medical Plan Coverage chart for details.) All covered expenses must be medically necessary and within the allowable amount. Prior authorization may be required.

This list is representative. If you have any questions about what is covered (or the level of benefits that apply), please contact Moda Health before you receive care. Eligible expenses are listed alphabetically.

For a list of expenses not covered by the plan, see the *What Is Not Covered* section that follows.

- **Allergy shots** and office visits for allergy testing.
- **Alternative Care.** Spinal manipulation and acupuncture services are covered if such services are within the scope of the professional provider's license. For in-network alternative care benefits, services must be provided by a Connexus network provider.
- **Ambulance.** Up to 300 miles per year to or from the nearest hospital when medically necessary. *Services provided by a stretcher car, wheelchair car or similar methods are considered custodial and are not covered benefits under the plan.*
- **Appliances.** Items used for performing or facilitating the performance of a particular bodily function, including orthopedic braces and compression stockings, are covered when medically necessary as determined by the plan's Insurer. *Appliances do not include dental appliances and braces, supporting devices such as corsets, eye glasses or contact lenses.*
- **Artificial Limbs.** The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to the plan that a new prosthetic device is medically necessary because of changing fit or poor function. *Testicular prostheses are not covered.*
- **Autism Spectrum Disorder.** Treatment of autism spectrum disorders is covered in accordance with the diagnostic guidelines as approved by the American Psychiatric Association, subject to prior authorization for medical necessity.
- **Autism Service Provider** means a behavior analyst licensed by the Oregon Behavior Analysis Regulatory Board (BARB), an assistant behavior analysis licensed by BARB and practicing under the supervision of a behavior analyst, and interventionist registered by BARB and practicing under the supervision of a behavior analyst, or a state-licensed or state certified health care professional providing services for autism spectrum disorder within the scope of his or her professional license. In states that do not license autism service providers, certification or registration with the Behavior Analysis Certification board may be accepted instead.
- **Applied Behavior Analysis:** Means a variety of psychosocial interventions that use behavioral principles to shape an individual's behavior. It is a type of treatment for individuals with autism spectrum disorder.
 - It includes direct observation, measurement and functional analysis of the relationship between environment and behavior.
- Typical goals include improving daily living skills, decreasing harmful behavior, improving social functioning and play skills, improving communication skills and developing skills that result in greater independence.
- **Breastfeeding Support.** Breastfeeding support and counseling are paid at no cost sharing when provided in-network; includes comprehensive lactation support and counseling during pregnancy and/or the breastfeeding period (covered 100% by the plan). The plan will cover the purchase or rental charge (not to exceed the purchase price) for a breast pump and equipment. *Charges for supplies such as milk storage bags and extra ice packs, bottles or coolers are not covered.*
 - **Note:** Hospital grade pumps are covered when medically necessary.
- **Chemical Dependency Treatment** (drug and/or alcohol). This benefit does not apply to addiction or dependency on tobacco, tobacco products or foods, nor does it include volunteer mutual support groups or educational programs for drinking drivers referred by the judicial system. Inpatient and residential treatment must be prior authorized (except for emergency hospital

admissions, which must be authorized within 48 hours of emergency admission or as soon as possible).

- **Clinical Trials.** Routine costs related to complications or adverse events of a clinical trial are eligible for coverage.
- **Colorectal Screening** is covered in accordance with the preventive care schedule and includes all forms of anesthesia.
 - Follow-up colonoscopy after positive result is covered at the medical benefit level for CityHDP participants.
- **Contraceptive** device insertion and removal.
 - All mandated contraceptive devices, drugs and products for women are covered at no cost share. Over-the-counter contraceptives, including condoms are covered on a reimbursement basis, as providers can't bill for this. Members must submit receipts.
 - In-Network abortion is covered at no cost share (CityNet) and no cost share after deductible (CityHDP)
 - In-Network male contraception, including sterilization. Is covered at no cost share (CityNet) and no cost share after deductible (CityHDP)
 - Out-of-Network service may be paid at no cost share (CityNet) or no cost share after deductible (CityHDP) if no In-network provider is geographically accessible and can provide the service in a reasonable amount of time.
 - Oregon HB 3391 requires coverage of ACA preventive services. Use the most current USPSTF and HRSA guidelines as well as the versions as of 01/01/17 as the basis to determine women's health services to be paid at no cost share.
 - SB 1549- Special accommodation to comply with IRS requirements on HSA plans.
- **Dental Services and Orthodontic Coverage** when medically necessary to treat congenital craniofacial anomalies, including (but not limited to) cleft palate and cleft lip.
- **Diabetes Self-Management.** The plan covers a benefit for diabetic education services for covered persons who are diagnosed to have insulin-dependent diabetes, insulin-using diabetes, gestational diabetes and non-insulin-using diabetes when prescribed by a health care professional legally authorized to prescribe such programs. These services are not subject to a deductible and are covered as in-network regardless of authorized program used. Services must be provided through an education program credentialed or accredited by a state or national entity accrediting such programs, or provided by a state licensed professional provider acting within the scope of his or her license. The medical benefit will not cover diabetic supplies such as insulin, strips, etc., normally covered under the prescription medication benefit. See the *Diabetes Education Programs* section for more information.
- **Diagnostic Services**, including x-rays and laboratory tests, psychological testing, and other diagnostic procedures related to treatment of a medical or mental health condition.
- **Durable Medical Equipment.** When medically necessary, limited to either the total rental cost or the purchase price of such equipment, whichever is less. *Dental appliances are not included.*
- **Emergency Medical Conditions.** Defined as a medical condition that manifests itself by symptoms of sufficient severity that a prudent layperson possessing an average knowledge of health and medicine would reasonably expect that failure to receive immediate medical attention

would place the health of a person, or a fetus in the case of a pregnant woman, in serious jeopardy. In other words, a condition that is life- or limb-threatening, or severe enough that any delay in treatment may place in jeopardy the health or a bodily function of the person.

- **Gender Reassignment Surgery.** Eligibility for gender reassignment is based on World Professional Association for Transgender Health (WPATH), Standard of Care. Medically necessary services to alter a member's physical characteristics to that of a new gender, including single stage or multiple stage reconstruction of genitalia and new reconstruction of breast tissue to achieve the appearance of the new gender. Services require prior authorization.
- **Habilitative physical, occupational or speech therapy** is covered only when medically necessary for treatment of a mental health condition.
- **Hearing Aids for Adults (age 26 and older).** 40% plus amount in excess of MPA (no deductible for CityNet); plan pays up to \$1,200 per ear; new hearing aid covered once every 36 months if medically necessary
- **Hearing Aids (under age 26).** 20% after you meet deductible, one per ear every 36 months, including bone conduction sound processors.
Covered benefits include the following:
 - A hearing aid (monaural or binaural) prescribed as a result of the examination
 - Ear molds
 - Cover replacement ear molds up to four times per plan year for children 8 and under; once per year for children ages 8 to 25
 - Cover Diagnostic and treatment services (hearing tests, hearing aid checks, aided testing) twice per year for children under age 4 and once per year for ages 4+
 - Cover hearing assistive technology systems for age under 19 for appropriate amplification of the hearing loss
 - Hearing aid instruments
 - Initial batteries, cords and other necessary supplementary equipment
 - A warranty
 - Repairs, servicing, or alteration of the hearing aid equipment
- **Hepilisav B Vaccine.** Effective 01/01/20 Hepilisav B Vaccine is on the standard ACA Vaccine list. Added and covered under the City of Portland's formulary effective 07/01/19.
- **Home Health Care.** Services must be ordered by the attending physician.
- **Hospice Care** for medically necessary charges. When ordered by an attending physician for patients who are terminally ill with a life expectancy of six months or less and provided by a state licensed agency or hospital. Care may be provided in a patient's home or in a hospice facility. Bereavement counseling is also included.
- **Hospital Services, Inpatient.** Includes:
 - Intensive Care/Coronary Care when medically necessary
 - Room and Board (medically necessary semi-private room and board); *personal comfort items are not covered*
 - Special Duty Nursing when ordered by the attending physician
 - Other miscellaneous medically necessary inpatient services and supplies furnished by the hospital which are not included in the room charge, such as:
 - X-ray and lab services billed by the hospital

- Anesthesia
- FDA-approved medications, IV solutions, etc. administered while you are an inpatient
- Physical therapy and speech therapy while you are an inpatient

Did You Know?

If an inpatient hospitalization begins while an employee or eligible dependent is covered under the plan and coverage subsequently ends, and the policy is immediately replaced by a policy with another carrier, coverage for the enrollee will extend for the duration of the hospitalization until the member is discharged, but not for subsequent hospitalizations.

To see how much you will pay for inpatient hospital care, or if you have questions about whether specific services or procedures are included, see the *Medical Plan Coverage* chart or contact Moda Health directly. You should also call Moda Health for prior authorization questions or help: **503-243-4496** or **1-800-258-2037**.

- **Hospital Services, Outpatient.** Includes:
 - Emergency Room service when medically necessary
 - Other medically necessary outpatient hospital charges
 - Outpatient hospital charges and general anesthesia for extensive dental treatment for children under 12 years of age, or a patient with mental incapacity

- **Infusion Therapy Benefits.** Specified medications are no longer covered in an outpatient hospital setting and instead allow the member to have the medication administered in their home. The medications below require pre-authorization and include:
 - Aerosolized pentamidine
 - Intravenous medication therapy
 - Total parenteral nutrition
 - Hydration therapy
 - Intravenous/subcutaneous pain management
 - Terbutaline infusion therapy
 - SynchroMed pump management
 - IV bolus/push medications
 - Blood product administration

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

- Solutions, medications, and pharmaceutical additives
- Pharmacy compounding and dispensing services
- Durable medical equipment for the infusion therapy
- Ancillary medical supplies
- Nursing services associated with:
 - Patient and/or alternative care giver training
 - Visits necessary to monitor intravenous therapy regimen

- Emergency services
 - Administration of therapy
 - Collection, analysis, and reporting of the results of laboratory testing services required to monitor response to therapy
- **Imaging Procedures.** The plan covers all standard imaging procedures (subject to the deductible and applicable coinsurance) when medically necessary and related to treatment of an illness or injury. Advanced imaging requires pre-authorization.
 - **Inborn Errors of Metabolism.** Treatment of inborn errors of metabolism that involve amino acid, carbohydrate and fat metabolism when standard methods of diagnosis, treatment and monitoring exist, including quantification of metabolites in blood, urine or spinal fluid, or enzyme or DNA confirmation in tissues. Includes diagnosing, monitoring and controlling the disorders by nutritional and medical assessment, including (but not limited to) clinical visits, biochemical analysis and medical foods used in treatment of such disorders.
 - **Intraocular Lens.** One conventional intraocular lens or one contact lens or eye glasses within 90 days following cataract surgery.
 - **Laboratory Services.** Diagnostic laboratory expenses are covered when medically necessary and performed or ordered by a professional provider due to illness, accident or injury and as part of a wellness exam. To maximize benefits, it is the patient's responsibility to make sure that referral is made to an in-network PPO service provider.
 - **Maternal Diabetes Management.** Coverage for CityNet members, the plan will include eligible expenses for covered health services, medications and supplies that are medically necessary for a woman to manage her diabetes from conception through six weeks postpartum—at no cost to the plan member. Members must notify Moda Health if eligible for this benefit. Services, medications, test strips and syringes are subject to network or formulary restrictions. Moda will reprocess claims if they are made aware of eligibility for the program after services have been performed.
 - **Maternity Care for the employee, spouse, domestic partner, and dependent children.** Coverage for the newborn, beyond the initial nursery care, will be allowed if the child meets the City's definition of an eligible dependent. Newborns are automatically covered for the first 30 days, but you must add your child (through a qualified status change) to your benefits within 60 days for benefits to continue.
 - **Maxillofacial Prosthetic Services.** For repair of head and facial structures damaged by trauma, disease, surgery or congenital deformity that cannot be managed with living tissue are covered when medically necessary and unrelated to TMJ treatment or therapy.
 - **Mental health inpatient and residential services** includes receiving services related to treatment or stabilization of behavioral, mental health and/or chemical dependency. This includes continuous treatment that provides 24-hour a day care in a medically staffed environment or treatment in a facility for at least four (4) hours per day as deemed medically necessary. Prior authorization required.
 - **Newborn Home Visits:** Newborn nurse home visits related to social determinants of health will be covered in specific counties where the Family Connects Oregon program is implemented. Visits must be by a certified provider as part of the program.
 - **Nonprescription Enteral Formula for Home Use and Inborn Errors of Metabolism.** When medically necessary, and ordered by the doctor for the treatment of severe intestinal malabsorption, and must comprise the sole source (or an essential source) of nutrition.

- **Oral Surgery.** Extraction of impacted teeth.
- **Organ Transplants.** The Plan will pay benefits for medically necessary and appropriate transplant procedures as approved by the Medical Management Program, which conform to accepted medical practice and are not experimental or investigational.

Definitions for Organ Transplants

Transplant means:

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

Transplant does not include:

- The collection of and/or transfusion of blood or blood products
- Corneal transplants

Transplant period means the time from the day of admission for transplant conditioning through the day of discharge for a transplant.

Complications resulting from a transplant means all medical and surgical treatments except the transplantation of hematopoietic cells or solid organ(s).

Covered Benefits for Organ Transplants

Benefits for transplants are limited as follows:

If the recipient or self-donor is enrolled under this plan, donor costs related to a covered transplant are covered in accordance with the plan's copays and maximums. "Donor costs" mean the covered expense of removing the tissue from the donor's body and preserving or transporting it to the site where the transplant is performed, as well as any other necessary charges directly related to locating and procuring the organ.

If the donor is covered under this Plan and the recipient is not, no benefits toward donor costs will be paid.

Expenses incurred by an enrolled donor resulting from complications and unforeseen effects of the donation will be covered as any other sickness. *Expenses incurred by a donor not enrolled in the Plan which results from complications and unforeseen effects of the donation are not covered.*

All transplants must meet the Prior Authorization/Utilization Management Program

Criteria. Prior authorization requests for transplants will be reviewed to ensure medical appropriateness and medical necessity of the proposed treatment for the enrollee's medical condition or disease.

- Physician or professional provider transplant services according to the benefits for physicians and professional providers under the Plan will be paid.
- Anti-rejection medications following the covered transplant will be paid according to the benefits for prescriptions medications, if any, under the Plan.
- The Plan will not pay for chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not approved for coverage.

Important note:

All transplant procedures must be authorized and be medically necessary and appropriate according to criteria established by Moda Health.

PRIOR AUTHORIZATION REQUIREMENTS FOR ORGAN TRANSPLANTS

To request prior authorization, the member's physician must contact the Medical Service

Authorization Unit of Moda Health prior to the transplant admission: **503-243-4496** or **1-800-258-2037**. Prior authorization should be obtained as soon as possible after an enrollee has been identified as a possible transplant candidate. To be valid, prior authorization approval must be in writing from Moda Health.

- **Orthopedic Shoes.** Covered if they are an integral part of a leg brace or if a professional provider determines they are medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. If the correction or support is accomplished by modification of a mass-produced shoe, then the covered expense will be limited to the cost of the modification (not the original cost of the shoe). *Orthopedic shoes or modifications are not covered if they are solely for comfort or convenience.*
- **Orthotic Devices.** Rigid or semi-rigid device supporting a weak or deformed leg, foot, arm, hand, back or neck; or, restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Coverage includes the device, repair and replacement of the device when medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities. *Orthotic devices are not covered if they are solely for comfort or convenience.*
- **Orthognathic Surgery.** Prior authorization for medical necessity required. Orthognathic surgery is covered for the correction of skeletal deformities of the maxilla or mandible when it is documented that these skeletal deformities are contributing to significant dysfunction and where the severity of the deformities precludes adequate treatment through dental therapeutics and orthodontics alone.
- **Osteopathic Manipulation.** Evaluation covered whether performed on the same or different day as osteopathic manipulation.
- **Preventive Care and Well Child Care.** Coverage for preventive care and well child care according to the schedule listed in the *Medical Plan Comparison* chart.

Did You Know?

Free preventive care is one of the easiest ways you can take care of yourself and lower medical costs for yourself and the City. The preventive care benefit allows you to take advantage of 100% covered preventive check-ups and testing when services are received in-network within the parameters set forth by plan, which are based on the age and/or gender guidelines of the U.S. Preventive Services Task Force.

Preventive Services include:

- Evidence-based services rated A or B by the United States Preventive Services Taskforce,
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Center for Disease Control and Prevention (ACIP), and

Preventive care and screenings recommended by the Health Resources and Services Administration for infants, children, adolescents, and women should be covered at no cost sharing when performed by in-network providers.

To find the A and B list for preventive services, go to <http://www.uspreventiveservicestaskforce.org/uspstf/uspsabrecs.htm>.

For a list of women's preventive services, go to <http://www.hrsa.gov/womensguidelines/>.

- **Qualified Mental Health Associates and Certified Peer Support Specialists.** Covered providers when working for a State-approved Program and providing services by DMAP to be within their scope.

Cover behavioral health assessment, case management and care coordination and related services that are medically necessary to transition a member with behavioral health crisis to a lower level of care.
- **Professional Services.** Medically necessary services of a professional provider (see the *CityNet PPO and CityHDP Plan Professional Providers* section) are covered subject to plan limits.
- **Prosthetic Devices.** Medically necessary artificial limb device or appliance designed to replace in whole or in part an arm or a leg. *Prosthetic devices are not covered if they are solely for comfort or convenience.*
- **Radium, Radioisotopic, X-ray Therapy, and Kidney Dialysis.** Covered expenses require pre-authorization and include:
 - Treatment planning and simulation
 - Professional services for administration and supervision
 - Treatments, including therapist, facility and equipment charges
- **Reconstructive Surgery After Breast Cancer.** Includes related inpatient stay, reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, and prostheses and treatment of physical complications at all stages of the mastectomy, including lymphedemas. All reconstructive procedures must be medically necessary and prior authorized. Includes inpatient care related to the mastectomy and post-mastectomy services as required under state mandated language.
- **Routine Costs in Qualified Clinical Trials.** Routine costs for the care of a member who is enrolled in or participating in qualifying clinical trials are covered. Routine costs mean medically necessary conventional care, items or services covered by the plan if typically provided absent a clinical trial. Routine costs will be subject to the applicable deductible and standard copayments/coinsurance if provided in the absence of a clinical trial. Moda Health is not liable for any adverse effects of the clinical trials. Qualified clinical trials are limited to those:
 - Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Health Care Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense, the United States Department of Energy, or the United States Department of Veterans Affairs;
 - Conducted as an investigational new medication application, an investigational device exemption or a biologics license application to the United States Food and Drug Administration; or
 - Exempt by federal law from the requirement to submit an investigational new medication application to the United States Food and Drug Administration.

The plan does not cover:

- *The medication, device or service being tested in the clinical trial unless it would be covered by the plan if provided outside of a clinical trial*
- *Items or services required solely for the provision of the medication device or service being tested in the clinical trial*

- *Items or services required solely for the clinically appropriate monitoring of the medication, device or service being tested in the clinical trial*
 - *Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member*
 - *Items or services customarily provided by a clinical trial sponsor free or charge to any person participating in the clinical trial*
 - *Items or services that are not covered by the Plan if provided outside of the clinical trial*
- **Short Term Rehabilitation.** Services consist of **physical therapy, occupational therapy, and/or speech or audiological therapy** furnished to a person who is not confined as an inpatient in a hospital or other facility for medical care. This therapy shall be expected to result in continued improvement of the person's condition. Rehabilitation services include physical, occupational, speech or audiological therapy services necessary to restore or improve lost function caused by illness or injury. *Recreational or educational therapy, non-medical self-help or training are not included.* Prior authorization is required.
 - **Skilled Nursing Facility Care.** Medically necessary skilled nursing care is covered up to a maximum 30 days per plan year. Services must be ordered by the attending physician. Prior authorization is required. *Charges are not covered related to an admission that began before the person was enrolled in the Plan or for a stay where care is provided primarily for senile deterioration, Alzheimer's disease, or for mental illness.*
 - **Surgical Benefits.** All **inpatient elective procedures and some outpatient surgeries and invasive diagnostic procedures** require prior authorization. Covered medically necessary surgical services include:
 - Primary surgeon
 - Assistant surgeon (as requested by the surgeon and only to the extent that hospital staff assistance is not available or appropriate)
 - Anesthesiologist (only as required by the surgeon)
 - Radio-active therapy
 - Iodine therapy
 - Super-voltage therapy
 - Deep x-ray therapy
 - Burn treatment, fractures and dislocations
 - Surgeon consultation while an inpatient, as required in the diagnosis or treatment of an illness or injury
 - Outpatient surgical and related services on the day of the surgery
 - Second surgical opinions
 - Medically necessary inpatient lab and x-ray expenses

For ambulatory surgery: certain diagnostic and therapeutic procedures can be performed without an inpatient admission or overnight stay in the hospital. Some services require prior

authorization. And, prior authorization is required if you have an overnight stay or an inpatient admission for a service that is commonly performed on an outpatient basis.

- **Surprise Billing:** When receiving care at an in-network facility ask to receive services performed by in-network providers to ensure the highest benefit level. When you are at an in-network facility and are not able to choose the provider, in-network cost sharing will apply to services performed at the facility by out-of-network providers, and the provider cannot charge you the difference between the maximum plan allowance and bill charged.

If you choose to receive services from an out-of-network provider, benefits will be at the out-of-network level and you will have to pay any amount over the maximum plan allowance.

- **Telehealth Services.** Covered in-network medical services, delivered through a two-way video communication that allows a physician or professional provider to interact with a member. Benefit will be subject to the applicable deductible and standard copayments for the covered medical services.

Out-of-Network Telehealth Services – Covered when provided out-of-network, to the extent the plan covers out-of-network service.

If telehealth services are in connection with covered treatment of diabetes, communication can also be delivered via audio, Voice over Internet Protocol (VoIP), or transmission of telemetry. The application and technology used must meet all state and federal standards for privacy and security of protected health information. Out-of-network telemedicine is excluded.

- **Temporomandibular Joint Disease (TMJ).** CityNet coverages includes non-surgical benefit subject to deductible, then you pay 20% up to plan year out-of-pocket maximum. CityNet TMJ Surgical treatment includes 1st surgery is covered at 20% up to the plan year out-of-pocket maximum, after you meet the deductible. Second surgical appliance subject to prior authorization. Surgical benefit subject to maximum lifetime benefit of \$3,000. TMJ-related surgical procedures and splints require pre-authorization, and are covered only when medically necessary as established by a history of advanced pathologic process (arthritic degeneration) documented in a physician's record or in cases of acute trauma. Benefits are subject to a lifetime maximum.

CityHDP surgical and non-surgical treatment of TMJ is covered at 20% up to plan year out-of-pocket maximum, after you meet deductible. TMJ-related surgical procedures and splints require pre-authorization, and are covered only when medically necessary as established by a history of advanced pathologic process (arthritic degeneration) documented in a physician's record or in cases of acute trauma. CityHDP TMJ benefits are subject to a lifetime maximum.

- **Tobacco Cessation.** This benefit provides reimbursement to members enrolled in a tobacco cessation program in which a professional provider offers an overall treatment program that follows the U.S. Public Health Service guidelines for tobacco cessation. This coverage allows reimbursement for prescription medication and for tobacco cessation educational meetings and programs. These services are not subject to a deductible and are covered as an in-network service regardless of authorized program used. Tobacco cessation services are available to all ages.
- **X-ray Services.** Medically necessary diagnostic x-ray expenses are covered when performed or ordered by a physician due to illness, accident or injury. To maximize benefits, it is the patient's responsibility to make sure referral is made to an in-network PPO service provider.

Important note:

Keep in mind that CityNet PPO medical plan benefits for care of eligible services received *out of the Connexus network* are based on the maximum plan allowance (MPA). You must pay your out-of-network provider all charges above this amount.

What Is Not Covered: CityNet PPO Plan and CityHDP Plan Limitations and Exclusions

The CityNet and CityHDP medical plans will not cover any expense incurred for which the member is not legally liable or which is not medically necessary. Other expenses not covered are those in excess of the Maximum Plan Allowance (MPA), or in excess of what would have been charged in the absence of plan coverage.

General Exclusions and Limitations

- Services that are not provided
- Services received before your effective date of coverage
- Services that are not a covered service or relate to complications resulting from a non-covered service, even if such service was previously covered under the plan
- Services that are not furnished by a provider acting within the scope of his/her license or qualified treatment service
- Services for which no charge is made or you would not be required to pay if you did not have health plan coverage
- Charges in excess of the Maximum Plan Allowance (MPA)
- Educational items including books, tapes, pamphlets, subscriptions, videos and computer programs (software). Educational programs as required under the ACA or mental health parity are not part of this exclusion.
- Services related to injury, illness or condition to the extent a payment or any other benefit including the amount received as a settlement is provided under any Workers' Compensation or City liability on the account of the injury, illness, or condition arising out of the course of gainful employment
- Services provided by a dentist (doctor of medical dentistry or doctor of dental surgery) except for treatment of an accidental injury to natural teeth provided within 12 months of the injury (or later if medically necessary), or for surgery that does not involve repair, removal or replacement of teeth, gums, or supporting tissue
- Bodily injury or illness arising out of duty as a member of the armed forces of any state or country, or a war or any act of war (declared or undeclared)
- Services and supplies for treatment of a medical condition caused by or arising out of a member's voluntary participation in a riot or arising directly from the member's illegal act. This includes any expense caused by, arising out of or related to declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority.
- Services or supplies not listed as covered services or not medically necessary for the treatment or diagnosis of a condition otherwise covered under the Plan or are prescribed for purposes other than treating the disease.

- Expenses or services provided by a local, state or federal agency and emergency rescue services (*except Medicaid*)
- Out-of-Network Telehealth Services Charges including telephone visits or consultations and telephone psychotherapy except as provided for in the paragraph titled “Telehealth Services” in the *What Is Covered* section
- Out-of-network services you receive while a patient at an in-network hospital, when ordered by a network provider, will be covered at the in-network level (subject to MPA) when you have no control over the choice of provider for the service. Applies to services received from an anesthesiologist, assistant surgeon, radiologist or pathologist, or supplies. The out-of-pocket expenses (except those in excess of MPA) will apply to the in-network out-of-pocket maximum.
- Services and supplies a member receives while in the custody of any state or federal law enforcement authorities or while in jail or prison, except when pending disposition of charges. Benefits paid under this exception may be limited to 115% of the Medicare allowable amount.
- Services provided or ordered by a relative. Relatives, for the purpose of this exclusion, include a member or a spouse or domestic partner, child, sibling, or parent of a member or his or her spouse or domestic partner.
- Third party liability claims. Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member—whether or not such benefits are requested. More information can be found in the *Injuries or Illness Alleged to Be Caused by Third Parties* section.
- Experimental or investigational procedures. Services, prescription medications, and supplies that are deemed by the Plan Administrator to be:
 - Those not rendered by an accepted institution, physician or provider within the United States or by one which has not demonstrated medical proficiency in the rendering of the service or supplies;
 - Those not recognized by the medical community in the service area in which they are received;
 - Those for which the approval of government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered;
 - Those for which scientific or medical assessment has not been completed and the effectiveness of the treatment has not been generally established;
 - Those rendered in the service area only as part of clinical trial or research program for the illness or condition being treated;
 - Those unavailable in the service area for the illness or condition being treated and available for that illness or condition within the United States as part of a clinical trial or research program (*except for routine costs of certain clinical trials*); and
 - Those expenses incidental to or incurred as a direct consequence of experimental or investigational procedures, if the expenses were incurred primarily as the result of obtaining experimental or investigational services, prescription medications, and supplies.

- Services, prescription medications, supplies, and/or treatment that is not medically necessary; including:
 - Services, prescription medications, and supplies that are either inappropriate or inconsistent with the symptoms or diagnosis of your condition or that of your dependent;
 - Services, prescription medications, and supplies that are inappropriate with regard to standards of good medical practice in the service area;
 - Services, prescription medications, and supplies that are primarily rendered for the convenience of you or your dependents or a physician or provider of services or supplies; and/or
 - Services that are not the least costly of the alternative supplies or levels of service, which can be safely provided to you or your dependent. For example, coverage would not be allowed for an inpatient hospital stay when the same level of treatment could be delivered in an outpatient setting such as an ambulatory surgery facility;
 - Treatment prescribed for purposes other than treating disease is not considered medically necessary treatment.
- Court-ordered services related to unlawful behavior by the member, including a sex offender treatment program. *Does not apply to chemical dependency services for members age 17 or younger, or to services provided pursuant to civil commitment proceedings for mental illness.*
- Any illness or injury arising from ionizing radiation, pollution or contamination by radioactivity from any nuclear waste from the combustion of nuclear fuel. And, the radioactive, toxic, explosive or other hazardous properties of any explosive nuclear assembly or component, unless otherwise required by law.

Exclusions Related to Miscellaneous Services and Items

- Support Education including Level 0.5 educational programs related to Driving Under the Influence (DUI); or family education or support groups except for support groups rated A or B by the United States Preventive Services Taskforce
- Behavior modification, psychological enrichment or self-help programs for mentally healthy individuals, except for medically necessary treatment for a covered medical condition. These include assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.
- Routine optometric eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, vision therapy, eye exercises, or fundus photography. Vision benefits may be available through the Vision Service Plan and are subject to the terms of that plan.
- Refractive surgery, laser vision correction, and any other procedure which alters the refractive character of the eye, the purpose of which is to cure or reduce myopia, hyperopia, or astigmatism. Includes radial keratotomy, corneal rings, LASIK, PRK, any procedure using the Holmium: YAG laser, and other procedures of the refractive keratoplasty type. Reversals or revision of any procedures that alter the refractive character of the eye and any complications of these procedures.
- Reversal of sterilization procedures

- Surrogacy - Members who enter into a surrogacy agreement must reimburse Moda Health, the plan administrator, for covered services related to conception, pregnancy, delivery or postpartum care that are received in connection with the surrogacy agreement. The amount the member must pay will not exceed the payments or other compensation she and any other payee is entitled to receive under the surrogacy agreement. Any cost sharing amounts the member pays will be credited toward the amount owed under this section.
 - By accepting services, the member assigns Moda Health, the plan administrator, the right to receive payments that are payable to the member or any other payee under the surrogacy agreement, regardless of whether those payments are characterized as being for medical expenses. Moda Health, the plan administrator, will secure its rights by having a lien on those payments and on any escrow account, trust or other account that holds those payments. Those payments shall first be applied to satisfy Moda Health's lien.
 - Within 30 days after entering a surrogacy agreement, the member must send written notice of the agreement, a copy of the agreement, and the names, addresses and telephone numbers of all parties involved in the agreement to Moda Health, the plan administrator. The member must also complete and send to Moda Health any consents, releases, authorizations, lien forms and other documents necessary for Moda Health to determine the existence of any rights Moda may have under this section and to satisfy those rights.
 - If the member's estate, parent, guardian or other party asserts a claim against a third party based on the surrogacy agreement, such person or entity shall be subject to the plan administrator, Moda Health's liens and other rights to the same extent as if the member had asserted the claim against the third party.
- Miscellaneous services, including (but not limited to):
 - Custodial Care, including routine nursing care and hospitalization for environmental change
 - Private Nursing Services even if related to a condition which is otherwise covered by the plan
 - Services provided by volunteer workers
 - Supplies intended for use outside hospital settings or considered personal in nature
 - Routine miniature chest x-ray films or full body scans
 - Other services and supplies not directly connected to the diagnosis or curative treatment of an illness or injury
- Supportive environmental materials, or any service or product that is primarily promoted as a personal convenience item; is prescribed or recommended by a health care provider and does not meet industry treatment standards or protocols or is a product or service that may be purchased or obtained by the general public without a prescription. Including, but not limited to, hand rails, ramps, bath benches, cervical pillows, humidifiers, air filters, air conditioners, heat lamps, tanning lights, whirlpools, saunas, whirlpools, hot tubs, fitness equipment, telephones, home furnishings and costs associated with local or distant travel, even if related to a condition otherwise covered by the plan.
- Normal necessities of living, including but not limited to food, clothing and household supplies

- Separate charges for the completion of reports, treatment plans or claim forms and the cost of records
- Ambulance services exceeding 300 miles per plan year
- Biofeedback therapy services are limited to medically necessary treatment of tension or migraine headaches and the plan will pay for no more than 10 visits during the member's lifetime
- **Cosmetic Surgery Exclusion.** Any procedure requested for the purpose of improving appearance without restoring bodily function or correcting physical impairment including procedures related to breast augmentation, lipectomy, liposuction and hair removal (including electrolysis and laser) and rhinoplasty. Exceptions are provided for medically necessary gender reassignment surgical procedures, reconstructive surgery following a mastectomy and complications of reconstructive surgeries, if medically necessary, clinically distinct and not specifically excluded; or if medically necessary to restore function due to craniofacial anomaly.
- In alternative health care environments, only traditional medical testing will be covered by the plan
- Expenses for routine nursing care, non-medical self-help or training, personal hygiene or custodial care
- Any services related to the treatment of infertility and/or the cause of infertility are excluded from coverage under the Plan. This includes artificial insemination procedures, including, but not limited to, in-vitro fertilization (IVF), Gamete Intrafallopian Transfer (GIFT), Zygote Intrafallopian Transplant (ZIFT), and Tubal Embryo Transplant (TET). *Only the initial visit and initial diagnostics to determine infertility are covered.*
- Replacement of lost hearing aids or batteries for hearing aids for enrollees age 26 or older
- The following hearing aid related charges:
 - Implantable hearing aids and surgical procedure to implant them
 - Replacement of a hearing aid, for any reason, in a 36-month period
 - Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid
 - A hearing aid exceeding the specifications prescribed for correction of hearing loss
 - Expenses incurred after coverage ends, unless the hearing aid is ordered before coverage terminated and it is received within 90 days of the end date
- Non-surgical treatment of oral diseases or other medical conditions, extraction of erupted teeth, and dental repair are not covered under the Oral Surgery benefit
- Certain over-the-counter medications when not prescribed by a provider, including nutritional supplement and herbal and homeopathic remedies. **Note:** Certain prescribed preventive medications and prescribed, FDA-approved contraceptive products are covered—even if they are over the counter.
- Treatments defined as holistic and/or are treatments outside of industry-recognized standards of care
- Non-medically necessary massage therapy is not covered
- Immunizations for the sole purpose of travel or to prevent illness which may be caused by a work environment

- Services/supplies requiring prior authorization are not covered under this plan unless certified as medically necessary through the City's contracted Prior Authorization Program
- Services and supplies provided for the treatment of obesity or weight reduction. *The plan will cover services and supplies that are necessary for the treatment of established medical conditions that may be caused by (or made worse by) obesity;* but services and supplies that do so by treating obesity directly, even if morbid obesity is present, are not covered—except for those rated A or B by the U.S. Preventive Services Taskforce. Services specifically excluded from this plan include, but are not limited to:
 - **Surgical:** Gastric restrictive procedures with or without gastric bypass, or the revision of such procedures.
 - **Weight Management:** Weight loss programs, exercise programs, counseling, hypnosis, biofeedback, neurolinguistic programming, guided imagery, or any form of relaxation training as well as subliminal suggestion used to modify eating behaviors.
 - **Pharmaceutical:** Any medication or formula related to or resulting from the treatment of weight loss or obesity even if prescribed by your physician.
- Chelation therapy, except for acute arsenic, gold, mercury or lead poisoning
- Transplant donor related services or supplies provided to an insured donor if the recipient is not enrolled under this Plan and eligible for transplant benefits. *This exclusion does not apply to complications or unforeseen infections resulting from the donation of tissue.*
- Services or supplies for any transplant not covered by the plan including the transplant of animal organs or artificial organs
- Chemotherapy with autologous or homogenic/allogenic bone marrow transplant for treatment of any type of cancer not specifically covered
- Foot orthoses (orthotics) which are solely for comfort or convenience
- Genetic testing or counseling unless medically necessary and prior authorized through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.
- Services and supplies for speech therapy, *unless rendered within one year of the onset of the illness/injury, congenital abnormality, or previous therapeutic process.*
- Counseling related to family, marriage, sex, career and “at risk” individuals, in the absence of medical necessity/illness
- Vocational, pastoral or spiritual counseling
- Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting
- Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation and Z therapy
- Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy
- Therapy performed to maintain current level of functioning without documentation of significant improvement, considered “maintenance therapy;” maintenance programs that prevent regression

of a condition or function; recreational or educational therapy; educational testing or training; non-medical self-help or training; services related to treatment, testing or training for learning disabilities; or hippotherapy

- Custodial services or supplies provided by an institution for the intellectually disabled; treatment for learning disorders
- Routine foot care services that are not medically necessary, including the following services unless required by the member's medical condition (e.g., diabetes):
 - Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus)
 - Trimming of dystrophic and non-dystrophic nails
 - Debridement of nail by any method
- Routine physical exams for employment, licensing, insurance coverage, participating in sports or other activities required for parole or probation
- Court-ordered sex offender treatment
- Designated blood donations. Collection, processing, and storage of blood donated by donors designated by plan members and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.
- Hypnotherapy
- Never events. Services and supplies related to never events, which are events that should never happen while receiving services in a hospital or facility, including but not limited to the wrong surgery, surgery on the wrong body part, or surgery on the wrong patient. These also apply to any hospital acquired condition, as that term is defined in the Centers for Medicare and Medicaid Services (CMS) guidelines, which includes but is not limited to serious preventable events.
- Treatment for sexual dysfunctions of organic origin, including impotence and decreased libido. This exclusion does not apply to sexual dysfunction diagnoses listed in the current edition of the diagnostic and statistical manual of mental disorders.
- Maternity supportive services, such as physical, emotional and information support to the mother before, during and after birth and during the postpartum period.

Frequently Asked Questions About the CityNet and CityHDP Medical Plan

1. **Who do I call when I have a question about how a service will be covered or how a claim was paid for the CityNet and CityHDP plan?** If you have a question about how a service will be covered or how a covered service was paid, please call Moda Health Customer Service at **503-243-3974** or **1-877-337-0649**.
2. **Do I need to designate a primary care physician (PCP) under CityNet and CityHDP Plan?** No. But, it is a good idea to go to one primary doctor who can get to know you and your health history. Find a physician you like and trust, and build a partnership with him or her.
3. **What is my coverage level if I have an emergency and I am taken by ambulance to the nearest hospital, but that hospital is out-of-network?** Emergency care will be covered at the in-network rate. You will pay the Emergency Room copay and your services will be paid at the in-network rate, up to MPA. You would be financially responsible for any charges above MPA. If you are admitted, call Moda Health as soon as possible (or have a family member or friend call on your behalf) to alert the plan and arrange for transfer to an in-network facility, if appropriate.

4. **The benefit for Women’s Annual Exams and Mammograms indicate the benefit is every 12 months, if I go one month early is it covered?** There is a 30-day variance for appointments within a 12-month period of time. It’s best for you to double check when your last routine exam occurred. Please also note that state mandate allows women’s annual exams and mammograms outside the 12-month period when recommended by your treating professional provider.
5. **Are Full Body Scans covered under the plan?** No.

CityNet and CityHDP Plan Prescription Medication Program

When you enroll in the CityNet and CityHDP medical plans you automatically receive prescription medication coverage, managed by Express Scripts. You have the option of purchasing prescriptions from a retail pharmacy or through mail order. Express Scripts has an extensive retail pharmacy network that includes most major retail pharmacy chains in the Portland area, such as Costco, Fred Meyer, QFC, Rite Aid, Safeway, Walgreen’s, and many independent pharmacies. For a complete list, log in to <http://www.express-scripts.com>

What Is Covered

The CityNet and CityHDP medical plan’s pharmacy coverage pays benefits based on the type of prescription medication you receive and it’s on the formulary, which is a broad list of prescription medications that are preferred for their value and effectiveness. If your medication is not on the formulary you may be required to pay 100% of the cost of the medication.

- **Generic medications** – Often considered the most cost-effective prescription medicines. They are former brand-name medications which are no longer protected by patents. The law requires generic medications to be “bio-equivalents” of their brand-name counterparts, meaning they are pharmaceutically and therapeutically equivalent to the brand name medication prescribed. They are safe, effective, and typically cost you less than other types of prescription medications.
- **Preferred brand-name medications on the Express Scripts formulary** – These are medications identified by Express Scripts as preferred for their effectiveness and value, when medically appropriate. Many preferred medications are brand-name medications without a generic equivalent. The Express Scripts formulary is used.
- **Non-preferred brand-name medications** – Brand-name medications available to you that are not on Express Script’s formulary medication list. Sometimes called “non-formulary medications.”

The plan’s tiering is revised at least annually; Express Scripts will continually review and update the tiering on recommendation by a panel of pharmacists and physicians. Should Express Scripts move the medication you take during the plan year to a different tier (Generic, Preferred or Non-Preferred) the amount you pay for your prescription may also change. You can find Express Script’s information by logging in to www.express-scripts.com or by calling 1-800-818-9289.

Certain medications require prior authorization to ensure appropriate utilization and cost effectiveness for the plans and members. Should your provider prescribe a medication that requires prior authorization, your provider will call Express Scripts to ensure the most appropriate medication is prescribed.

Did You Know?

Prescription medications provided when you are admitted to the hospital are covered by your medical plan as an inpatient expense; the prescription medication benefit described here does not apply.

Prescription Medication Program		
Prescription type	In-network retail (up to 30-day supply) *	Out-of-network retail (up to 30-day supply)
Generic – includes both generic & cost-effective brand medications	You pay 10% of the cost (\$5 minimum, \$35 maximum); Plan pays 90%	You pay the full cost at the pharmacy, then submit claims to Moda Health. You pay 40% after you meet the out-of-network deductible (Plan reimburses 60%).
Preferred – includes both brand and generic medications that have a more cost-effective alternative.	You pay 20% of the cost; (\$5 minimum, \$35 maximum); Plan pays 80%	
Non-preferred	You pay 30% of the cost (\$5 minimum, \$35 maximum); Plan pays 70%	
Mail Order (up to 90-day supply)*	Same as retail benefit shown above, based on type of medication, but maximum copay per prescription is \$50	Not applicable

*Maximum limits for contraceptive prescription fills may be up to 12 months when permitted by law.

CityHDP Prescription Medication Program		
Prescription type	In-network retail (up to 30-day supply)	Out-of-network retail (up to 30-day supply)
Generic	You pay 10% of the cost (\$0 minimum, \$150 maximum); Plan pays 90% after you have met your deductible	You pay full cost, then file claim with Moda for reimbursement of up to 60% (after you meet out-of-network medical plan deductible)
Preferred Brand (including Specialty)	You pay 20% of the cost; (\$0 minimum, \$150 maximum); Plan pays 80% after you have met your deductible	
Non-preferred Brand (including Specialty)	You pay 30% of the cost (\$0 minimum, \$150 maximum); Plan pays 70% after you have met your deductible	
Retail or Mail Order (up to 90-day supply)	Same as retail benefit shown above, based on type of medication. Specialty medications are subject to a 2x copay for a 90-day supply after you have met your deductible	Not applicable
Maintenance Plus Formulary	You pay the appropriate co-insurance or maximum listed above., whichever is less for medications on this list. Medications on this list are not subject to the deductible	Not applicable

Express Scripts Online Account

It's easy to get started and manage your prescription benefit with a secure and confidential online account. Just go to Express-Scripts.com or download the Express Scripts Mobile App from your device's app store.

- Select **Create online account** or select **Register Now**
- Complete the information requested, including personal information and your member ID number (from your Moda ID card) and create your user name and password
- Click **Register Now**

Once you have registered, if you select “Getting Started” from the menu under Health & Benefits Information you’ll have access to a wide range of services.

Specialty Medications

Specialty drugs are prescription medications that require special handling, administration or monitoring. These drugs are used to treat complex, chronic and often costly conditions, such as multiple sclerosis, rheumatoid arthritis, hepatitis C, immune and bleeding disorders. With Express Scripts, these specialty medications must be purchased through Accredo, a specialty pharmacy. Specialty pharmacies are distinct from traditional pharmacies because they coordinate many aspects of patient care to more effectively manage treatment, side effects and interactions with other therapies. If you need specialty medications, you must order them through Accredo or you’ll pay the entire cost at retail. 90-day supplies of specialty medications are subject to a 2x (30-day supply) copay. Accredo will work with participants on any acute medications that may be required. Exceptions can be made with Accredo’s approval at a retail pharmacy for an acute need.

Express Scripts SaveOn Program

The City of Portland partners with Express-Scripts’ program **SaveOn**, to help CityNet participants save money on certain specialty medications. CityNet members who participate in this program, select specialty medications will be free of charge (\$0). Prescriptions will still be filled through your approved specialty pharmacy.

If you are currently taking or will be taking a medication on the *Non-Essential Health Benefit Specialty Drug List*, you are eligible to participate in the SaveOn program. To participate, simply call SaveOn SP at 1-800-683-1074 to avoid delays in obtaining your prescription(s). Participation in this program is voluntary. If you choose not to participate, you will be responsible for the entire copay (see example below). Keep in mind that the copay will not count towards your deductible or out-of-pocket maximums, in accordance with the Affordable Care Act (ACA).

For example:

If you were taking Copaxone, your copay is currently \$75.00. Effective July 1, 2020, your copay will increase to \$1,000.

- *If you participate in the SaveOn program, your full copay will be paid through the manufacturer copay assistance program and you **will pay nothing (\$0)**.*
- *If you choose **not** to participate in the SaveOn program, **your financial responsibility will be the full \$1,000 copay**. In addition, the \$1,000 copay will **not count towards your deductible or out-of-pocket maximum**, because Non-Essential Health Benefits do not apply to out-of-pocket accumulators.*

If you have any further questions or concerns, please contact SaveOn at 1-800-683-1074 Monday – Thursday 8:00 a.m. – 8:00 p.m. Eastern and Friday 8:00 a.m. – 6:00 p.m. Eastern, or contact.

Did You Know?

What’s the difference between a generic and a brand-name medication?

Differences include things such as shape, packaging, fillers (including colors, flavors and preservatives), expiration time, name, and price. A generic medication is called by its chemical name; a manufacturer assigns a brand name. Generic medications are “copies” of brand-name medications that have the same dosage, intended use, intended effects, safety and strength as their brand-name counterparts.

Standard practice and most state laws require that a generic medication be *generically equivalent* to its brand-name counterpart. That is, it must have the same active ingredients, strength and dosage form: pill, liquid or injection. The generic medication also must be *therapeutically equivalent*—it must be the same chemically and have the same intended medical effect.

Do all medications have generic equivalents?

No. Some medications are protected by patents and are supplied by only one company. But, over half of the medications on the market are available in a generic form—or have a generic available in the same therapeutic class.

Will my doctor automatically prescribe generic medications?

It depends on your doctor. You can ask your doctor to prescribe a generic or to write or electronically submit a prescription that allows the pharmacist to substitute a generic when available—and that will save you and the plan money.

More About Maintenance Medications

Maintenance medications are those you take on a regular, continual basis to manage an ongoing or long-term condition, such as asthma, diabetes, high cholesterol, or birth control. For maintenance medications, you may choose to get a 90-day supply through mail order. See the chart above, or the Medical Plan Coverage chart for details on associated charges. The Mail Order Customer Care line can be reached at 1-800-818-9289.

How to Use the Mail Order Service

With this service, you get a 90-day supply of your prescription mailed directly to your home from Express Scripts. Your copay is based on the total cost of the medication for the 90-day supply at the copay levels shown in the *Medical Plan Comparison* chart.

Generic medications will be substituted for brand-name medications when available and allowed by the prescribing physician.

Initiating a New Mail Order Prescription

Follow these steps when you have a new mail order prescription:

1. Ask your doctor to write a prescription or send an electronic prescription for a 90-day supply (with up to three refills, as appropriate).
2. If your prescription is a written prescription, on the front of each new prescription, print clearly the member’s name and relationship to the primary covered person (e.g., self, spouse/domestic partner, child) and the member’s ID number:
 - Be sure the prescribing doctor’s name is clearly indicated
 - Complete the Express Scripts Pharmacy Prescription Order Form

- Provide a street address for delivery. Some medications, such as narcotics and medications requiring refrigeration are restricted from delivery to a post office box.
3. Send your prescription(s), completed order form and copay in the envelope provided. A new order form and envelope will be returned with each delivery.
 4. You will need to call Express Scripts to find out how much your prescription will cost. A representative will ask you for the name of the medication, strength, quantity and dosage, then quote you a discounted price. You will use this price to calculate your copay.

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

You may order refills by calling 1-800-818-9289.

Immunizations: While immunizations are available through the medical plan through your primary care physician, you may now also obtain immunizations, at no charge (including some travel vaccines) through the Express Scripts pharmacy network. The coverage of an immunization under the pharmacy benefit may require a prescription written by a licensed health care professional. (Flu vaccines do not require a prescription.) Some immunizations may have different eligibility requirements through the pharmacy than through the medical plan. (For example, shingles vaccines will be covered at age 60 or older, while the medical plan allows them at age 50.) Members are encouraged to contact their local network pharmacy for additional clarification.

What Is Not Covered: CityNet and CityHDP Plan Prescription Medication Program Exclusions

- Medications purchased or obtained without a physician's written prescription
- Over-the-counter products not required by the ACA (including hair growth, infertility medications and medications not approved by the FDA)
- Products not recognized or designated as FDA-approved medications
- Nose drops or nasal preparations that do not require a physician's written prescription
- Immunization agents for travel
- Non-medication items, dietary supplements, vitamins (other than prescription prenatal vitamins), or health and beauty aids
- Medications dispensed by a hospital, nursing care facility, health care center, urgent or immediate care center, ambulatory surgical center, doctor's office, or other institution
- Medications obtained after eligibility and/or coverage terminates
- Any refill of a prescription that exceeds the number specified by the prescribing physician or that is dispensed after one year from the date of the prescription
- Medications prescribed or used for cosmetic purposes
- Services and supplies subject to the *What Is Not Covered: CityNet and CityHDP Medical Plan Limitations and Exclusions* section of this SPD
- Non-legend or over-the-counter (OTC) medications except as required under the ACA
- Prescriptions that are covered by Workers' Compensation laws, the Fire and Police Disability Retirement Fund, or other county, state, or federal programs

- Compounds, unless the prescription includes at least one legend medication that is an essential ingredient
- Naturopathic supplements, including when prescribed as a compound medication
- Medications that are determined by the Plan Administrator to be experimental or investigational or that are labeled: "Caution: Limited by federal law to investigational use"
- Medications prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission (*Moda Health may evaluate individual requests*)
- Charges over the maximum plan allowance
- Medication administration (charges for administration or injection of a medicine, except for selected immunizations at an in-network pharmacy)
- Foreign medication claims (medications purchased for non-U.S. mail order or online pharmacies, or U.S. mail or online pharmacies acting as agents of non-U.S. pharmacies)
- Off-label use (medications prescribed for or used for non-FDA approved indications, unless approved by the Health Resources Commission)
- Repackaged medications

Special Programs

MyModa Healthcare Cost Estimator

You can access the MyModa HealthCare Cost Estimator tool as a resource to easily understand how much a procedure will cost, compare costs between various providers and take into account your specific medical benefits. This tool will even consider your current accumulators, such as your deductible and Out of Pocket Maximum to give you an accurate estimate of what your health care expenses will be! This tool is easy to use and can even be accessed on a mobile device. This tool will help you to find and compare providers that provide the following:

- Checkups & Physicals
- Physical Therapy, Chiropractic and Orthopedic services
- MRIs & other imaging services
- Women's Health
- Colonoscopy
- Various Specialties

To access the Healthcare Cost Estimator, you can log into your mymoda.com account and select the myHealth tab.

This tool is a research tool to assist employees with researching and determining an *estimate* of their healthcare costs and provider comparison. The actual cost that is billed to you, may fluctuate up or down from the Healthcare Cost Estimator, as services are billed on an individual case by case bases.

Care Coordination Services (Case Management)

If you or one of your enrolled dependents is diagnosed with complex or high risk medical or mental health condition or experiencing unusual and serious complications from the treatment of a medical condition, you can get help. Care Coordination (case management) is performed by registered nurses. They work to create an individualized treatment program for you or your family member—acting as your advocate when you need a helping hand. Examples of when you may require case management services include, but are not limited to:

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

If you believe that you may qualify for this service, please call Moda Health directly at **503-948-5561** or **1-877-337-0649** or 711 for Relay Service (deaf or hard of hearing).

Disease Management/Health Promotion

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

Disease Management programs provide individualized education plans for those with a chronic disease such as asthma or diabetes. Health Promotion activities focus on wellness, prevention of illness and early diagnosis—including immunization reminders and maternity wellness. You can also request information on specific diseases or other medical concerns. Specifically, the program can:

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

If you are interested in talking with a coach or think you may qualify for this service, please call Moda Health at **503-948-5561** or **1-877-337-0649** (or 711 for Relay Service for the deaf or hard of hearing).

Medical and Behavioral Management Services

The City's Medical and Behavioral Health (mental health and chemical dependency) Management programs cover a range of services designed to assist you and your family with your health care needs and to assure that medical treatments are medically necessary, appropriate and reasonable. **Note:** The City's medical plan complies with all mental health parity laws.

Programs include: prior authorization for specified services, medical review of complex or high cost claims, case management of complex or high cost claims, disease management assistance for chronic conditions plus wellness and health promotion services.

Using these services will ensure you receive the maximum benefits under the CityNet PPO medical plan. If you have any questions about this information or are unsure about whether a particular procedure is required, please call Moda Health for clarification and guidance.

Who Performs the Medical Management Services?

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

Your Role

Taking an active role in your health care is critical. You or your doctor should call Moda Health to request participation if any of the following conditions occur:

- When your physician recommends an inpatient hospitalization
- Within 48 hours of an emergency admission, or the first working day following a weekend or holiday admission
- If your physician recommends any of the health care services that require prior authorization. These services are listed in the *Medical Review Services* section.
- When a mental health or chemical dependency admission has been recommended
- By the fourth month of pregnancy (end of first trimester)

To access medical management staff, call Moda Health Customer Service at **503-243-3974** (in Portland metropolitan area) or **1-877-337-0649**. Representatives are available Monday through Friday, from 7:30 a.m. to 5:30 p.m. Pacific time. For assistance for the hearing and speech impaired, call the Telecommunications Relay Service at 711.

To access behavioral health management (mental health and chemical dependency) staff, call **503-624-9382** or **1-800-799-9391** (or 711 for Relay Service). Representatives are available Monday through Friday, 7:30 a.m. to 5:30 p.m. Pacific time.

Medical Review Services

Services Requiring Prior Authorization

When a professional provider suggests admission to the hospital or a residential program, or a non-emergency surgery, you should ask the provider to contact Moda Health for prior authorization.

The professional provider or his or her office staff calls Moda Health or submits a prior authorization form. Moda Health will either approve the procedure or admission and when applicable, assign the expected length of stay and an appropriate time of admission (such as the morning of, or the night before, a scheduled surgery), ask for additional information and/or request that the member get a second opinion. The hospital, professional provider and member are notified of the outcome of the authorization process by letter.

Prior authorization does not guarantee coverage. When a service is not medically necessary, or is otherwise excluded from benefits, charges will be denied.

A member may obtain authorization information by contacting Moda Health Customer Service at **503-243-3974**, or for mental health or chemical dependency services by contacting Moda Health Behavioral Health at **503-624-9382**.

Inpatient Services, Partial Hospitalization, and Residential Programs

All non-emergency hospital confinements that are scheduled in advance, and admission to any residential treatment program, must be prior authorized in order for maximum plan benefits to be payable. If the hospitalization, partial hospitalization or residential stay is not medically necessary, claims will be denied. Moda Health will authorize medically necessary lengths of stay, based upon the medical condition. Additional hospital or residential days are covered only upon medical evidence of need.

Authorization for emergency hospital admissions must be obtained by calling Moda Health within 48 hours of the emergency hospital admission (or as soon as reasonably possible).

Ambulatory Surgery

Certain diagnostic and therapeutic procedures can be performed without an inpatient admission or overnight stay in a hospital. **Prior authorization must be obtained for any inpatient admission or overnight stay for a service that is commonly performed on an outpatient basis.** Some outpatient or ambulatory services also require prior authorization. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.

Important note:

Failure to follow the prior authorization procedure described here for the services listed will result in an initial *denial of reimbursement* for the services. If your claim is denied, you must request a retrospective authorization. If the retrospective authorization is approved your claim will be adjusted. You will still be responsible for any applicable in- or out-of-network deductibles, copayments and charges in excess of what would have been authorized by the plan.

Outpatient Services

The Plan requires prior authorization for many outpatient services. You can find a complete list on myModa (at www.modahealth.com/members) or by calling Customer Service at **503-243-3974** or **1-877-337-0649**.

Prior Authorization Procedures

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

Non-Emergency Prior Authorization Procedure

In the event you (or a covered dependent) require a non-emergency service or treatment that has a prior authorization requirement, the following procedure must be followed **prior** to receiving the service or treatment:

1. Your physician must call for a prior authorization before admission at **503-243-4496** (in the Portland metropolitan area) or **1-800-258-2037**.
2. Provide the covered member's name and identification number, covered patient's name, date and place of admission, physician's name and telephone number, diagnosis and surgery or procedure.
3. The physician and/or hospital will be contacted for further information regarding diagnosis, proposed length of stay, reason for admission, surgical procedure, nature of prescribed service or treatment, etc. Once the service or treatment is determined to be a covered benefit and medically necessary, a prior authorization approval is entered into the Moda Health claims payment system. An authorization letter is sent to the member, treating provider, and facility if applicable.

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

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

Emergency Procedure Authorization

Authorization for emergency hospital admission must be obtained by calling Moda Health at **503-243-4496** (in the Portland metropolitan area) or **1-800-258-2037** within 48 hours of the emergency hospital admission (or as soon as is reasonably possible).

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

- **Concurrent Review.** Review of your progress during a hospitalization and verification of the appropriate level of care for continued stay.
- **Discharge Planning.** Coordination of discharge planning needs between all health care providers and your family to facilitate your return home or transfer to an appropriate facility.
- **High Risk Pregnancy.** Prenatal screening.

Filing a Claim for CityNet PPO and CityHDP Plan Benefits

If you see an in-network provider (part of the Connexus network), the provider will directly bill Moda Health. A provider may collect any applicable copayments at the time of service. Some provider contracts may allow providers to collect payment at the time of service.

If you go to an out-of-network (or non-network) provider, you may need to pay the provider for the full cost of services received (at the time of your appointment), then file a claim to be reimbursed any benefit available to you. You'll need to submit a completed claim form and a copy of billings from non-network providers directly to Moda Health, the Medical Insurer. It is important to include the employee's name, health plan ID number and to note "City of Portland" on the billing form. Most providers use a uniform billing system which tells Moda Health the diagnosis and nature of treatment.

When the City of Portland claim form is used, it should be accompanied by the itemized bill from the provider. This form allows the member to indicate whether payments are to be made directly to the provider of service or to you, the member. All medical claims should be submitted to:

Medical Claims
P.O. Box 40384
Portland, OR 97240-0384

Telephone Inquiries: 503-243-3974 or 1-877-337-0649 Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by the Plan. The Plan does not cover benefits for which a third party may be legally liable. Because recovery from a third party may be difficult and take a long time, as a service to the member the Plan will pay a member's expenses based on the understanding and agreement that the Plan is entitled to be reimbursed in full from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party, as defined below.

The member agrees that the Plan has the rights described in this section. The Plan may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of recovery or subrogation as discussed in this section. Moda Health has discretion to interpret and construe these recovery and subrogation provisions.

Definitions

For purposes of this section, the following definitions apply:

Benefits means any amount paid by the Plan, or submitted for payment to or on behalf of a member. Bills, statements or invoices submitted by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Recovery Funds means any amount recovered from a third party.

Third Party means any person or entity responsible for the medical condition, or the aggravation of a medical condition, of a member. Third party includes any insurer of such person or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection (PIP) coverage, and workers' compensation insurance.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member.

Subrogation

Upon payment by the Plan, the Plan has the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan.

Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply:

- a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that medical condition.
- b. The Plan is entitled to receive the amount of benefits it has paid for a medical condition out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, the Plan is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third party recovery.
- c. If the Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.
- d. This right of recovery includes the full amount of the benefits paid or pending payment by the Plan, out of any recovery made by the member from the third party, including without limitation any and all amounts from the first dollars paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. The Plan's recovery rights will not be reduced due to the member's own negligence.
- f. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.
- g. In third party claims involving the use or operation of a motor vehicle, the Plan, at its sole discretion and option, is entitled to seek reimbursement under the personal injury protection statutes of the state of Oregon, including ORS 742.534, ORS 742.536, or ORS 742.538, or under other applicable state law.

Additional Provisions

Members shall comply with the following, and agree that Moda Health may do one or more of the following at its discretion:

- a. The member shall cooperate with Moda Health to protect the Plan's recovery rights, including by:
 - i. Signing and delivering any documents Moda Health reasonably requires to protect the Plan's rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement. The Plan will not be required to pay benefits until the agreement is properly signed and returned
 - ii. Providing any information to Moda Health relevant to the application of the provisions of this section, including all information available to the member, or any representative or attorney representing the member, relating to the potential third party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
 - iii. Notifying Moda Health of the potential third party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
 - iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing the Plan's third party recovery rights
- b. The member and his or her representatives are obligated to notify Moda Health in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any

damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party.

- c. By accepting payment of benefits by the Plan, the member agrees that Moda Health has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.
- d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in this section.
- e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of this section.
- f. This section applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.
- g. If the member continues to receive treatment for a medical condition after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that medical condition only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.
- h. If the member or the member's representatives fail to do any of the above mentioned acts, then the Plan has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any medical condition resulting from the event giving rise to, or the allegations in, the third party claim. Moda Health may notify medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.

Coordination of benefits (where the member has healthcare coverage under more than one plan or health insurance policy) is not considered a third party claim.

Claim Deadline

Claims must be submitted within 12 months of the date the expense was incurred in order to be eligible for benefits under the Plan. Claims submitted by Medicaid must be completed within three years after the date the expense was incurred.

Explanation of Benefits (EOB)

Soon after receiving a claim, Moda Health will report its action on the claim by providing the member a document called an Explanation of Benefits (EOB). Members are encouraged to access their EOBs electronically by signing up through myModa (found on www.modahealth.com). Moda Health may pay claims, deny them, or accumulate them toward satisfying the deductible.

Moda Health does not always pay claims in the order in which charges are incurred. This may affect how a member's cost sharing is applied to claims. For example, a deductible may not be applied to the first date a member sought services in the plan year, if a later date of service has already been paid.

If all or part of a claim is denied, the reason will be stated in the EOB. Review it carefully and call Moda Health if you have any questions or see any issues.

Did You Know?

Here are some tips to make filing your claim easier (if you see an out-of-network provider):

- Take a claim form with you when you go to the doctor or lab. Complete the form, sign it and ask your doctor any applicable questions while you are there.
- Attach all related itemized receipts from your provider and submit them with your claim form. The claim form must show what services were performed during your visit, the date of your visit, and the cost.
- Keep copies of all your medical receipts. You should also maintain separate files for all covered dependents.

Continuity of Care

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

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

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

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

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

- The member must request continuity of care from Moda Health;
- The member is undergoing an active course of treatment that is medically necessary and, by agreement of the individual provider and the member, it is desirable to maintain continuity of care; and
- The contractual relationship between the professional provider and Moda Health, with respect to the plan covering the member has ended. However, Moda Health will not be required to provide continuity of care when the contractual relationship between the professional provider and Moda Health ends under one of the following circumstances, when the provider:
 - Has retired
 - Has died
 - No longer holds an active license
 - Has relocated out of the service area
 - Has gone on sabbatical

- Is prevented from continuing to care for patients because of other circumstances
- The contractual relationship has terminated in accordance with provisions of the medical services contract relating to quality of care and all contractual appeal rights of the individual physician or provider have been exhausted.

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

Length of Continuity of Care

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

- The day following the date on which the active course of treatment entitling the enrollee to continuity of care is completed
- The 120th day after the date of notification by Moda Health to the enrollee of the termination of the contractual relationship with the professional provider

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

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

Notice Requirement

Moda Health, the plan administrator, will give written notice of the termination of the contractual relationship with a professional provider and of the right to obtain continuity of care to those enrollees that Moda Health knows or reasonably should know are under the care of the professional provider. The notice shall be given to the enrollees no later than the 10th day after the date on which the termination of the contractual relationship takes effect or no later than the 10th day after Moda Health first learns the identity of an affected enrollee after the date of termination of the contractual relationship.

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

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

Third Party Liability

A member may have a legal right to recover benefit or healthcare costs from a third party as a result of a medical condition for which such costs were paid by the Plan. The Plan does not cover benefits for which a third party may be legally liable, except for those related to a motor vehicle accident (see section for [motor vehicle accident recovery](#)). Because recovery from a third party may be difficult and take a long time, as a service to the member the Plan will pay a member's expenses based on the understanding and agreement that the Plan is entitled to be reimbursed from any recovery the member may receive for any benefits paid that are or may be recoverable from a third party, as defined below.

The member agrees that the Plan has the rights described. The Plan may seek recovery under one or more of the procedures outlined in this section. The member agrees to do whatever is necessary to fully secure and protect, and to do nothing to prejudice, the Plan's right of recovery or subrogation as discussed in this section. Moda Health has discretion to interpret and construe these recovery and subrogation provisions.

Definitions

For purposes of this section, the following definitions apply:

Benefits means any amount paid by the Plan or submitted for payment to or on behalf of a member. Bills, statements or invoices submitted by a provider to or on behalf of a member are considered requests for payment of benefits by the member.

Third Party means any person or entity responsible for the medical condition, or the aggravation of a medical condition, of a member. Third party includes any insurer of such person or entity, including different forms of liability insurance, or any other form of insurance that may pay money to or on behalf of the member including uninsured motorist coverage, under-insured motorist coverage, premises med-pay coverage, personal injury protection (PIP) coverage and workers' compensation insurance.

Third Party Claim means any claim, lawsuit, settlement, award, verdict, judgment, arbitration decision or other action against a third party (or any right to such an action) by or on behalf of a member.

Subrogation

Upon payment, the Plan has the right to pursue the third party in its own name or in the name of the member. The member shall do whatever is necessary to secure such subrogation rights and do nothing to prejudice them. The Plan is entitled to all subrogation rights and remedies under common and statutory law, as well as under the Plan's provisions.

Right of Recovery

In addition to its subrogation rights, the Plan may, at its sole discretion and option, require a member, and his or her attorney, if any, to protect its recovery rights. The following rules apply to all recovery except for those related to motor vehicle accidents (see section for [motor vehicle recovery rights](#)):

- a. The member holds any rights of recovery against the third party in trust for the Plan, but only for the amount of benefits the Plan paid for that medical condition.
- b. The Plan is entitled to receive the amount of benefits it has paid for a medical condition out of any settlement or judgment that results from exercising the right of recovery against the third party. This is so whether or not the third party admits liability or claims that the member is also at fault. In addition, the Plan is entitled to receive the amount of benefits it has paid whether the healthcare expenses are itemized or expressly excluded in the third-party recovery.
- c. If the Plan requires the member and his or her attorney to protect its recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party..
- d. This right of recovery includes the full amount of the benefits paid or pending payment by the Plan out of any recovery made by the member from the third party, including without limitation any and all amounts paid or payable to the member (including his or her legal representatives, estate or heirs, or any trust established for the purpose of paying for the future income, care or medical expenses of the member), regardless of the characterization of the recovery, whether or not the member is made whole, or whether or not any amounts are paid or payable directly by the third party, an insurer or another source. The Plan's recovery rights will not be reduced due to the member's own negligence.

- e. If it is reasonable to expect that the member will incur future expenses for which benefits might be paid by the Plan, the member shall seek recovery of such future expenses in any third party claim.

Additional Provisions

Members shall comply with the following, and agree that the Plan may do one or more of the following at its discretion:

- a. The member shall cooperate with Moda Health to protect the Plan's recovery rights, including by:
 - i. Signing and delivering any documents Moda Health reasonably requires protecting the Plan's rights, including a Third Party Reimbursement Questionnaire and Agreement. If the member has retained an attorney, then the attorney must also sign the agreement.
 - ii. Providing any information to Moda Health relevant to the application of the provisions of section [third-party liability](#), including all information available to the member, or any representative or attorney representing the member, relating to the potential third-party claim. This may include medical information, settlement correspondence, copies of pleadings or demands, and settlement agreements, releases or judgments
 - iii. Notifying Moda Health of the potential third-party claim for which the Plan may issue benefits. The member has this responsibility even if the first request for payment of benefits is a bill or invoice submitted to Moda Health by the member's provider
 - iv. Taking such actions as Moda Health may reasonably request to assist it in enforcing the Plan's third-party recovery rights
- b. The member and his or her representatives are obligated to notify Moda Health in advance of any claim (written or oral) and/or any lawsuit made against a third party seeking recovery of any damages from the third party, whether or not the member is seeking recovery of benefits paid by the Plan from the third party.
- c. By accepting payment of benefits by the Plan, the member agrees that Moda Health or the Plan has the right to intervene in any lawsuit or arbitration filed by or on behalf of a member seeking damages from a third party.
- d. The member agrees that Moda Health may notify any third party, or third party's representatives or insurers, of the Plan's recovery rights described in section [third-party liability](#).
- e. Even without the member's written authorization, Moda Health may release to, or obtain from, any other insurer, organization or person, any information it needs to carry out the provisions of section [third-party liability](#).
- f. Section [third-party liability](#) applies to any member for whom advance payment of benefits is made by the Plan whether or not the event giving rise to the member's injuries occurred before the member became covered by the Plan.
- g. If the member continues to receive treatment for a medical condition after obtaining a settlement or recovery from a third party, the Plan will provide benefits for the continuing treatment of that medical condition only to the extent that the member can establish that any sums that may have been recovered from the third party have been exhausted.

- h. If the member or the member's representatives fail to do any of the above mentioned acts, then Moda Health has the right to not advance payment or to suspend payment of any benefits, or to recover any benefits it has advanced, for any medical condition resulting from the event giving rise to, or the allegations in, the third party claim except for claims related to motor vehicle accidents (see section [motor vehicle recovery rights](#)). Moda Health may notify medical providers seeking authorization of payment of benefits that all payments have been suspended and may not be paid.
- i. Coordination of benefits (where the member has healthcare coverage under more than one plan or health insurance policy) is not considered a third party claim.

Motor Vehicle Accident Recovery

If a claim for healthcare expenses arising out of a motor vehicle accident is filed with Moda Health and motor vehicle insurance has not yet paid, the Plan will advance benefits. The Plan retains the right to repayment of any benefits paid from the proceeds of any settlement, judgement or other payment received by the member that exceeds the amount that fully compensates the member for their motor vehicle accident related injuries.

If Moda Health requires the member or his or her attorney to protect the Plan's recovery rights under this section, then the member may subtract from the money to be paid back to the Plan a proportionate share of reasonable attorney fees as an expense for collecting from the other party.

The member shall do whatever is proper to secure, and may not prejudice, the rights of the Plan under this section.

Kaiser Permanente Medical Plan (HMO)

For more details about the Kaiser Medical Plan, please view the *Medical Plan Coverage* chart. Kaiser information added to this handbook and all other City publications is added for convenience. Any misstatement of benefits within these documents does not allow for coverage if Kaiser Permanente documents represent different coverage levels. Please contact Kaiser NW directly at 503-813-2000 for any confirmation of coverage and/or benefit limitations/exclusions

Here are some of the plan's highlights:

- You must use providers and facilities that are part of the Kaiser network to receive any benefit
- When you enroll in the Kaiser medical plan, you automatically receive vision coverage through Kaiser also
- Kaiser providers will file claims and handle prior authorization for you
- There is no annual deductible to meet before the plan starts sharing costs with you. Most services will cost you a copay (a fixed dollar amount).
 - Primary care office visit copays are \$10
 - Urgent care visits, physical therapy and specialist office visit copays are \$20
 - Prescription copays are \$15 for a 30-day supply at a Kaiser pharmacy; \$30 for a 90-day supply of maintenance prescriptions through the Kaiser mail order program
 - Emergency Room copays are \$75 (at Kaiser facilities, out-of-plan and out-of-area facilities)
 - Ambulance copay is \$75 per trip
 - Advanced imaging services copays are \$50

- Infertility diagnosis and treatment is covered at 50%
- Outpatient administered medications have a 20% coinsurance (you pay 20%, the plan pays 80%)
- Immunizations and prescription medications related to travel are covered

IMPORTANT NOTE FOR RETIREES:

If you are eligible for Medicare, you are no longer eligible for the Kaiser plan for active employees. You ARE eligible for the Kaiser Medicare Advantage Plan. Please see the *Kaiser Permanente Senior Advantage Benefit Summary* chart for more details. This rule does not apply if you are Medicare eligible and/or age 65 or older and have NOT yet retired, and continue to be an active employee.

For More Information,

For additional information about Kaiser Permanente or the medical plan available to you, go to www.kp.org or call Kaiser at **503-813-2000**.

Kaiser Service Area

The Kaiser Medical Plan (and the Kaiser Medicare Advantage plan) is available in the following Oregon and Washington counties:

In Oregon...

- Columbia, Multnomah, Polk, Washington and Yamhill Counties: all zip codes
- Benton: 97330-31, 97333, 97339, 97370
- Clackamas: 97004, 97009, 97011, 97013, 97015, 97017, 97022-23, 97027, 97034-36, 97038, 97042, 97045, 97049, 97055, 97067-68, 97070, 97086, 97089, 97222, 97267-69
- Hood River: 97014
- Linn: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389
- Marion: 97002, 97020, 97026, 97032, 97071, 97137, 97301-03, 97305-12, 97314, 97325, 97342, 97346, 97352, 97359, 97362, 97373, 97375, 97381, 97383-85, 97392

In Washington...

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

Out-of-Area Coverage for Dependents

A limited benefit will be offered to subscribers' eligible dependents who live outside of the Kaiser Permanente service areas. The benefits are limited to ten office visits, ten lab and x-rays and ten prescription fills. Services are covered at a 20% coinsurance of the actual cost of services. Emergency and urgent care still covered as in-network. Payments for these services accumulate toward the out-of-pocket maximum.

Call Kaiser Member Relations at 503-813-4468 if you have questions concerning this benefit.

RETIREEES – This does not apply to the Kaiser Senior Advantage Plan.

What Is Covered

How the Kaiser Permanente Plan Works

Kaiser Permanente provides services directly to members through an integrated medical care program. If you live or work in specific geographic areas, you may elect medical coverage under Kaiser Permanente.

When you choose Kaiser Permanente you agree to receive all of your medical care from the physicians, specialists, hospitals, pharmacies, and labs associated with Kaiser Permanente.

Kaiser Permanente provides services both through its own hospitals and medical offices, and through qualified community facilities.

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

As a participant of Kaiser Permanente, you avoid deductibles and claim forms. Some services (such as office visits or lab tests) may require a **copayment**, which is due when you receive care. You can find this general information and the copayment amounts in the *Medical Plan Comparison* chart. **(Medicare-eligible retirees in the Kaiser Medicare Advantage Plan should review the Kaiser Permanente Senior Advantage Benefit Summary chart.)** For more specific information about your coverage or for a summary of your benefit plan, contact Kaiser Permanente's Membership Services at **503-813-2000** or **1-800-813-2000**.

Kaiser Emergency and Urgent Care Coverage

In an emergency... A medical condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

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

If you have an Emergency Medical Condition, Kaiser will cover licensed ambulance services that are not ordered by a Participating Provider *only if* all of the following are true:

- Your condition requires use of the medical services that only a licensed ambulance can provide
- Use of all other means of transportation, whether or not available, would endanger your health
- The ambulance transports you to a hospital where you receive covered Emergency Services

Emergency Services are available from Participating Hospital emergency departments 24 hours a day, seven days a week. Please contact Membership Services or see the Kaiser Medical Directory for locations of these emergency departments.

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

Outside the service area

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

Inside the service area

When you are inside the Kaiser Permanente service area, you must receive emergency care at an emergency facility owned by or affiliated with Kaiser Permanente for your benefits to apply, unless the

extra travel time to reach a Kaiser Permanente facility would result in serious medical consequence, such as risk of death.

For Questions or Problems with Kaiser Care or Services

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

What Is Not Covered: Kaiser Permanente Limits and Exclusions

Exclusions

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

- **Chiropractic Services** received without a referral from Kaiser Permanente
- **Custodial Care.** Non-skilled, personal services such as help with activities of daily living (for example, walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine); or care that can be performed safely and effectively by persons who, in order to provide the care, do not require licensure or certification or the presence of a supervising licensed nurse.
- **Cosmetic Services.** Cosmetic services means those services that are intended primarily to change or maintain your appearance and that will not result in significant improvement in physical function. *This exclusion does not apply to reconstructive surgery services required by the Women's Health and Cancer Rights Act.*
- **Dental Services.** Dental care and dental X-rays, such as dental services following accidental injury to teeth; dental appliances; dental implants; orthodontia; and dental services necessary for or resulting from medical treatment such as surgery on the jawbone and radiation treatment, except that *this exclusion does not apply to dental Emergency Care or to extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease.*
- **Designated Blood Donations.** Collection, processing and storage of blood donated by donors whom you designate, and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.
- **Employer or Governmental Responsibility.**
 - *Employer responsibility:* Kaiser does not reimburse the employer for any services that the law requires an employer to provide. When Kaiser covers any such services, Kaiser may recover the charges for the services from the employer.
 - *Government agency responsibility:* For any services that the law requires be provided only by or received from a government agency, Kaiser will not pay the government agency and when Kaiser covers any such services they may recover the charges for the services from the government agency. *This exclusion does not apply to Medicaid.*

- **Experimental or Investigational Services.** Services are excluded if any of the following are true about the service:
 - The service cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted; or is the subject of a current new medication or new device application on file with the FDA; or is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity, or efficacy of the service; or is provided pursuant to a written protocol or other document that lists an evaluation of the service's safety, toxicity, or efficacy as among its objectives; or is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity, or efficacy of services; or is provided pursuant to informed consent documents that describe the service as experimental or investigational, or in other terms that indicate that the service is being evaluated for its safety, toxicity, or efficacy; or the prevailing opinion among experts as expressed in the published authoritative medical or scientific literature is that;
 - Use of the service should be substantially confined to research settings, or
 - Further research is necessary to determine the safety, toxicity, or efficacy of the service
 - In making determinations whether a service is experimental or investigational, the following sources of information will be relied upon exclusively: the member's medical records, the written protocol(s) or other document(s) pursuant to which the service has been or will be provided, any consent document(s) the member or the member's representative has executed or will be asked to execute, to receive the service, the files and records of the IRB or similar body that approves or reviews research at the institution where the service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body, the published authoritative medical or scientific literature regarding the service, as applied to the member's illness or injury, and regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.
 - If two or more services are part of the same plan of treatment or diagnosis, all of the services are excluded if one of the services is experimental or investigational
 - Kaiser Permanente consults the Medical Group and then uses the criteria described above to decide if a particular service is experimental or investigational
- **Certain Examinations and Related Services.** Physical examinations and related services required for obtaining or maintaining employment or participation in employee programs; insurance or governmental licensing; or court order or required for parole or probation. *This exclusion does not apply if a Plan Physician determines that the services are Medically Necessary.*
- **Eye Surgery.** Radial keratotomy, photorefractive keratectomy and refractive surgery, including evaluations for the procedures.

- **Genetic Testing.** Genetic testing and related services are excluded *except for genetic counseling and medically appropriate genetic testing for the purpose of diagnostic testing to determine disease and/or predisposition of disease, and to develop treatment plans*. Covered services are limited to preconception and prenatal testing for detection of congenital and heritable disorders, and testing for the prediction of high-risk occurrence or reoccurrence of disease when medically necessary as determined by a Physician.
- **Hearing Aids.** Limited to one hearing aid per ear every four years per member age 18 years or younger, or enrollees age 19 to 25 and enrolled in an accredited educational institution.
- **Hypnotherapy.** All services related to hypnotherapy.
- **Intermediate Care.** Care in an intermediate care facility.
- **Massage therapy** services received without a referral from Kaiser Permanente
- **Naturopathy Services** received without a referral from Kaiser Permanente
- **Non-medically necessary services**
- **Prescription medications used for the treatment and prevention of sexual dysfunction,** except for those FDA-approved drugs used to treat mental health symptoms of sexual dysfunction
- **Replacement of External Prosthetic Devices and Orthotic Devices** due to loss or misuse.
- **Services Related to a Non-Covered Service.** When a service is not covered, all services related to the non-covered service are excluded, except that *this exclusion does not apply to services we would otherwise cover to treat complications arising after the non-covered service*.
- **Travel and Lodging.** Transportation or living expenses for any person, including the patient, *except for Medically Necessary ambulance service and certain expenses that Kaiser preauthorizes in accord with Kaiser's travel and lodging guidelines related to transplants* or in those cases where travel and lodging expenses are needed for a Member to receive covered services outside of Kaiser's service area when approved through Utilization Review
- **Workers' Compensation or Employer's Liability.** Financial responsibility for services is excluded for any illness, injury, or condition to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided under any Workers' Compensation or employer's liability law. Kaiser will provide services even if it is unclear whether you are entitled to a Financial Benefit, but Kaiser may recover charges for any such services from the following sources:
 - Any source providing a Financial Benefit or from whom a Financial Benefit is due
 - You, to the extent that a Financial Benefit is provided or payable—or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit—under any Workers' Compensation or employer's liability law
- **Travel-related services,** including travel-only immunizations (such as yellow fever, typhoid and Japanese encephalitis)

Limitations

Kaiser Permanente will do its best to provide or arrange for your health care needs in the event of unusual circumstances that delay or render impractical the provision of services under this contract, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities and labor disputes. However, in these circumstances,

neither Kaiser, Plan Hospitals, Medical Group, nor any Plan Physician shall have any liability or obligation because of a delay or failure to provide these services. In the case of a labor dispute involving Health Plan, Plan Hospitals, or Medical Group, Kaiser may postpone non-emergency care until after resolution of the labor dispute.

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

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

Injuries or Illnesses Alleged to Be Caused by Third Parties

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

To secure their rights, Kaiser Permanente will have a lien on the proceeds of any judgment or settlement the Member obtains against a third party. The proceeds of any judgment or settlement that the member obtains shall first be applied to satisfy Kaiser's lien regardless of whether the total amount of the recovery is less than the actual losses and damages the member incurred.

Members must make all reasonable efforts to pursue any claim they may have against a third party. Within 30 days after submitting or filing a claim or legal action against a third party, the member must send written notice of the claim or legal action to Kaiser at:

Claims Administration

Kaiser Foundation Health Plan of the Northwest

500 NE Multnomah St. #100

Portland, OR 97232-2099

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

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

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

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

Grievances, Claims, Appeals, and External Review

We want you to be satisfied with the services you receive from Kaiser Permanente. If you have questions about your Service or your coverage, please contact Membership Services. You may contact Membership Services at **503-813-2000** in Portland or at **1-800-813-2000** in all other areas. Membership Services representatives are available Monday through Friday, 8 a.m. to 6 p.m.

We encourage you to discuss any questions or concerns about your care with your Participating Provider or another member of your health care team. If you are not satisfied with your Participating Provider, you may request another. Contact Membership Services for assistance. You always have the right to a second opinion from a qualified Participating Provider at the applicable copayment or coinsurance.

If you feel that additional assistance is needed, complaint and grievance procedures are available to help. All complaints and grievances are handled in a confidential manner.

Complaints

If you want to talk to someone because you are dissatisfied with the availability, delivery, or quality of our Participating Provider services, benefits, or administrative matters, you can make an oral complaint. Examples include appointment delays or the manner of communication by staff members.

To make a complaint, you can contact the administrative office in the Participating Facility where you are having the problem or contact Membership Services for assistance. Discuss your complaint fully with the staff and be specific about how you want the matter to be resolved.

If you have a concern involving a denial of future care, refer to the *Claims and Appeals* section. If your concern involves a claim denial for services you already received, refer to the *Grievances* section below.

Grievances

A grievance is a written or oral complaint submitted by or on behalf of a member.

You can file a grievance regarding the availability, delivery, or quality of Participating Provider services, including a complaint regarding an adverse benefit determination, claims payment handling, reimbursement for health care services, or administrative matters. Examples include delays in hearing back from your Participating Provider's office; not receiving an appointment in a timely manner; a disagreement with a bill from Kaiser Permanente; or disagreement with our denial of your claim for services that you received from a Non-Participating Provider or Facility.

To file a written grievance, explain your concerns in writing and be specific about your request. You may include any written comments, documents, records, and other information related to your grievance. Send your written grievance to:

**Kaiser Foundation Health Plan of the Northwest
Member Relations Department
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099
Fax: 503-813-3985**

Written grievances will be acknowledged in writing within seven days of receipt.

If you need assistance filing a grievance, call Membership Services at **1-800-813-2000** or if your grievance is urgent call Member Relations at **503-813-4480**.

We will forward your grievance to the appropriate manager or department for resolution. An independent review will be conducted and we will provide you with a written decision within 30 days except as follows: If you fail to provide information necessary for us to make a determination on a grievance that is an initial claim, we will allow you 50 days from the date on our written notification to submit the information. We will make a decision within 15 days after receiving the information or within 15 days after the end of the 50-day period if we do not receive the information.

If your grievance included a specific request and we deny that request, our decision letter will include detailed information about the basis of the decision, how to appeal the decision, and how to file a complaint with the Oregon Department of Consumer and Business Services (DCBS).

While we encourage you to use our complaint and grievance procedures, you have the right to seek assistance from the Consumer Protection Unit at the Oregon Insurance Division. Contact them by mail, telephone, over the internet, or by email:

Oregon Insurance Division
P.O. Box 14480
Salem, OR 97309-0405
503-947-7984 or 1-888-877-4894

Online: www.cbs.state.or.us/ins/consumer/consumer.html
Email: cp.ins@state.or.us

Wellness Resources Available Through Your Medical Plan

You are the City's most important infrastructure! So, when you enroll in a medical plan (CityNet PPO or Kaiser HMO), you have access to programs that can help you manage your diabetes and quit using tobacco for good.

You can find all of the details below about the programs that are available. Please take advantage of them so you can learn how to be the best, healthiest version of yourself. These resources can help you live longer, and live better.

The Centers for Disease Control and Prevention (CDC) estimates that 40% of cancer and 80% of heart disease, stroke, and type 2 diabetes could be prevented if we exercised more, stopped smoking, and ate healthier.

Tips for Good Physical, Mental and Emotional Health

- Eat nutritious foods in reasonable portions
- Be physically active every day (your job may require this!)
- Get preventive screenings you need at your particular age, and get an annual physical or check-up (all FREE when you use a network doctor)
- Manage your stress
- Get restful sleep
- Carefully manage health conditions you already have
- Quit, if you use tobacco
- Practice safety—like wearing your seatbelt every time you are in a moving vehicle
- Take advantage of the City's confidential diabetes management and tobacco cessation programs if they are appropriate for you

Employee Assistance Program (EAP)

The City of Portland's Employee Assistance Program (EAP) through Cascade Centers is a confidential, short-term counseling, assessment and referral service that can help you deal with all of life's challenges and adventures. EAP is designed to help you deal with personal problems as they come up, in addition to providing information and resources to solve life's everyday challenges, big and small.

You and your dependents can have on-the-spot advice over the phone, or a referral to work with a network clinician for up to ten (10) face-to-face or virtual visits per plan year (July 1 through June 30). PFFA employees and their dependents can have up to thirteen (13) face-to-face or virtual visits per plan year. Reach out to a trained EAP specialist for help with a wide range of personal issues, including, but not limited to, substance abuse, relationship issues, mental and emotional problems and work-related issues. The EAP also provides services such as a Listening Library, tax resolution assistance, free online will preparation, career development services, life coaching and parent coaching.

Getting help is easy, convenient and confidential. Just call **1-800-433-2320**.

Other EAP services include:

- **Legal:** Each covered member is eligible for one initial 30-minute office or telephone consultation per separate legal matter (limit three per year) If you decide to retain the attorney after the initial consultation, you will be provided with a preferred rate reduction of 25% from the attorney's normal hourly rate.
- **Financial:** Each employee is eligible to receive 30 consecutive days of free, unlimited telephonic financial coaching.
- **Identity Theft Services:** This service provides members with up to a 60-minute free consultation with a highly trained Fraud Resolution Specialist™ (FRS)
- **Cascade Personal Advantage** (Interactive Website): Access to health assessments, financial calculators, informational videos/articles and monthly interactive electronic brochures.
- **Home Ownership Program:** Assistance and discounts on services associated with selling, buying and refinancing a home.
- **Life Balance:** Discounts on movie tickets, vacation discounts, Blazer tickets and so much more! Visit lifebalanceprogram.com and enter code CAS2948.
- **WholeLife Directions:** This personalized emotional wellness tool is available whenever you need it. Take the fast and easy quiz to get immediate feedback and recommendations for nine health domains including: depression, anxiety, PTSD, work engagement, relationships, substance abuse, stress, anger, and sleep. Immediate support is available when needed. Visit the website [here](#).

Substance Abuse

Substance abuse refers to the harmful or hazardous use of psychoactive (mood altering) substances, including alcohol, prescription and illicit drugs.

Many people don't understand why or how others become addicted to drugs. They may mistakenly think that those who use drugs lack moral principles or willpower and that they could stop their drug use simply by choosing to. Drug addiction is actually a complex disease and quitting usually takes more than good intentions or a strong will. Drugs change the brain in ways that makes quitting hard, even for those who want to. Fortunately, researchers know more than ever about how drugs affect the brain and have found

treatments that can help people recover from drug addiction and lead productive lives. To learn more about treatment options, visit portlandoregon.gov/bhr/article/750305.

Fertility and Family Planning Benefit

The City of Portland is proud to be partnering with Carrot starting July 1, 2021. Your Carrot benefit gives you access to fertility and family-forming education, virtual chats with physicians and other specialists, an expert-authored library of resources, exclusive discounts, and holistic pregnancy support through Carrot Pregnancy.

Carrot Supports all Paths to Parenthood

Fertility and family-forming benefits designed for your unique parenthood journey:

- Carrot gives you access to education and expert chats on topics including fertility education and assessments, fertility preservation (egg, sperm, and embryo freezing), in vitro fertilization (IVF), third-party reproduction including gestational carrier services and adoption.
- Lower negotiated rates for treatments at top fertility clinics — more than \$2,000 USD savings per treatment.
- Guidance and support from the Carrot Care Team, including education, coaching, and identification of top provider options in your area.
- Mental health and emotional support including, unlimited access to family therapists, relationship coaches, and grief counselors.
- Unlimited virtual visits with reproductive endocrinologists, urologists, adoption experts, and more — a benefit worth up to \$500 USD on its own.
- A dedicated clinician available anytime, day or night.
- Virtual appointments with a fertility nurse to help with your medications, treatments, and injection administration.
- Significant savings on fertility medications.
- Easy prescription, vitamin, and supplement ordering.
- Free overnight delivery and same-day delivery on most medications

Ready to get Started?

Activate your carrot benefit starting July 1, 2021 and explore all the resources Carrot has to offer. To activate and explore go to carrotfertility.com If you have any questions you can send an email to Carrot Customer Service support@get-carrot.com.

Wellness Education Programs

Introduction

The City of Portland cares about you and your health. To support you, your City Benefits provide a variety of programs, resources, and services to help make the healthy choice the easy choice.

You can find all the details below about the programs that are available. Please take advantage of them and become the best, healthiest version of yourself possible! These resources can help you live a longer and healthier life and save you money on healthcare costs down the road.

CityStrong

CityStrong is our internal, cross-bureau wellness program offered through the Occupational Health and Well-being team. This is an all-inclusive wellness program customized for each worksite that provides information, engagement opportunities, and resources to help you reach your physical and mental health goals. These programs & activities are available for all employees to attend. CityStrong activities (listed below) will be held at various worksites and times and are also made available virtually via webinar or webcast.

- Fitness Classes
- Mindfulness Meditation
- Wellness Workshops
- Wellness and Movement Challenges
- InBody – Body Composition Testing
- Health Coaching

CityStrong is open to **all city employees**, regardless of City benefits coverage.

For more information, please email CityStrong@portlandoregon.gov or visit our webpage at www.portlandoregon.gov/citystrong.

Moda Health - Wellness Services

Healthy Foundations

Is a free health coaching and medical coordination program that provides one-on-one guidance to help individuals with chronic and ongoing health conditions achieve and sustain personal health and wellness goals. Health and wellness experts assist with making behavioral changes in nutrition, movement, stress management, emotional health, and chronic disease management. This program is designed to support your health and well-being and prevent health issues down the road.

If you're a CityCore participant living with chronic health conditions, give us a call to learn more. The program is tailored to your individual health goals and offers guidance, education, and incentives to help you be your best self.

To learn more, call 855-232-6899 or email healthyfoundations@modahealth.com.

Nutritional Counseling and Hospital-Based Weight Reduction Programs

Note: This feature is available for CityCore Medical Plan participants.

Because obesity is a factor in a wide range of health issues, including heart disease, diabetes and musculoskeletal problems, the CityCore and CityHD plan provides an annual benefit for nutritional counseling (with an in-network provider of your choice) and/or hospital-based weight management programs. **This benefit includes nutritional counseling and hospital-based weight management program.** Your cost is 20% coinsurance, not subject to the deductible for CityCore.

Additional Wellness Resources:

- Behavioral health services
- Nutritional counseling
- Diabetes education and pharmaceutical incentive program
- Tobacco Cessation programs
- Moda participant discounts to Weight Watchers (WW) online

For more information, please call at 503.948.5561 or 1.800.592.8283 or visit www.modahealth.com/portland.

Kaiser Permanente – Wellness Services

Health Engagement and Wellness Services

Health Engagement & Wellness Services is your one-stop shop to explore topics and tools as you take a journey towards managing your health. KP has a team of educators, health coaches and specialists that provide you with engaging information, activities, and support to improve your health. With your medical plan, you will have access to the following:

- Online total health assessment to identify health risk early.
- myStrength is a personal program that includes interactive activities, in-the-moment coping tools, inspiration resources, and community support. myStrength helps with depression, anxiety, sleep, stress, substance abuse and chronic pain.
- Telephonic Health Coaching allows one-on-one telephone visits with a health coach to support employees with their health goals. Topics include tobacco cessation, sleep, weight management, stress management, and chronic health conditions.
- The nurse advice line gives you access to medical information 24/7 at no cost to you. Call at 1.800.813.2000 (TTY 711)

For more information regarding these offerings through Kaiser Permanente, call 503.823.2000 or visit at healthengagement.kaiserpermanente.org/about.

Vision Plans

This section describes the vision coverage available to you. Eye exams are an important component to preserving eyesight. Regular exams can detect problems at their earliest stages when they are most treatable. The vision plans available from the City of Portland encourage preventive eye care by offering coverage for comprehensive eye exams and allowances for lenses and frames or contact lenses.

IMPORTANT NOTE FOR RETIREES:

When you become eligible for Medicare you are no longer eligible to participate in vision coverage through the City of Portland.

Note: This rule does not apply if you are Medicare eligible and/or age 65 or older and have NOT yet retired, and continue to be an active employee.

Coverage Options

You are eligible for vision coverage if you are eligible for medical benefits—active employees and retirees as described in the *Who Is Eligible* section, and eligible family members. Vision coverage is included when you enroll in a medical plan; your vision coverage depends on the medical plan you choose:

- *If you elect the CityNet or CityHDP medical plan*, vision coverage is provided through Vision Service Plan (VSP). You can choose Basic or Buy-Up coverage.
- *If you elect the Kaiser medical plan*, vision coverage is provided through Kaiser Vision

The coverage tier (employee only, employee + 1, family) you choose for medical coverage will apply to vision coverage.

Vision Plan Comparison

The following chart outlines the benefits available under each of the vision plan options. Keep in mind, if you enroll in the CityNet and CityHDP medical plan, you have the option to choose “Buy-Up” vision coverage for an additional premium share.

Vision Plan Feature	VSP Basic Plan		VSP Buy-Up Plan		Kaiser Vision Plan
	VSP Provider	Non-VSP Provider	VSP Provider	Non-VSP Provider	
General Information					
Am I required to use a network provider?	Yes – VSP Participants use the VSP Signature Plan	No	Yes – VSP Participants use the VSP Signature Plan	No	Yes
How do I enroll?	Automatic enrollment with election of CityNet and CityHDP Medical Plan		If you elect the CityNet and CityHDP Medical Plan, you may elect to pay for this higher level of benefit.		Automatic enrollment with election of Kaiser HMO Medical Plan
For the following treatments and services, you pay:					

Vision Plan Feature	VSP Basic Plan		VSP Buy-Up Plan		Kaiser Vision Plan
	VSP Provider	Non-VSP Provider	VSP Provider	Non-VSP Provider	
Exams	<p>\$15 copay for exam and materials</p> <p>Adult: 1 exam every 24 months</p> <p>Children: 1 exam every 12 months</p>	<p>\$15 copay; plan pays up to \$50 less any applicable copayment, you pay any additional costs.</p> <p><i>Claims must be filed within 365 days from date of service.</i></p>	<p>\$15 copay for exam and materials</p> <p>Adults and children—1 exam every 12 months</p>	<p>\$15 copay; Plan pays up to \$50, less any applicable copayment, you pay any additional costs.</p> <p><i>Claims must be filed within 365 days from date of service.</i></p>	<p>\$10 office visit copay. No visit limit.</p> <p>\$30 contact lens fitting & evaluation fee plus co-pay</p>
Eyeglass frames	<p>Plan covers up to \$150 toward the cost of frames (less any applicable copayment).</p> <p>Plan covers up to \$170 toward the cost of featured frames (less any applicable copayment).</p> <p>20% discount on costs in excess of the allowance.</p> <p>Plan pays up to \$80 per Costco equivalent frame, you pay any additional costs.</p> <p><i>Limited to one pair every 24 months</i></p>	<p>Plan pays up to \$70 per out of network equivalent, you pay any additional costs.</p> <p>Client charge is determined by the applicable wholesale/retail equivalent conversion factor</p> <p><i>Claims must be filed within 365 days from date of service.</i></p>	<p>Plan covers up to \$200 toward the cost of frames (less any applicable copayment).</p> <p>Plan covers up to \$190 toward the cost of featured frames (less any applicable copayment).</p> <p>20% discount on costs in excess of the allowance.</p> <p>Plan pays up to \$110 per Costco equivalent frame, you pay any additional costs.</p> <p><i>Limited to one pair every 12 months</i></p>	<p>Plan pays up to \$95 per Costco equivalent frame, you pay any additional costs.</p> <p>Client charge is determined by the applicable wholesale/retail equivalent conversion factor</p> <p><i>Claims must be filed within 365 days from date of service.</i></p>	<p>Note: Coverage details included with the “Eyeglass lenses” row below.</p>

<p>Eyeglass lenses</p> <p>Note: Tinted or coated lenses, UV protected lenses, blended lenses, color contacts, etc. are not covered.</p>	<p>You pay \$15 combined copay for exam and glasses</p> <p>Plan pays 100% of prescribed lenses (1 pair every 24 months)</p> <ul style="list-style-type: none"> ▪ Single lenses (pair) ▪ Lined bifocals (pair) ▪ Lined trifocals (pair) <p><i>Plan provides:</i></p> <ul style="list-style-type: none"> ▪ \$0 - \$110 copay for progressive lenses ▪ \$7 - \$45 copay for anti-reflective lenses <p>Note: Tinted or coated lenses, UV protected lenses, blended lenses, color contacts, etc. are not covered.</p> <p><i>Limited to one pair every 24 months</i></p>	<p>You pay all costs in excess of Plan allowances.</p> <p>Plan pays up to:</p> <ul style="list-style-type: none"> ▪ Single lenses (pair): \$50 ▪ Lined Bifocals (pair): \$75 ▪ Lined Trifocals (pair): \$100 <p><i>Plan provides:</i></p> <ul style="list-style-type: none"> ▪ \$75 copay for progressive lenses <p><i>Claims must be filed within 365 days from date of service.</i></p>	<p>You pay \$15 combined copay for exam and glasses</p> <p>Plan pays 100% of prescribed lenses (1 pair every 12 months)</p> <ul style="list-style-type: none"> ▪ Single lenses (pair) ▪ Lined bifocals (pair) ▪ Lined trifocals (pair) <p><i>Plan provides:</i></p> <ul style="list-style-type: none"> ▪ \$0 - copay for standard progressive lenses ▪ \$30 - Premium and custom progressive lenses ▪ \$30 copay for anti-reflective lenses <p>Note: Tinted or coated lenses, UV protected lenses, blended lenses, color contacts, etc. are not covered.</p> <p><i>Limited to one pair every 12 months</i></p>	<p>You pay all costs in excess of Plan allowances.</p> <p>Plan pays up to:</p> <ul style="list-style-type: none"> ▪ Single lenses (pair): \$50 ▪ Lined Bifocals (pair): \$75 ▪ Lined Trifocals (pair): \$100 <p><i>Plan provides:</i></p> <ul style="list-style-type: none"> ▪ \$75 copay for progressive lenses <p><i>Claims must be filed within 365 days from date of service.</i></p>	<p>Adults age 19 and older: Plan provides \$150 allowance toward the cost of covered, standard lenses and frames (or contact lenses) in a 2 plan year period; you pay any additional costs.</p> <p>Children under age 19: no dollar maximum but limited to one pair of covered, standard lenses and frames (or contact lenses) every 12 months.</p>
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Vision Plan Feature	VSP Basic Plan		VSP Buy-Up Plan		Kaiser Vision Plan
	VSP Provider	Non-VSP Provider	VSP Provider	Non-VSP Provider	
Elective contacts*	Exam fees and materials covered in full; subject to copay of up to \$60 Plan pays up to \$130 every 24 months in lieu of glasses (copay does not apply)	Plan pays up to \$105; you pay any additional costs <i>Claims must be filed within 365 days from date of service.</i>	Exam fees and materials covered in full; subject to copay of up to \$60 Plan pays up to \$200 every 12 months in lieu of glasses (copay does not apply)	Plan pays up to \$105; you pay any additional costs <i>Claims must be filed within 365 days from date of service.</i>	
Medically necessary contacts <i>Limited to one pair every 24 months</i>	Plan pays 100% after applicable copays	Plan pays up to \$210 after applicable copay; you pay any additional costs. <i>Claims must be filed within 365 days from date of service.</i>	Plan pays 100% after applicable copay	Plan pays up to \$210; you pay any additional costs. <i>Claims must be filed within 365 days from date of service.</i>	\$0 (Plan pays 100%)

***Contact Lens Benefit:** Contact lens benefit design will separate the contact lens exam (fitting and evaluation) from the material coverage. Members choosing contact lenses will receive a covered-in-full contact lens exam after not-to exceed \$60 copay. This copay applies to both standard *and* premium fit contact lens wearers. Members will also receive a 15% discount on all contact lens exam services.

VSP SunCare Benefit

The VSP SunCare benefit allows both VSP Core and VSP Buy-Up participants to use their frame allowance towards non-prescription sunglasses.

Did You Know?

You can use pre-tax dollars from your Healthcare FSA to pay your portion of vision expenses. You can use money from your Healthcare FSA to cover the exam copay, plus any out-of-pocket costs you incur when purchasing eyeglasses or contacts. Using pre-tax dollars saves you about 30% (actual savings depend on your tax bracket). For a list of eligible expenses, go to www.irs.gov (search Publication 503) or www.wageworks.com.

Your Vision Plan Benefits – More Details

If you have questions about the information presented, please contact:

- City of Portland Benefit Information Line at **503-823-6031** or benefits@portlandoregon.gov
- VSP: **1-800-877-7195**, or www.vsp.com
- Kaiser: **503-813-2000** or www.kp.org

Vision Service Plan (VSP) for CityNet PPO Medical Plan Participants

You must see a VSP Signature plan provider for the in-network level of benefits. To find a VSP provider, go to www.vsp.com. When asked to select a network, choose the VSP signature network.

Did You Know?

You have access to a **Diabetic Eyecare Plus** program. This program provides additional eye care coverage for participants in the plan who have type 1 or type 2 diabetes. This includes services related to diabetic eye disease, glaucoma and age-related macular degeneration (AMD). Retinal screening is covered for eligible members with diabetes. Limitations and coordination with medical coverage may apply. Ask your VSP doctor for details.

Vision Buy-Up Option

CityNet and CityHDP medical plan participants with vision coverage through VSP may select the Buy-Up Option for richer benefits. There is an additional premium you are responsible to pay for your participation in the VSP Buy-up Option and the cost is based on your election tier. The tier (employee only, employee + 1, family) you select for the VSP Buy-Up option must match your medical plan election. The buy-up option allows for exams, lenses and frames on an annual basis as well as some other enhancements. Please see the chart listed above for additional details.

Vision Care Providers

The VSP plan gives you a choice when it comes to getting eye care.

In-network

Go to a Signature Plan in-network provider—any licensed eye care professional that VSP has designated as part of its network—and receive a higher level of benefit. To do this, follow these steps:

1. Choose an in-network provider. VSP has designated over 25,000 in-network eye care professionals nationwide, including ophthalmologists and optometrists. You can find an in-network provider online at www.vsp.com or by calling **1-800-877-7195**.
2. When you schedule your appointment, identify yourself as a VSP member. The provider will contact VSP to verify your eligibility for benefits and obtain authorization for services and supplies.
3. Only your copayment is required when you receive an eye exam from an in-network doctor. There are no claim forms to complete. VSP will pay your in-network provider directly for all covered eye care services and eyewear provided. You will pay separately for any additional services not covered under the plan.

Out-of-Network

Go to an out-of-network provider—a licensed eye care professional VSP has not designated as part of its network—and receive a lower level of benefit. The plan pays up to \$50 for an out-of-network provider when you get an eye exam. You will have to pay for any eye care services and supplies beyond \$50 at the time you receive the care, and you'll be responsible for filing your own claim form for reimbursement from VSP within one year of receiving the service.

VSP Affiliated Providers

VSP also gives you the option of using Costco Optical, VisionWorks, and other affiliate providers. These providers are not in-network, but have an agreement with VSP to provide services to VSP members at discounted rates.

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

The following chart provides the VSP affiliate provider plan benefits for the Basic and the Buy-Up Plans:

Benefits Through a VSP Affiliate Provider		
	Basic Plan	Buy-Up Plan
Providers	Costco Optical locations, VisionWorks Eye Care Centers, additional affiliate locations. To verify eye doctor participation, go to www.vsp.com .	
Exams	Thorough eye exam covered in full, less any applicable in-network copay. Ask your Costco® optometrist if they are a participating VSP retail provider.	
Lens Options	Subject to Costco pricing at Costco; 20% off at other affiliate locations	
Frames	Frame allowance is \$80 at Costco and up to \$150 at other affiliate locations less applicable copay	Frame allowance is \$110 at Costco and up to \$170 at other affiliate locations less applicable copay

What Is Not Covered: VSP Exclusions and Limitations of Benefits

Some brands of spectacle frames may be unavailable for purchase as Plan Benefits, or may be subject to additional limitations. Covered Persons may obtain details regarding frame brand availability from their VSP Network Doctor or by calling VSP's Customer Care Division at (800) 877-7195.

Patient Options

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

- Optional cosmetic processes
- Anti-reflective coating
- Color coating

- Mirror coating
- Scratch coating
- Blended lenses
- Cosmetic lenses
- Laminated lenses
- Oversize lenses
- Polycarbonate lenses
- Photochromic lenses, tinted lenses except Pink #1 and Pink #2
- Progressive multifocal lenses
- UV (ultraviolet) protected lenses
- Certain limitations on low vision care

Not Covered

There are no benefits for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing
- Plano lenses (less than a $\pm .50$ diopter power)
- Two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this Policy that are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes
- Corrective vision treatment of an Experimental Nature
- Costs for services and/or materials above Plan Benefit allowances
- Services and/or materials not indicated on this Schedule as covered Plan Benefits

Filing a Claim for VSP Vision Plan Benefits

Vision claims covered by VSP must be submitted within one year of the date the charges were incurred; send to:

Vision Service Plan (VSP)
P.O. Box 385018, Birmingham, AL 35238-5018

Kaiser Permanente Eye Care Services for Kaiser HMO Medical Plan Participants

If you enroll in the Kaiser HMO medical plan, you automatically receive coverage in the Kaiser Permanente vision plan. For more details, please contact Kaiser directly at **503-813-2000**, or go to www.kp.org. Kaiser information added to this handbook and all other City publications is added for convenience. Any misstatement of benefits within these documents does not allow for coverage if Kaiser Permanente documents represent different coverage levels. Please contact Kaiser NW directly at 503-813-2000 for any confirmation of coverage and/or benefit limitations/exclusions

What Is Covered

Eye exams are covered to determine the need for vision correction. The plan pays 100% after your \$10 copay.

Eyeglasses and Contact Lenses

Kaiser Permanente provides lenses, frames, industrial safety glasses and/or contact lenses as prescribed by a Plan Physician or Optometrist who is part of the Kaiser network. The plan will pay up to \$150 every 24 months. **Only one purchase will be covered—any part of the allowance (\$150) that is not exhausted at the initial point of sale will be lost.**

There is an exception: If your prescription changes by .50 diopters or greater in either lens (as determined by a Physician or Optometrist in the Kaiser network), within 12 months of the initial exam, lenses with the new prescription will be covered up to:

- \$60 for single vision and cosmetic contact lenses, or
- \$90 for multifocal lenses

Replacement coverage is for the original product type (contacts or eyeglasses) only. Includes lenses, industrial safety lenses, or contact lens(es).

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

- Refractive error of 12 diopters or greater in any meridian
- Keratoconus which corrects to 20/30 or worse with best eyeglasses
- Anisometropia where the difference in refractive status between the two eyes is greater than five diopters and binocular vision can be significantly improved
- When vision with contact lens(es) as compared with glasses is improved by greater than two lines (such as 20/70 to 20/40)
- Aniridia

Eyeglasses and Contact Lens(es) After Cataract Surgery

Coverage is as follows:

- **Cataract Surgery Involving an Intra-Ocular Lens Implant.** After each cataract surgery involving an intra-ocular lens implant, the member receives one pair of regular eyeglass lenses and frames from a specified selection of frames or contact lens(es) without charge.
- **Cataract Surgery Not Involving an Intra-Ocular Lens Implant.** After each cataract surgery *not* involving an intra-ocular lens implant, the member receives one pair of regular lenses and frames from a specified selection and/or contact lens(es). Both eyeglass lenses and frames from a specified selection of frames and contact lens(es) are covered without charge if, in the judgment of a network Physician or Optometrist, the member must wear eyeglass lenses and contact lens(es) at the same time to provide a significant improvement in visual acuity or binocular vision not obtainable with regular lenses or contact lens(es) alone.
- When the benefits following cataract surgery have been exhausted, the member may be entitled to receive benefits in accordance with the Optical Services benefits as described in the Kaiser packet (plan pays up to \$150 every 24 months).

What Is Not Covered: Kaiser Exclusions

The following are excluded from coverage:

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

Did You Know?

You can use pre-tax dollars from your Healthcare FSA to pay your portion of vision expenses. You can use money from your Healthcare FSA to cover the exam copay, plus any out-of-pocket costs you incur when purchasing eyeglasses or contacts. Using pre-tax dollars saves you about 30% (actual savings depend on your tax bracket). For a list of eligible expenses search Publication 503 on www.irs.gov or www.wageworks.com.

Dental Plans

This section describes the dental coverage available to you as an eligible employee or retiree, as described in the *Who Is Eligible?* section. These important benefits help you meet the cost of regular and unanticipated dental services that you and your family need, and the preventive care features help you maintain healthy teeth and gums.

IMPORTANT NOTE FOR RETIREES:

You may elect to continue your dental coverage until you reach age 65 and/or become eligible for Medicare, whichever comes first. Dental coverage through the City of Portland is not available to retirees who have reached age 65 and/or become eligible for Medicare.

If you drop coverage for any reason before you are eligible for Medicare, you will be able to re-elect coverage at a later date *only if* you can provide proof that you have been covered continuously under another group-sponsored plan.

Coverage Options

You have four dental plan options:

- Delta Dental Plan of Oregon
- Delta Dental Buy-Up Plan
- Kaiser NW Dental Plan or
- Opt out of dental

The plan you choose for yourself will also apply to any eligible dependents you enroll.

To decide which plan is better for you, think about these things:

If you...	Take a closer look at...	
	Delta Dental Plan of Oregon or Delta Dental Buy-Up Plans	Kaiser Dental Plan
Prefer to have a broad network of eligible providers	✓	
Need major care?		✓
Want to know exactly what your costs will be when you incur a service		✓
Use a dentist who is not in the network	✓	

Keep in mind: you pay your premium share whether or not you receive any dental services. Also, consider:

- How many people in your family will take advantage of dental benefits?
- Do you expect to have major dental work done this plan year, that may exceed the maximum amount the Delta Dental Premier Plan will cover?
- Remember that you can use money you contribute to the Healthcare FSA to pay for eligible out-of-pocket dental expenses you incur.

Plan Highlights

Both plans help cover the cost of preventive services (like cleanings), and major services (like crowns) for you and your eligible, covered dependents. All three plans cover orthodontia. The main differences between the plans include:

- How much you pay for certain services
- The network of dentists you may use
- The amount you pay for coverage
- Whether the plan limits the amount of money it will contribute to your care each year. See the *Dental Plan Comparison* chart for details. Information about what specific services and procedures are covered under each plan is provided in the following sections.

Dental Plan Comparison

Please note: the plan year maximum benefit does not apply for children under age 19 (excludes orthodontia).

Dental Plan Feature	Delta Dental Plan of Oregon	Delta Dental Buy-Up Plan	Kaiser Dental Plan
	General Information		
Am I required to use a network dentist?	No	No	Yes
Plan Year Deductible	\$25/member; \$75/family of three or more	\$25/member; \$75/family of three or more	None
Plan Year Maximum Benefit	\$2,000/person age 19 and older	\$2,500/person age 19 and older	None
Maximum Plan Allowance (MPA)	Plan pays benefits based on MPA; you pay coinsurance amount plus any amount over the MPA for providers who are not in the network	Plan pays benefits based on MPA; you pay coinsurance amount plus any amount over the MPA for providers who are not in the network	Not applicable
Dental Plan Feature	Delta Core Dental Plan	Delta Buy-up Dental Plan	Kaiser Dental Plan
	For the following treatments and services, you pay:		
Diagnostic and Preventive Care	Class I* – \$0 (Plan pays 100%, no deductible for eligible services) Cleanings covered once every 6 months.	Class I* – \$0 (Plan pays 100%, no deductible for eligible services) Cleanings covered once every 4 months. Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional per year.	\$10 copay/visit, then Plan pays 100%**
Routine Services	Class II* – You pay 20%, after you meet deductible	Class II* – You pay 20%, after you meet deductible	

Dental Plan Feature	Delta Dental Plan of Oregon	Delta Dental Buy-Up Plan	Kaiser Dental Plan
Major Services Note: Includes inlays, onlays, crowns, and permanent prosthetics. Kaiser plan includes periodontics and endodontics.	Class III* – You pay 50%, after you meet deductible Occlusal guards (night guard) covered once every two years at 100% with no deductible up to a \$150.00 maximum benefit. Over-the-counter night guards are excluded	Class III* – You pay 20%, after you meet deductible Occlusal guards (night guard) covered once every two years at 100% with no deductible up to a \$150.00 maximum benefit. Over-the-counter night guards are excluded. Full mouth debridement is limited to once in a 2-year period for adults absent other cleanings within 24 months	\$10 copay/visit, plus 20% of applicable charges. 50% coverage for implants subject to a \$2,000 plan year benefit maximum
	Note: Occlusal guard repairs and relines are not covered within initial 6 months of placement		
Orthodontics (children and adults)	You pay 50%; Plan pays up to \$3,000 lifetime maximum	You pay 50%; Plan pays up to \$3,000 lifetime maximum	You pay 50%; Plan covers 50% of eligible charges up to \$5,000 lifetime maximum

*See below for details on what services are included in each Class.

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

Your Dental Plan Benefits – More Details

The dental plans have specific rules about what services are covered and how the plan pays benefits. The plans are described in detail in the following sections, starting with the Delta Dental Plan of Oregon and the Delta Buy-Up Plan. If you have questions about the information presented, please contact:

- City of Portland Benefit Information Line at **503-823-6031** or benefits@portlandoregon.gov
- Delta Dental Customer Service: **503-265-5680** or **1-877-277-7280**, or www.modahealth.com/members
- Kaiser Customer Service: **503-813-2000** or www.kp.org

Delta Dental Plan of Oregon and Delta Dental Buy-Up Plan

The Delta plans cover services when they are performed by a dental provider (licensed dentist, certified denturist or registered hygienist) and the plan considers the services necessary and customary. Limitations may apply. If you have a question about whether a service or treatment will be covered, please contact Moda before treatment is received.

Annual Deductible

Before the Delta Dental Plan of Oregon or the Delta Dental Buy-Up Plans pay their share of some covered expenses, you pay your annual deductible:

- \$25/person, maximum of \$75/family

The annual deductible is the dollar value of covered expenses you pay in a year before the the Delta Dental Plan of Oregon or the Delta Dental Buy-Up Plans begin paying benefits for that care. In other words, it is the amount you must spend out of your own pocket before the Plan will begin sharing costs with you. A separate annual deductible applies to you and each covered family member (although, the deductible is capped at \$75 for the family).

The Dental Plan's annual deductible applies to Class II and Class III covered expenses (a list follows). The annual deductible does not apply to Diagnostic and Preventive Services (Class I) or orthodontia. A new deductible applies each plan year—eligible expenses do not carry over from one plan year to the next.

Maximum Annual Benefit

The plan limits the amount of benefits that will be paid for any covered individual during a plan year (July 1 – June 30). The maximum payment limit of \$2,000 for the standard Delta Dental Plan and the maximum payment limit of \$2,500 for the Buy-up plan is for all Class I, II and III services. Once the plan has paid the maximum benefit, you are responsible for the full cost of any additional dental expenses for the rest of the plan year. The plan also has a maximum lifetime benefit for Orthodontia services of \$3,000 per individual; this is separate from the maximum annual benefit.

Delta Dental Plan of Oregon and Delta Dental Buy-Up Plans: What Is Covered

The plan provides coverage for the following services and supplies whether you see an in-network dentist or a dentist outside the network. Please note limitations on coverage based on frequency of care, materials selected and lower cost alternatives available.

Follow these tips to get the most value from the Delta Dental Plans...

- **Use participating, network providers.** They have agreed to charge individuals enrolled in the Delta plan lower, pre-negotiated rates for services. If you go to a provider who is not part of the network, you may be responsible for paying more out of your pocket. The plan may reimburse out-of-network expenses at a lower level, and your dentist may charge more than the “allowed amount.” You will be responsible for paying the difference.
- **Before you receive care, ask if there is a less expensive alternative.** The Delta plans will pay for the least costly treatment that is considered functionally adequate. If a more expensive treatment is performed when a less costly treatment would be considered functionally adequate, you will be responsible for paying the difference. If you have questions about what will be covered, please call Moda before treatment is received: **503-265-5680** or **1-877-277-7280**.

Class I: Plan Pays 100%, You Pay \$0

Class I includes diagnostic exams and x-rays, as well as preventive dental care. These procedures help your dentist evaluate your dental health and prevent the deterioration of teeth and gums. The plan covers:

Diagnostic services

- Routine or comprehensive oral exams or consultations, once every six months*
- X-rays: complete series or panoramic, periapical, occlusal, bitewing

- Complete series of x-rays or a panoramic x-ray, once every five years*
- Supplementary bitewing x-rays, once every 12 months*
- Intra-oral x-rays to help your dentist determine required treatment
- ViziLite Plus TBlue is covered once in any 6-month period

Preventive services

- Prophylaxis (cleanings), once every six months for the Delta Dental Plan of Oregon (every four months for the Delta Dental Buy-Up Plan) Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional per year).
- Periodontal maintenance, once every six months*
- Topical application of fluoride for covered children age 18 and under, once every six months*
 - May be covered for covered members age 19 and older if there is a recent history of periodontal surgery, or high risk of decay due to medical disease, chemotherapy or similar medical treatment; six-month frequency limit does apply
- Sealants for unrestored, occlusal surfaces (chewing surfaces) of permanent bicuspid and molars, limited to one sealant per tooth every five years*
- Space maintainers for covered members covered once per space
 - Space maintainers for primary anterior teeth or missing permanent teeth are not covered

Please note that separate charges for the review of a proposed treatment plan, or charges for diagnostic aids such as study models and certain lab tests are not covered.

* Time periods are calculated from the previous date of service.

Did You Know?

You can have an “extra” cleaning if you have diabetes, or if you’re in your third trimester of pregnancy. To take advantage of the additional cleaning benefit, you must enroll in the Oral Health, Total Health program. See the *Special Program: Oral Health, Total Health* section for more details.

Class II: Plan Pays 80%, You Pay 20% After You Meet the Deductible

Class II includes restorative services, oral surgery, endodontic services (for diseased or damaged nerves) and periodontic services (for gums), as follows. The plan covers:

Restorative services

- Amalgam (silver) fillings to treat decay on back teeth
- Composite (tooth-colored) fillings to treat decay on back teeth
- Composite (tooth-colored) fillings to treat decay on front teeth
- Inlays are considered optional, and benefits will be limited to the amount the plan would pay for a composite (filling). You will be responsible for the difference in cost.
- Stainless steel crowns with a frequency of 24 months by the same dentist.

- Crown buildups (included in crown restoration cost), if necessary for tooth retention. See Class III for more information regarding crowns.
- Pulp capping due to exposure of the pulp.

Note: General anesthesia and/or IV sedation is not covered when used in non-surgical situations.

Oral surgery

- Extractions (including surgical extractions)
 - Separate charges for alveoloplasty (shaping of the bone)—done in conjunction with surgical removal of teeth—are not covered
- Minor surgical procedures
 - Surgery on larger or malignant (cancerous) lesions is not considered “minor”
- General anesthesia or IV sedation, only when administered by a dentist in conjunction with a covered surgical procedure in a dental office
- Brush biopsy, once every six months
 - Collecting the sample is covered; associated lab services and fees are not covered

Endodontic procedures

- Pulpal therapy for teeth with diseased or damaged nerves
- Root canal filling
 - The cost for retreatment of the same tooth by the same dentist within 24 months of a root canal will not be paid by the plan; retreatment in this situation is included in the charge for the original root canal

Periodontic procedures (treatment of diseases of the gums and supporting structure of teeth and/or implants)

- Periodontal scaling and root planning, once per quadrant in any six-month period
- Full mouth debridement, once every three years; covered only if there has been no cleaning within 24 months (Full mouth debridement is limited to once in a 2-year period for adults absent other cleanings within 24 months under the buy-up plan).
- Separate charges for post-operative care done within three months following periodontal surgery are not covered

Note: Periodontal maintenance is considered a Class I procedure and is covered 100%.

Class III: Delta Dental Plan of Oregon Pays 50% - You pay 50% after you meet the deductible, Delta Dental Buy-UP Plan Pays 80% - You pay 20% after you meet the deductible

Class III includes major restorative services, such as crowns, onlays or veneers that are necessary to restore normal tooth function. Class III services also include athletic mouthguards and prosthodontics, including bridges, implants and dentures. The plan covers:

Restorative services

- Cast restorations (crowns, onlays, lab veneers, pontics), once every seven years on any tooth
 - Crowns are covered only when the tooth cannot be restored by a routine filling

- Porcelain restorations are considered cosmetic when placed on the upper second or third molars, or the lower first, second or third molars. The plan will cover gold restorations on these teeth; if you choose porcelain, you will be responsible for paying the difference in cost.
- If a tooth can be restored with a material such as amalgam (silver), but you or your dentist chooses to use another restoration (such as tooth-colored porcelain), benefits will be limited to the amount the plan would pay for the lower cost material. You will be responsible for the difference in cost.

Prosthodontic devices and procedures

Note: Porcelain restorations are considered cosmetic when placed on the upper second or third molars, or the lower first, second or third molars. The plan will cover corresponding metallic prosthetics on these teeth; if you choose porcelain, you will be responsible for paying the difference in cost.

▪ Implants

- Surgical placement and removal of implants, covered once per lifetime per tooth space
- Final crown and implant abutment over a single implant, covered once per tooth/tooth space over the lifetime of the implant. Implant maintenance is limited to once every 3 years, except when dentally necessary. As an alternate treatment:
 - When the implant is placed to support a prosthetic device, you can receive a benefit per arch of a denture (full or partial) for the final implant-supported denture; limited to once every seven years
 - Final implant-supported bridge abutment and implant abutment, or pontic (covered once per tooth/tooth space every seven years)

Note: Implant-supported bridges are not covered if one (or more) of the abutments is supported by a natural tooth. The benefits listed above are provided as long as the tooth, implant or tooth space has not received a cast restoration or prosthodontic benefit within the previous seven years.

▪ Bridges

- Covered once in a seven-year period as long as the tooth, tooth site or teeth involved have not received a cast restoration benefit in the past seven years
- Fixed bridges are not covered for children under age 16

▪ Dentures: partial and complete, and relines, with the following limitations:

- Covered once in a seven-year period as long as the tooth, tooth site or teeth involved have not received a cast restoration benefit in the past seven years
- Tissue conditioning, twice per denture every three years (36-month period)
- **Full, immediate and overdentures:**
 - Benefits will be limited to the cost for a standard full denture; if personalized or specialized techniques are used, you will be responsible for the difference in cost
 - Temporary complete dentures (interim or provisional) are not covered

- **Partial dentures:**
 - Temporary partial dentures are covered only when placed within two months of the extraction of an anterior tooth, or when used for missing anterior permanent teeth of covered children age 16 or younger
 - Removable cast partial dentures are not covered for children under age 16
 - Benefits will be limited to the cost for a standard cast partial denture; if a specialized or precision device is used, you will be responsible for the difference in cost
 - Cast restorations for partial denture abutment teeth are only covered if the tooth requires a cast restoration due to decay or breakage
- **Adjustments, repairs and relines:**
 - Separate charges for adjustments, repairs or relines done within six months following initial placement are not covered
 - Subsequent relines are covered once per denture per year (12-month period)
 - Subsequent adjustments are covered twice per denture per year (12-month period)
- Repair of an existing prosthodontic device

Athletic mouth guards

- Covered once per year for children ages 15 and under
- Covered once every two years for individuals ages 16 and older
- Over-the-counter mouth guards are excluded.

Class III: Core Plan Pays 50% You Pay 50% After You Meet the Deductible, Buy-up Plan Pays 80%, You Pay 20% After You Meet the Deductible

Class III includes major restorative services, such as crowns, onlays or veneers that are necessary to restore normal tooth function. Class III services also include athletic mouth guards and prosthodontics, including bridges, implants and dentures. The plan covers:

Restorative services

- Cast restorations (crowns, onlays, lab veneers, pontics), once every five years on any tooth
 - Crowns are covered only when the tooth cannot be restored by a routine filling
 - Porcelain restorations are considered cosmetic when placed on the upper second or third molars, or the lower first, second or third molars. The plan will cover gold restorations on these teeth; if you choose porcelain, you will be responsible for paying the difference in cost.
 - If a tooth can be restored with a material such as amalgam (silver), but you or your dentist chooses to use another restoration (such as tooth-colored porcelain), benefits will be limited to the amount the plan would pay for the lower cost material. You will be responsible for the difference in cost.

Prosthodontic devices and procedures

Note: Porcelain restorations are considered cosmetic when placed on the upper second or third molars, or the lower first, second or third molars. The plan will cover corresponding metallic prosthetics on these teeth; if you choose porcelain, you will be responsible for paying the difference in cost.

- Implants

- Surgical placement and removal of implants, covered once per lifetime per tooth space
- Final crown and implant abutment over a single implant, covered once per tooth/tooth space every five years. Implant maintenance is limited to once every 3 years, except when dentally necessary. As an alternate treatment:
 - When the implant is placed to support a prosthetic device, you can receive a benefit per arch of a denture (full or partial) for the final implant-supported denture; limited to once every five years
 - Final implant-supported bridge abutment and implant abutment, or pontic (covered once per tooth/tooth space every five years)

Note: Implant-supported bridges are not covered if one (or more) of the abutments is supported by a natural tooth. The benefits listed above are provided as long as the tooth, implant or tooth space has not received a cast restoration or prosthodontic benefit within the previous five years.

- Bridges

- Covered once in a five-year period as long as the tooth, tooth site or teeth involved have not received a cast restoration benefit in the past five years
- Fixed bridges are not covered for children under age 16

- Dentures: partial and complete, and relines, with the following limitations:

- Covered once in a five-year period as long as the tooth, tooth site or teeth involved have not received a cast restoration benefit in the past five years
- Tissue conditioning, twice per denture every three years (36-month period)
- **Full, immediate and overdentures:**
 - Benefits will be limited to the cost for a standard full denture; if personalized or specialized techniques are used, you will be responsible for the difference in cost
 - Temporary complete dentures (interim or provisional) are not covered
- **Partial dentures:**
 - Temporary partial dentures are covered only when placed within two months of the extraction of an anterior tooth, or when used for missing anterior permanent teeth of covered children age 16 or younger
 - Removable cast partial dentures are not covered for children under age 16
 - Benefits will be limited to the cost for a standard cast partial denture; if a specialized or precision device is used, you will be responsible for the difference in cost
 - Cast restorations for partial denture abutment teeth are only covered if the tooth requires a cast restoration due to decay or breakage

- **Adjustments, repairs and relines:**

- Separate charges for adjustments, repairs or relines done within six months following initial placement are not covered
- Subsequent relines are covered once per denture per year (12-month period)
- Subsequent adjustments are covered twice per denture per year (12-month period)
- Repair of an existing prosthodontic device

Athletic mouth guards

- Covered once per year for children ages 15 and under
- Covered once every two years for individuals ages 16 and older
- Over-the-counter mouth guards are excluded

Orthodontia: Plan Pays 50%, You Pay 50% (No Deductible)

The Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plans offer orthodontic services to straighten or realign teeth. This benefit is available to adults and children enrolled in the Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plans. You do not need to satisfy your deductible before benefits begin.

When you receive services from a Delta Dental Premier Network provider, Moda will pay 50% of the allowed fee (up to the maximum benefit of \$3,000 per person). If you go to a non-participating orthodontist, Moda will pay either 50% of the orthodontist's fees or 50% of the average fee charged by all participating Delta Dental Premier Network orthodontists, whichever is less (up to the maximum benefit of \$3,000 per person).

The lifetime maximum amount Moda will pay toward any covered individual's orthodontic services is \$3,000. *This is separate from the \$2,000 plan year maximum.*

Notes:

- Repair or replacement of an appliance furnished under the plan is not covered
- If treatment began before an individual was eligible for the Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plans through the City of Portland, the plan will pay benefits based on the remaining balance of the dentist's normal payment pattern. (The plan will not pay for services received before you became eligible.) The orthodontic maximum of \$3,000 will apply to this amount.

Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plan: What Is NOT Covered

The following exclusions apply to individuals enrolled in the Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plans. These services and fees are not covered.

- Procedures, appliances, restorations or any services that are primarily for cosmetic purposes
- Services that are not established as necessary for the treatment or prevention of a dental injury or disease otherwise covered under this Plan
- Services that are inappropriate with regard to standards of good dental practice

- Services with poor prognosis
- Services Otherwise Available, including:
 - Services compensable under Workers' Compensation or employer's liability laws;
 - Services provided by any city, county, state or federal law, *except for Medicaid coverage*;
 - Services provided, without cost to the enrollee, by any municipality, county or other political subdivision or community agency, except to the extent that such payments are insufficient to pay for the applicable covered dental services provided under this Plan; and
- A separate charge for periodontal charting
- Duplication and Interpretation of X-rays – dentist to dentist, dentist to specialist, dentist to patient, and/or dentist to insurer.
- Services or supplies caused by or provided to correct congenital or developmental malformations, including (but not limited to): treatment of cleft palate, maxillary and/or mandibular (upper and lower jaw) malformations, enamel hypoplasia, and fluorosis (discoloration of teeth)
- Services or supplies for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. This includes services only to prevent wear or protect worn or cracked teeth. Such services include increasing vertical dimension, equilibration, periodontal splinting, and night guards (occlusal guard).
- Services for Rebuilding or Maintaining Chewing Services & Stabilizing Teeth
 - Includes services only to prevent wear or protect worn or cracked teeth. Excluded services include increasing vertical dimension, equilibration and periodontal splinting
- Services or supplies for treatment of any disturbance of the temporomandibular joint (TMJ)
- Gnathologic recordings or similar procedures
- Dental services started prior to the date the member became eligible for such services under the Policy
- Hypnosis, premedications, analgesics (e.g., nitrous oxide), local anesthetics or any other prescribed medications
- Hospital or facility charges for services or supplies, or additional fees charged by the dental provider for hospital, extended care facility or home care treatment
- Charges for missed or broken appointments
- Experimental procedures or supplies
- Services provided or supplies furnished after the date coverage ends, except for Class III services which were ordered and fitted while still eligible, and then only if such items are cemented within 31 days after individual eligibility ends. This provision is not applicable if the Group transfers the plan to another carrier.
- General anesthesia and/or IV sedation, except when administered by a dentist in conjunction with covered oral surgery in his or her office or in conjunction with covered services when necessary due to concurrent medical conditions
- Plaque control and oral hygiene or dietary instruction

- Claims submitted more than 12 months after the date of service (except as stated in the *Claims and Appeals* section)
- Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue
- Services performed on the tongue, lip or cheeks
- Precision attachments
- Taxes
- All other services or supplies not specifically included in this Policy as covered dental services
- Services and supplies for treatment of a condition caused by or arising out of a member's voluntary participation in a riot or arising directly from the member's illegal act. This includes any expense caused by, arising out of or related to declared or undeclared war, including civil war, martial law, insurrection, revolution, invasion, bombardment or any use of military force or usurped power by any government, military or other authority.
- Services provided by a member to himself or herself
- Services and supplies related to never events, which are events that should never happen while receiving services in a dental office, including but not limited to removing a non-diseased tooth structure or performing a procedure on the wrong patient or wrong tooth
- Third Party Liability Claims. Services and supplies for treatment of illness or injury for which a third party is or may be responsible to the extent of any recovery received from or on behalf of the third party (see section (*refer to TPL provisions*))

Special Program: Oral Health, Total Health

Did you know that keeping your mouth healthy is critical to keeping the rest of your body healthy? Studies have indicated a relationship between periodontal disease, bacteria in the mouth, and various health problems—including pre-term, low birth weight babies and diabetes. Based on this evidence, the City of Portland provides an additional benefit for covered individuals who are pregnant or have been diagnosed with diabetes.

Oral Health, Total Health Benefits

This program provides additional cleanings (prophylaxis or periodontal maintenance) for Delta Dental members. This benefit is for the cleaning only. Coverage for a routine exam (and other services) is subject to the frequency limitations outlined in the *Delta Dental Plan of Oregon and Delta Dental Buy-Up Plan: What Is Covered* section.

If You Are Pregnant...

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

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

Talk to your dentist about scheduling a routine cleaning or periodontal maintenance during the third trimester of pregnancy. **Covered individuals who are pregnant are eligible for a cleaning in the third trimester of pregnancy regardless of normal plan frequency limits.**

If You Have Diabetes...

Elevated blood sugar levels can have a negative effect on your oral health. Diabetes increases your risk of cavities, gum disease, tooth loss, dry mouth and infection. Conversely, poor oral health can make your diabetes more difficult to manage. Infections may cause your blood sugar to rise and require more insulin to keep it under control. Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes.

Covered individuals who have been diagnosed with diabetes are eligible for a total of four cleanings per calendar year.

Ready to Enroll?

Enrolling in the Oral Health, Total Health program is easy. Contact Moda Dental Customer Service or complete and return the Oral Health, Total Health enrollment form found on the myModa website: www.modahealth.com/members. Members with diabetes must include proof of diagnosis.

Frequently Asked Questions About the Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plan

- 1. Does Moda have a network of dental providers?** Yes. You may review the Delta dental premier network online at www.modahealth.com under "Find Care" or by calling Moda at **503-265-5680** or **1-877-277-7280**. When online, choose the Premier (Traditional) dental network. Dentists posted as network dentists are those who have agreed that their charges will not exceed the plan allowance. Network dentists have also agreed to submit any necessary claims to Moda.
- 2. What dentist can I see?** The City of Portland's service agreement with Moda gives you the option of seeing any licensed dentist. However, a non-participating dentist may charge more than the plan allows, and you will be responsible for any charge above that amount.
- 3. Can I see a dental specialist, such as an orthodontist or endodontist?** Yes. Specialist services are a covered benefit under the service agreement between the City of Portland and Moda. You are encouraged to have the specialist submit a request for preauthorization and predetermination of benefits to determine how much benefit the Plan will pay *before you receive care*.
- 4. How can I find out what my remaining benefits are for this current benefit year?** Contact Moda Dental Customer Service at **503-265-5680** or **1-877-277-7280** (toll free) and Moda will review your claims history to determine how much in benefits you have remaining. Or, visit Moda's website at www.modahealth.com and look under myModa.
- 5. What do I do if I have a dental emergency and I'm out of town?** In case of an emergency, you may seek services through any licensed dentist. Payment may be required at the time of service. For determination of allowable reimbursement of your expenses, you must submit a paper claim to Moda with the itemized receipts from the dentist's office. Keep in mind, a non-participating dentist may charge more than the plan allows, and you will be responsible for any charge above that amount.
- 6. How long are my children covered under my dental plan?** Eligible children may be covered until age 26.
- 7. What does the term "least costly" mean?** If a tooth can be safely and functionally restored with a procedure that is less expensive than the procedure your dentist actually performs, benefits paid will

be based on the procedure that costs less. If your dentist recommends a treatment or procedure and you would like to know if there is a less expensive alternative, please contact Moda before you receive treatment.

If you have a question that is not answered in this SPD, please contact Moda directly at **503-265-5680** or **1-877-277-7280**. Or, reach out to the City of Portland Benefit Information Line at www.portlandoregon.gov/benefits or **503-823-6031**.

Kaiser Dental Plan

The Kaiser Permanente Dental Plan (referred to as the Kaiser plan) is a prepaid group practice offering comprehensive dental care. **This plan covers services only when they are performed in a Kaiser Permanente facility.** General information about what the plan covers is included below. For more specific information about this coverage, please contact Kaiser Permanente's Member Services group at **503-813-2000** or **1-800-813-2000**. Also, see the *Dental Plan Comparison* chart at the beginning of this Dental Plan portion of the SPD. Kaiser information added to this handbook and all other City publications is added for convenience. Any misstatement of benefits within these documents does not allow for coverage if Kaiser Permanente documents represent different coverage levels. Please contact Kaiser NW directly at 503-813-2000 for any confirmation of coverage and/or benefit limitations/exclusions

Keep in mind, there is no annual deductible to meet before the Kaiser Dental Plan begins paying benefits. And, there is no maximum annual benefit—the plan does not limit how much it will pay toward eligible services in a plan year.

Kaiser Dental Plan: What Is Covered

The plan provides coverage for the following services and supplies when you use a Kaiser Permanente facility. Coverage is based on the least costly treatment alternative.

Preventive and Diagnostic Services:

Plan Pays 100% After You Pay \$10 Copay

Includes exams and x-rays, teeth cleaning (prophylaxis), fluoride treatments, instruction in the care of your teeth and gums, and prescribed space maintainers. Kaiser will cover up to two visits for oral prophylaxis treatments in any 12-consecutive month period as Dentally Necessary.

Basic Restorative Services and Prosthetic Services:

Plan Pays 100% After You Pay \$10 Copay

Includes routine fillings, plastic and stainless steel crowns, and simple tooth extractions.

Major Restorative and Prosthetic Services:

Plan Pays 80% After You Pay \$10 Copay

Includes full and partial dentures, relines and rebases, noble metal gold crowns and porcelain crowns, inlays and band bridge pontics, prescribed by a Kaiser Permanente dentist.

Periodontics:

Plan Pays 80% After You Pay \$10 Copay

Treatment of disease of the gums, including scaling and root planing.

Endodontics:

Plan Pays 80% After You Pay \$10 Copay

Includes root canal and related therapy.

Oral Surgery:

Plan Pays 80% After You Pay \$10 Copay

Surgical tooth extractions.

Emergency Treatment

Within the service area: You must use Kaiser Permanente facilities. You must pay a \$25 urgent care copay, in addition to the regular \$10 copay.

Outside the service area: The plan will pay up to \$100 *only* for the relief of pain, acute infection, hemorrhage or injury.

Orthodontics:

Plan Pays 50%, You Pay 50%

Includes orthodontic services and braces for children and adults. The Kaiser Plan will pay 50% of charges, up to a \$5,000 lifetime maximum benefit per person.

Dental Implants:

Plan Pays 50%, You Pay 50%

Allows for implant coverage at 50% up to \$2,000 per plan year. *This is an annual benefit maximum and not per implant.*

Kaiser Dental Plan: What Is NOT Covered

The following exclusions and limitations apply, and are in addition to any exclusions or limitations listed in the *Kaiser Dental Plan: What Is Covered* section. Regarding Kaiser Permanente dental coverage, “service” means any treatment, therapeutic or diagnostic procedure, medication, facility, equipment, device or supply. When a particular service is excluded, all services that are necessary or related to the excluded service are also excluded.

Exclusions and Limitations

Exclusions include:

- Care for conditions that are covered by Workers’ Compensation or that are the employer’s responsibility
- Conditions for which care or reimbursement is required by law to be provided at or by a government agency
- Cosmetic services
- Experimental or investigational treatments, procedures and other services that are not commonly considered standard dental practice or that require governmental approval
- Full mouth reconstruction and occlusal rehabilitation, including appliances, restorations and procedures needed to alter vertical dimension or occlusion or to splint or correct attrition or abrasion
- General anesthesia

- Genetic testing
- Intravenous sedation
- Medical, hospital and certain dental services
- More than two visits for routine teeth cleaning (oral prophylaxis) treatments in any 12-consecutive month period
- Prescription medications
- Prosthetic devices when necessary or desired following your decision to have a tooth (or teeth) extracted for non-clinical reasons or when a tooth is restorable
- Removal and replacement, with alternative materials, of clinically acceptable material or restorations for any reason except the pathological condition of the tooth or teeth
- Repair or replacement of fixed prosthetics or removable prosthetic appliances that are less than five years' old
- Replacement of prefabricated, non-cast crowns, including non-cast stainless steel crowns that were not placed by a Kaiser Permanente dentist
- Replacement of temporary removable appliances within five years of the date you received the appliance
- Restorative or reconstructive treatment for specific congenital or developmental malformations
- Services not approved by a Kaiser Permanente dentist. Kaiser Permanente does not pay for unauthorized services from dentists or facilities not affiliated with Kaiser Permanente, except as described under "Emergency Benefits."
- Surgery to correct malocclusion or temporomandibular joint (TMJ) disorders; treatment for problems of the jaw joint, including temporomandibular joint syndrome and craniomandibular disorders; and treatment of conditions of the joint linking the jaw bone and skull and of the complex of muscles, nerves and other tissues related to that joint
- Services performed or started prior to your coverage becoming effective, or started after your membership terminates.
- Speech-aid prosthetic devices and follow-up modifications
- Treatment to restore tooth structure lost due to attrition, erosion or abrasion

Limitations in service include:

- Kaiser Permanente is not responsible for delay or failure to render service because of unusual circumstances, such as wars, riots, labor disputes not involving Kaiser Permanente, or major disasters or epidemics affecting Kaiser Permanente facilities or personnel. Non-emergency care may be postponed in the event of labor disputes involving Kaiser Permanente organizations.
- In the event of a strike, lockout or labor dispute affecting the City of Portland, you may continue your group coverage for the term of the disruption or six months, whichever is less. You are responsible for payment of premiums during this period of time.

24-Hour Service Line

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

- Make return cleaning appointments, any time day or night
- Receive advice or help in a dental emergency

- Verify or cancel appointments
- Change and reschedule appointments (6:30 a.m. – 7:00 p.m. weekdays; 7:30 a.m. – 4:00 p.m. Saturdays)
- Get directions to Kaiser Permanente dental offices
- Talk to a dental member assistant (6:30 a.m. – 7:00 p.m. weekdays; 7:30 a.m. – 4:00 p.m. Saturdays)

From Portland..... 503-286-6868
From Vancouver 360-254-9158
From Salem..... 503-370-4311
From Longview..... 360-575-4800

Frequently Asked Questions About the Kaiser Dental Plan

If you have a question that is not answered in this SPD, please contact Kaiser Permanente directly. Or, reach out to the City of Portland Benefit Information Line at www.portlandoregon.gov/benefits or **503-823-6031**.

1. **What is the office visit copay for dental services through Kaiser?** The office visit copay is \$10 plus any additional percentage determined under the service agreement between Kaiser Permanente and the City of Portland.

2. **What other dental copays may I be responsible to pay under Kaiser?**

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

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

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

Participants will be charged \$15 for nitrous oxide for adults and children 13 and older (not subject to or counted toward the deductible or benefit maximum).

Participants will pay 10% of charges for night guards (not subject to or counted toward the deductible or benefit maximum).

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

Flexible Spending Accounts (FSAs)

This section describes the Flexible Spending Accounts available to you. You have two accounts to help you save money—the Healthcare FSA and the Dependent Care FSA.

The Healthcare FSA pays for qualified medical expenses not covered or reimbursed by your medical plan. Generally, it covers the eligible out-of-pocket expenses you pay *other than* your premium share. The Dependent Care FSA pays for childcare or adult dependent care expenses that are necessary to allow you (and your spouse, if married) to work or attend school full-time. Both accounts allow you to pay for qualified expenses with before-tax dollars, which can save you 20% to 30%.

Keep in mind; you cannot be reimbursed for expenses under the FSAs in addition to claiming a tax credit on your annual tax return, or if you are reimbursing yourself through other pre-tax health expense related accounts, like a VEBA (PPA). Also, if you have a Health Savings Account because you had participated in a Health Savings Account, any expenses that could be paid through a Health Savings Account are not reimbursable under the Healthcare FSA.

Please note: Retirees do not have access to flexible spending accounts.

Annual Enrollment

Your enrollment for the Healthcare FSA and Dependent Care FSA is a little different from your other health benefits. Just like your other health care benefits, once you sign up for an account your elected contributions and your participation cannot be changed until the next Annual Enrollment, unless you have a qualified family status change before that time. However, you must make an active election each Annual Enrollment period to take advantage of the Healthcare FSA and Dependent Care FSA. **Your spending account elections for one plan year will not roll over into the next plan year with one exception: you will be able to carry over up to \$550 of unused Healthcare FSA funds for use the following plan year.**

If you are hired after the beginning of the plan year (July 1), you may enroll on a prorated basis for the pay periods remaining in the plan year.

Special note concerning Healthcare FSA carryover: *You may not carryover less than \$50 or more than \$550 per plan year. Any carried over amount must be used within twelve months from the date of carryover, or before you terminate employment, whichever comes first. If you have less than \$50 in your account at the end of the plan year (June 30), you are at risk of forfeiting those funds. Your carryover funds will be added to your new plan year election; so if you elect the maximum of \$2,750 for the new plan year and have carried over \$550 from the prior year, your available balance available for that year will be \$3,250.*

If you decide to participate in a flexible spending account, enroll through BenefitsOnline during Annual Enrollment or within 35 days of your date of hire. Your pre-tax payroll deductions will be divided and spread over 24 pay periods, beginning with your first paycheck in the plan year. **(If you are hired during the year,** you should base your contribution on the amount of money you think you will need between the time you are hired and the end of the plan year (June 30); your contributions will be taken from your paychecks in equal amounts through the end of the plan year.)

For the Healthcare FSA account, the maximum contribution for the plan year is \$2,750. The minimum Healthcare FSA contribution is \$120 per plan year.

For the Dependent Care FSA account, the maximum contribution for the plan year is \$5,000. The minimum Dependent Care FSA contribution is \$120 per plan year. (The Dependent Care FSA does not allow a rollover at the end of the year.)

Flexible Spending Accounts & COVID

The Internal Revenue Service (IRS) issued new Flexible Spending Account (FSA) guidance due to the COVID-19 national emergency. In response, the City has made the following temporary changes to our current plan year Healthcare and Dependent Care Flexible Spending Accounts. These changes include:

- 2019-20 HealthCare FSA participants have until December 31, 2021 to submit claims incurred from July 1, 2019 through December 31, 2020.
- 2020-21 HealthCare FSA participants can have any unused funds over \$50 rollover into the 2021-22 plan year.
- 2020-21 Dependent Care FSA participants can have any unused funds rollover into the 2021-22 plan year.

For updated information related to COVID-19 and the City's FSA plans please visit: <https://www.portlandoregon.gov/bhr/article/761031>.

The Before-Tax Advantage

What is the advantage to having your contributions taken out before taxes?

You may save money on taxes. The City simply deducts the amount you wish to set aside from your pay before any taxes (Social Security, Medicare, federal income and, in most areas, state and local income tax) are withheld. The following example shows your potential tax savings by making contributions with before-tax dollars.

The chart below is for illustrative purposes only.

	With Before-tax Dollars	Without Before-tax Dollars
Yearly salary	\$40,000	\$40,000
Plan-year contribution to the Healthcare FSA	- \$2,700	\$ 0
Plan-year contribution to the Dependent Care FSA	- \$5,000	\$ 0
Taxable salary	\$32,300	\$40,000
Taxes (assumes 15% tax)	- \$4,845.00	\$6,000
Annual income	\$27,455.00	\$34,000
After-tax costs for health care and dependent care expenses	\$ 0	\$8,500
Take-home pay	\$27,455.00	\$25,500
Your annual savings in taxes:	\$1,955.00	
That's almost \$2,000 a year more for you—simply because you take advantage of the Flexible Spending Accounts and use before-tax dollars to pay for health and dependent care expenses.		

How Your Flexible Spending Accounts Can Work For You

Here are some highlights of what each spending account can offer you.

Your Spending Accounts At-a-Glance		
	Medical Expense Reimbursement Plan (Healthcare FSA)	Dependent Care Assistance Plan (Dependent Care FSA)
What expenses are eligible?	<p>Your Medical Expense Reimbursement Plan (Healthcare FSA) reimburses you for certain health-related expenses that are not paid by your medical, dental and/or vision plans or through other pre-tax health care related savings. Expenses can be for you or your eligible dependents, even if you or they are not covered under the City's plans.</p> <p>Effective January 1, 2020 Over-The-Counter medications are covered as eligible expenses. Participants must submit receipts for reimbursement.</p>	<p>A Dependent Care Assistance Plan (Dependent Care FSA) reimburses you (on a before-tax basis) for childcare or adult dependent care expenses for qualified dependents. The day care expenses must be necessary so that you or your spouse can work, look for work, or attend school full-time.</p>
What does "eligible dependent" mean to each spending account?	<p>Under the Medical Expense Reimbursement Plan (Healthcare FSA), an "eligible dependent" is either an individual whom you can claim as your dependent for federal income tax purposes or a child for whom you are required to provide health benefits under a court order. As a result, expenses for domestic partners and children of domestic partners may be considered for tax-free reimbursement <i>only</i> if they meet the spouse or dependent eligibility requirements set out in IRS Code section 152(a) and 152(a)9. You must provide proof of dependency when filing a claim for reimbursement.</p>	<p>Within the Dependent Care Assistance Plan (Dependent Care FSA), the term "eligible dependent" means a dependent that meets the IRS definition of dependent for income tax purposes. Generally, this means a child up to age 13. An adult (e.g., parent, grandparent, adult, disabled child) also may qualify as a dependent if you provide more than half of that person's maintenance/support for the year.</p>
How much can I contribute?	<p>You can contribute a minimum of \$120 up to a maximum of \$2,750.</p>	<p>You can contribute up to a maximum of \$5,000 (if you are single or married and filing taxes jointly) or \$2,500 (if you are married and filing separately).</p>
Is the account "use it or lose it"?	<p>You are allowed to roll over money in your account that you have not used—from \$50 up to \$550—for use in the subsequent plan year (as long as you remain eligible). Any leftover funds less than \$50 or in excess of \$550 will be forfeited.</p>	<p>Yes. You must use and claim all of the money in your account each year, or it will be forfeited.</p>

Healthcare FSA

How Does It Work?

The Healthcare FSA helps you save money on health care expenses by allowing you to use money that isn't taxed to pay your share of health-related expenses. When you join, you choose to contribute a set amount to your account through payroll deductions on a pre-tax basis. You can contribute a maximum of \$2,750 and a minimum of \$120. As you incur eligible out-of-pocket health care expenses (medical, prescription, dental, and vision), you reimburse yourself throughout the plan year. As a result, you reduce your taxable income because your flexible spending account contributions come out of your paycheck before taxes are deducted. When you are reimbursed, the money remains tax-free. ***If you are enrolled in the City's High Deductible Health Plan, and contribute to an individual health savings account (the City does not sponsor an HSA) your Healthcare FSA can only be used for dental and vision expenses. The Healthcare FSA account becomes a "Limited Purpose" FSA,***

When you pay for an eligible health care or dependent care expense, you want to put your FSA account to work right away. HealthEquity/WageWorks gives you several options to use your money the way you choose.

1. Automatic Health Plan Claim (AHPC)

When you visit a health care provider such as a doctor or dentist, your insurance carrier (applicable to Moda, VSP and ExpressScripts) later provides the amount of the transaction not covered by the health plan to HealthEquity/WageWorks. This amount represents the "out-of-pocket" cost for which your FSA can be used. HealthEquity/WageWorks uses this data to initiate payment directly to you from your Health Care FSA. If you would like to set up auto pay from your account, simply follow the instructions below. 4

- Log into www.wageworks.com.
- From the Dashboard, select your Health Care FSA program then click on the "Program Options" link.
- Under "Your Options" select the "Automatic Health Plan Claims "On" radio button.
- Click "Save Changes."

1. Using your HealthEquity/WageWorks Health Care Card

- When you swipe your Card at the checkout, choose "credit" (even though it isn't a credit card).
- Pay for services or purchases on the same day you receive them.

If your health plan covers a portion of the cost, make sure you know what amount you need to pay before using the Card, by presenting your health plan member ID card first, so the merchant can identify your copay or coinsurance amount and ensure the service is claimed to your health care, dental or vision insurance plan

- Save your receipts or digital copies. You may need them for tax purposes. Plus, even when your Card is approved, a detailed receipt may still be requested.
- If you've lost or can't produce a receipt for an expense, your options may range from submitting a substitute receipt to paying back the plan for the amount of the transaction

- If you use your Card at an eye doctor's or dentist's office, we will most likely ask you to submit an Explanation of Benefits (EOB) or other documentation for verification. Failure to do so may result in your Card being suspended.
- If you lose your Card, please call HealthEquity/WageWorks immediately and order a new one. You will be responsible for any charges until you report the lost Card.

2. Paying online

You can pay many of your eligible health care and dependent care expenses directly from your FSA account with no need to fill out paper forms*. It's quick, easy, secure and available online at any time.

To pay a provider:

- Log into your FSA account at www.wageworks.com
- Click "Submit Receipt or Claim."
- Request "Pay My Provider" from the menu and follow the instructions
- Make sure to provide an invoice or appropriate documentation.

When you're done, HealthEquity/WageWorks will schedule the checks to be sent in accordance with the payment guidelines. If you pay for eligible recurring expenses, follow the online instructions to set up automatic payments.

3. Filing a claim

You also can file a claim online to request reimbursement for your eligible expenses.

- Go to www.wageworks.com, log into your account and click "Submit Receipt or Claim."
- Select "Pay Me Back."
- Fill in all the information requested on the form and submit.
- Scan or take a photo of your receipts, EOBs and other supporting documentation.
- Attach supporting documentation to your claim by using the upload utility.
- Make sure your documentation includes the five following pieces of information required by the IRS:
 - Date of service or purchase**
 - Patient name**
 - Detailed description**
 - Patient portion or amount owed**
 - Provider or merchant name**

Most claims are processed within one to two business days after they are received, and payments are sent shortly thereafter. If you prefer to submit a paper claim by fax or mail, download a Pay Me Back claim form at www.wageworks.com and follow the instructions for submission.

4. Using your Smartphone or Mobile Device

With the EZ Receipts mobile app from HealthEquity/WageWorks, you can file and manage your reimbursement claims and Card usage paperwork on the spot, with a click of your smartphone or mobile device camera, from anywhere.

To use EZ Receipts:

- Download at www.wageworks.com/employees/go-mobile.
- Log into your account.
- Choose the type of receipt from the simple menu.

- Enter some basic information about the claim or Card transaction.
- Use your smartphone camera or device to capture the documentation.
- Submit the image and details to HealthEquity/WageWorks.

Did You Know?

Your claim form must be faxed or postmarked by the last day of the three-month period following the plan year or you will forfeit any remaining contributions that are not available for carryover in the Healthcare FSA due to the “use it or lose it” rule.

If you want to submit a claim, send your claim form (with the appropriate information attached) to:

WageWorks

877-WageWorks

877-924-3967

M-F 8am-8pm (Eastern Time)

Be sure to keep a copy of the claim form and any attachments for your personal records. If you have questions, please call HealthEquity/WageWorks at **877-WageWorks or 877-924-3967**.

Healthcare FSA – Benefits Card

Here are the benefits card swipes that can be automatically approved per the IRS rules:

- Prescription medications purchased at a pharmacy that has Inventory Information Approval System (IIAS) software (most major retail pharmacies have the IIAS software)
- Copayment matches—like a \$10 copay for a doctor's visit with your Kaiser physician will be automatically approved because the plan recognizes the Kaiser network \$10 copay
- Recurring expenses of the same amount to the same provider, established with documentation
- Eligible over-the-counter products purchased at a pharmacy with IIAS

The following types of benefits card swipes ***will not be automatically approved*** and will require you to submit documentation to verify that the charges are valid (and not paid by any other health plan). The paperwork required is called “substantiation documentation.”

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

When HealthEquity/WageWorks requires additional documentation, you'll receive a notification outlining the details they need. Respond with a copy of the provider bill or the health plan's Explanation of Benefits to complete the transaction.

Using your Benefits Card after the plan year

You should not use your benefits card to pay for expenses *incurred* during the prior plan year (July 1 to June 30) but *charged* during the current plan year, even if the charge is made during the run-out period (July 1 to September 30). Your Benefits Card should only be used for expenses incurred within the current plan year.

What Is “Substantiated Documentation”?

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

- Who was treated?
- What services were provided?
- When was the service provided?
- How was the service paid—what amount is covered by your insurance plan?
- Who provided the service?

To provide these answers, you can submit:

- An Explanation of Benefits (EOB) from your insurance carrier
- A flexible spending account (FSA) itemization from the provider, if the services are not covered by your insurance carrier

More Details

What is a letter of medical necessity, and when would I need one?

A letter of medical necessity (LOMN) is required when expenses may or may not be eligible, depending on the condition being treated. Vitamins and other supplements fall into this category. Go to www.wageworks.com for a list of eligible and ineligible expenses and documentation requirements.

Do I need to get a prescription for OTC products?

No. You can use your HealthCare FSA funds to pay for OTC products. **Do I need a prescription as well as a letter of medical necessity?**

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

What if I cannot substantiate a card swipe?

If a card swipe is not substantiated, it becomes an ineligible expense. You can:

- Submit manual claims that can be used to offset the ineligible expenses (to use up your balance with legitimate claims). These are considered “offset claims” and must be submitted before September 30 of the following plan year.
- Refund the plan

What is a recurring expense?

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

- The first time you use the card to pay an orthodontic installment, for example, you will get a notification from HealthEquity/WageWorks requesting documentation
- Provide HealthEquity/WageWorks a copy of the contract between you and the provider showing the payment schedule and the amount, and request a recurring expense
- HealthEquity/WageWorks will substantiate the first card swipe. The provider and the amount will be set up as a recurring expense for future installments.
- Once the recurring expense is set up, every month when the installment payment is made with the card, it will be approved automatically

Other examples of recurring expenses include ongoing chiropractic manipulation visits, naturopathic office visits, etc. Please note that if the provider or the amount changes, it is no longer a recurring expense. Recurring expenses must be re-established each plan year.

How to Use Your Healthcare FSA

Choose your contribution amount. Decide how much you may spend for health care for the coming year. This can help determine how much you should contribute to your Healthcare FSA. Contributions must fall within the minimum (\$120) and maximum (\$2,750). Look at how much you spent last year by adding up your receipts. Then, think about whether you or your dependents have any planned surgeries or procedures, or need braces or glasses, etc. If you have never used this type of account, contribute a conservative amount until you are more comfortable with it.

How Much Should I Contribute?

Need some help deciding how much to contribute? Use the following worksheet to help estimate your health care expenses for the upcoming plan year. This worksheet will help you calculate how much you may want to deposit in the Healthcare FSA. Just follow these steps:

1. Based on your records for the past few years, fill in your anticipated eligible expenses
 - If the expense is paid by a health care plan, enter your copayment and any deductible
 - If the expense is not covered by the health care plan, enter the entire cost
 - Remember, the money in your Healthcare FSA account can be used to pay your portion of out-of-pocket health-related expenses that your insurance plans do not cover
2. Add up the total annual expenses for you and your family
3. Enter this amount when you enroll

Cost For:	For You:	For Your Spouse	For Your Children:
Medical/Dental Plan deductibles	\$ _____	\$ _____	\$ _____
Medical/Dental Plan copayments/coinsurance	\$ _____	\$ _____	\$ _____
Doctor or clinic visits, urgent care visits	\$ _____	\$ _____	\$ _____
Prescription medication copayments	\$ _____	\$ _____	\$ _____
Out-of-pocket physical therapy services	\$ _____	\$ _____	\$ _____
Chiropractor visits	\$ _____	\$ _____	\$ _____
Dental care/orthodontia	\$ _____	\$ _____	\$ _____
Vision care, expenses for glasses and contacts	\$ _____	\$ _____	\$ _____
Hearing care, including hearing aids	\$ _____	\$ _____	\$ _____

Cost For:	For You:	For Your Spouse	For Your Children:
Health services/supplies	\$ _____	\$ _____	\$ _____
Other eligible expenses	\$ _____	\$ _____	\$ _____
Total Annual Health Care Expenses:	\$ _____ +	\$ _____ +	\$ _____
Your Annual Election (up to \$2,750)	= \$ _____ (This is the amount you may want to contribute.)		
Contribution Per Pay Period	= \$ _____ (Divide your annual contribution by 24 to see what will come out of each paycheck.)		

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

Tax Considerations

Flexible spending accounts are based on current tax laws and give you the advantage of those laws. Please keep in mind the following tax considerations before participating in the Healthcare FSA:

- Plan participation may affect your future Social Security retirement benefits. This could happen if your taxable pay, after spending account contributions are taken out, is below the Social Security taxable wage base. However, for most employees, the immediate tax savings is of far greater benefit than the long-term impact on Social Security benefits.
- You cannot claim the same expenses through the Healthcare FSA and on your tax return. Currently, a percentage of your health care expenses above your adjusted gross income are deductible for income tax purposes. With the Healthcare FSA, you can save taxes immediately on the very first dollar not reimbursed by your health care plan.
- You cannot claim expenses under your Healthcare FSA and then also claim the same expense under a VEBA or a Health Savings Account (HSA). If you are enrolled in a High Deductible Health Plan, any Healthcare FSA elections you make can only be used for dental and vision expenses, as a "Limited Purpose" Flexible Spending Account (FSA).
- Please consult a tax advisor for guidance.

\$550 Carryover Allowed

Active employees are allowed to carry over up to \$550 of their account balance to the following year. That means if you participate in the Healthcare FSA, but you don't use all of the money you've set aside for the year, you can keep up to \$550 and use it in subsequent years. To account for the costs of administrative fees to maintain these carryover balances, the City has set a minimum carryover amount of \$50. This means that if at the end of the plan year you have at least \$50 of unused funds in your Healthcare FSA account, you may carryover that amount, up to a maximum of \$550.

Here's an example: The Healthcare FSA plan year is from July 1 to June 30, like your other benefits. Let's say you contribute \$2,000 to the Healthcare FSA during the 2021-22 plan year. Between July 1, 2021 and June 30, 2022, you only have \$1,600 in claims leaving \$400 in your account. You can carry over that \$400 and use it to pay eligible health care expenses in the next plan year or until you terminate employment.

You should still plan your Healthcare FSA contributions carefully; you can only carry over from \$50 to \$550. Any amount less than \$50 or over \$550 in your Healthcare FSA account at the end of the plan year (June 30) will be forfeited.

Healthcare FSA – What’s Covered

The Medical Expense Reimbursement Plan (Healthcare FSA) can be used for health care expenses that are otherwise eligible to be claimed as deductions on your federal income tax return. To be eligible under the Healthcare FSA, the expenses must be incurred while you and/or your eligible dependents are participating in the Healthcare FSA. Expenses incurred before you enroll, after you quit making contributions to the spending account, or after the deadline for incurred claims are not eligible.

Did You Know?

Examples of eligible expenses are listed here, but this list is not comprehensive. For the most up-to-date list, go to www.wageworks.com.

Eligible health care expenses include, but are not limited to, the following:

- Insurance deductibles and copayments
- Alcohol, drug or chemical dependency treatment
- Prescription medication copayments
- Chiropractic, naturopathic, osteopathic and/or acupuncture treatment
- Dental treatments (x-rays, fillings, crowns, etc.)
- Orthodontia, dental surgery, exams, cleanings
- Eyeglasses, contacts, vision exams
- Laser eye surgery, when performed to promote the correct function of the eye
- Hearing aids, aids and assistance for the handicapped
- Doctor and hospitalization expenses and services
- Lab fees, physical exams, x-rays and vaccinations
- Infertility treatment such as shots, treatments, surgery, GIFT—as long as the procedure or treatment is done to overcome an inability to have children
- Nursing homes and nursing services
- Psychiatric, psychology and/or psychotherapy treatment
- Surgery, sterilization, gynecology, obstetrics, anesthesia
- Over-the-counter medications used to alleviate or cure a sickness (any **over-the-counter medications must be prescribed by a doctor** to be reimbursable) *
- Over-the-counter contraception prescribed by a doctor
- Over-the-counter supplies such as band-aids, gauze and first-aid kits, provided the amount purchased can be reasonably used within a plan year
- Mileage to and from health provider visits

- Weight loss services for morbid obesity (not including the cost of food and/or over the counter medications)
- Speech or physical therapy, transplants, and other medically necessary treatment

* Some over-the-counter medications may be reimbursable with a Letter of Medical Necessity from your doctor. Over-the-counter herbs, supplements and vitamins are eligible only with a prescription and Letter of Medical Necessity from your doctor.

Healthcare FSA – What’s Not Covered

While certain expenses are eligible, others are not. Ineligible health care expenses include, but are not limited to:

- Insurance premiums
- Fitness programs
- Health club dues
- Expenses reimbursed by other sources of insurance
- Nutritional supplements which are merely beneficial to general health and are not used in a course of treatment for a medical condition (or that you do not have a doctor-provided prescription *and* Letter of Medical Necessity for)
- Massage therapy is generally not covered, but may be an eligible expense when for treatment related to an acute or chronic medical condition. You are required to provide a letter of medical necessity with the diagnosis from your physician **or** the claim received from the massage therapist must include information indicating the condition being treated and that you were referred by your physician. You need to provide this information only once, per condition. Massage therapy is not covered for treatment for a non-medical reason or for depression.

Did You Know?

You can use the money in your Healthcare FSA account to pay for eligible health-related expenses for your dependents—even if they are not enrolled in a plan offered by City of Portland.

For example: your child is covered by your spouse’s dental plan, and needs braces. You can use your Healthcare FSA funds to pay eligible out-of-pocket orthodontia expenses for your child (as long as the charges are not covered by your spouse’s dental plan and as long as the child is your qualified tax dependent).

Dependent Care FSA

How Does It Work?

The Dependent Care Assistance Plan (Dependent Care FSA) allows you to pay for eligible dependent day care expenses on a pre-tax, salary reduction basis. After you enroll, the Dependent Care FSA works like this:

1. The amount of money you specify when you enroll is taken from your paychecks in equal amounts and deposited in your Dependent Care FSA account
2. You pay your dependent care expenses as usual

3. After the dependent care has been provided, you file a claim form and receipts for reimbursement and you will be reimbursed up to the amount actually in your account at the time your claim is processed. When future contributions are made to your Dependent Care FSA, you automatically receive another reimbursement until your total claim has been reimbursed or you reach your election amount for the plan year.

Did You Know?

The Dependent Care FSA can save you money on your taxes—your contributions are deducted from your paycheck on a pre-tax basis (before federal, state, and Social Security (FICA) taxes are taken out). For example, if you earn \$3,000 a month and contribute \$200/month to the Dependent Care FSA, you only pay income taxes on \$2,800 a month. The tax savings are reflected in your paycheck each month.

You may be able to reduce your taxes further by using the dependent care tax credit *instead of* the Dependent Care FSA. The tax credit is a percentage of allowable expenses, which varies according to your income level. Expenses reimbursed under the Dependent Care FSA reduce, dollar-for-dollar, the expenses eligible for the tax credit on your income tax return. The savings depend on your particular tax situation.

How to Use Your Dependent Care FSA

The Dependent Care FSA account is used to pay for day care expenses for your dependents who require care while you (and your spouse if you're married) go to work or attend school full-time. Eligible dependents include:

- Your children **under age 14**
- Disabled dependents who require care (such as a spouse, parent or other eligible dependent who is incapable of self-care and qualifies as your tax dependent on your federal tax return)

If you participate in the Dependent Care FSA, you decide how much money you want to put into your account while taking in to consideration the limits to the amount you can contribute. If you're married and file a separate tax return, you can contribute up to \$2,500 a year into your Dependent Care FSA account. If you're single/head of household or married/filing jointly, you can contribute up to \$5,000 a year (this is to enforce a limit of \$5,000 per household).

Dependent Care FSA – What Is Covered

Eligible expenses (subject to the limitations described in this section) include:

- Day care center fees
- Before- or after-school care for your children under age 14
- Care in your home, including salary and the Social Security taxes you pay for your dependent care provider. Keep in mind, expenses are not covered if the care is provided by someone you can claim as a dependent on your tax return, or by your child or stepchild under age 20.

Remember to estimate your expenses carefully; the Dependent Care FSA also has a “use it or lose it” feature, so any money you do not claim before the deadline will be lost.

More Details

Keep the following limitations in mind when making your election for the year:

Limitation for Contributions	
If...	Then...
You and your spouse both work, regardless of your income tax filing status...	...your maximum annual contribution cannot be more than what you or your spouse earns (or is expected to earn), whichever is less
If your spouse does not have any earned income but is disabled or a full-time student...	...your spouse will be considered to earn \$3,000 a year (if you have one eligible dependent) or \$6,000 a year (if you have two or more eligible dependents)
If your spouse does not have any earned income...	... you may contribute up to \$2,500 per year
If you and your spouse file a joint income tax return...	...you may contribute up to \$5,000 for the year, regardless of the number of eligible dependents you have
If you and your working spouse file separate income tax returns...	...the maximum annual contribution you can make is \$2,500

The Dependent Care FSA vs. the Federal Tax Credit

The City is not permitted by law to provide legal, tax or accounting advice. Our purpose is to provide the information and the perspective for you to make sound decisions based on your personal situation. Federal tax laws allow you to reduce your income taxes if you pay someone to care for your child or other dependent so that you may work. You may reduce your taxes by participating in the Dependent Care FSA account or by using the federal tax credit, but not a combination of the two unless they are used for different dependent care expenses.

The amount you save on taxes will vary depending on the method you use, your salary, your expenses and your tax status. Different tax-savings methods affect your cash flow, financial flexibility and federal income tax return preparation in different ways. You should see your tax advisor for help determining what’s best for you.

Frequently Asked Questions About the Flexible Spending Accounts

- 1. Who is eligible to participate in the Medical Expense Reimbursement Plan (Healthcare FSA)?**
Your eligible dependents must be *eligible* to participate in the City’s medical/vision and dental plans to be eligible to have expenses reimbursed under a Healthcare FSA, with one exception. Domestic partners and their children are not eligible to have expenses reimbursed through a Healthcare FSA unless they are considered to be a tax dependent under Code 152 of the Internal Revenue Code.
- 2. How much can I claim from the Healthcare FSA?** You can submit a claim for reimbursement from the Healthcare FSA at any time during the plan year for an amount equal to your annual salary reduction election, minus amounts of your prior claim reimbursements.

3. **Can my Healthcare FSA claim reimbursements go directly into my checking or savings account?** Absolutely. To make the reimbursement process even easier, you can set up direct deposit for your claims reimbursements. To do so, go to www.wageworks.com to print out a form. Complete the form, attach a copy of a voided check for automatic checking account deposit **or** savings account deposit slip for automatic savings account deposit and submit the form to HealthEquity/WageWorks at the address listed in the *How Does It Work?* section.
4. **I've recently gotten married. Can I change my Healthcare FSA contribution amount mid-year?** You may change your Healthcare FSA contribution amount but the eligible expenses must be consistent with the specific family member. Only expenses incurred while your spouse is eligible for City benefits are allowed.
5. **If I leave the City, when will my Healthcare FSA expire?** If you terminate employment or cease to be an eligible employee for any reason, your contributions end on your last day of work. You will only be able to seek reimbursement for expenses you incurred from July 1 of the plan year through your termination date, unless you elect to continue your coverage under COBRA on an after-tax basis. If you are subsequently re-employed during the same plan year (and after 30 days following your termination) and have not elected to continue your medical reimbursement plan under COBRA on a post-tax contribution, no new election may be made until the next plan year. If you are on an approved family leave, contact the Benefits Office at **503-823-6031** for information concerning your options for continuing or terminating your Healthcare FSA or Dependent Care FSA participation.
6. **If I leave the City, when will my Dependent Care FSA expire?** If you terminate employment or cease to be an eligible employee for any reason, your contributions to the Dependent Care Assistance Plan terminate on your last day of work. You may, however, be able to seek reimbursement for eligible expenses you incurred during the remainder of the plan year (June 30th) at any time until ninety days following the end of the plan year. No reimbursement shall exceed the balance in your Dependent Care Account for the plan year in which expenses were incurred. If you are subsequently re-employed during the same plan year no new election may be made until the next plan year
7. **What are some examples of dependent care expenses that are not eligible for reimbursement through the Dependent Care FSA?** Non-eligible expenses include babysitting during non-working hours, transportation costs to and from a day care facility, education supplies and activities (such as field trips).
8. **Can I change my Dependent Care FSA contribution amount mid-year?** Depending on the cause of the mid-year change, you may be eligible to change your Dependent Care FSA election for the balance of the plan year. Contact the Benefits Office at **503-823-6031** within 60 days of the date of the change.
9. **My disabled parent lives with me and is dependent on me for support—and can't be left alone while I am at work. Can the care required for my parent be covered by my Dependent Care FSA funds?** Yes, as long as your parent is your tax dependent.

Life Insurance

If you're like most people, when someone says life insurance you quickly change the subject. After all, the thought of dying isn't a topic we want to dwell on. Truth is, life insurance is almost as much about living as it is about dying. It gives you reassurance that those you love will have a better chance of living with financial security. Because, when you think about life insurance, isn't your first thought 'what will happen when I die'? What will happen to my family? My home? How will the bills get paid? Good planning and an understanding of your City life benefits can give you satisfying answers.

The life insurance plans have specific rules about what is covered and how the plan pays benefits. You have access to basic life insurance and supplemental life insurance. Both plans are described in detail in the following sections. If you have questions about the information presented, please contact the City of Portland Benefit Information Line at **503-823-6031** or www.portlandoregon.gov/benefits.

Please note: Retirees do not have access to life insurance through the City of Portland.

Basic Life Insurance

The “Basics” of Basic Life Insurance

Basic life insurance provides valuable financial protection for your family. If you, your spouse/domestic partner or dependent children die, your basic life insurance benefit can replace your income for a period of time or help your family pay for one-time expenses like a funeral or paying off a home. Basic life coverage provides peace of mind for you and basic financial security to you or your beneficiaries in the event of death.

Basic life insurance is only available to City employees. **The City will pay for your basic life insurance if you are a full-time employee working at least 72 hours each pay period.** Part-time employees pay 50% of the cost for coverage and are not eligible to opt-out of the coverage.

Who Is Eligible?

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

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

You do not qualify if you are a temporary or seasonal employee who is not in a benefits eligible position, or as a retiree.

Your spouse/domestic partner is not eligible for basic life insurance. However, they may qualify for supplemental life coverage if you are enrolled in supplemental life coverage for yourself.

Coverage Amount: Basic Life

If you die while covered by the Plan, your beneficiary(ies) will receive a benefit of \$50,000. The City pays the entire cost of basic life insurance coverage for full-time PPA employees.

Part-time employees pay 50% of the cost of the basic life coverage.

Supplemental Life Insurance

The “Basics” of Supplemental Life Insurance

You may purchase additional life insurance coverage for yourself, your spouse/domestic partner, and your eligible dependents. This plan provides you with an additional benefit if you, your spouse/domestic partner, or your dependent(s) were to die.

Supplemental life insurance is available to all eligible employees. However, you pay the full cost of this benefit, and your dependents are only offered coverage if you enroll in supplemental life coverage for yourself. When you leave the City, if you are not disabled and are under age 75, you may “port” up to \$150,000 in coverage (\$30,000 for your spouse/domestic partner) by paying the premiums directly to the insurance carrier. Coverage ends at age 75.

Who’s Eligible?

Your dependents may qualify for supplemental life insurance if they meet the definition shown here:

This dependent:	Must meet this criteria:
Spouse/Domestic Partner	<ul style="list-style-type: none"> ▪ Your legal spouse <ul style="list-style-type: none"> ○ A divorced or legally separated spouse is not eligible for City-paid coverage ▪ Your same-sex or opposite-sex domestic partner
Children	<p>Unmarried child from live birth to age 26, who is:</p> <ul style="list-style-type: none"> ▪ A biological child ▪ An adopted child ▪ The child of your spouse or domestic partner who lives with you and your spouse or domestic partner ▪ The child of your spouse or domestic partner, if your spouse or domestic partner is required by divorce decree or court order to provide health insurance for the child, or is primarily responsible for financial support of the child ▪ The child of your child, if your child is insured for Supplemental Life for Dependents under the City of Portland’s plan ▪ Any other child related to you or your spouse or domestic partner by blood or marriage, for whom you or your spouse or domestic partner has been awarded court appointed guardianship, and of whom you or your spouse or domestic partner has custody <p>Note: To qualify for coverage as a child, one of the following additional dependency tests must be met with respect to a child under age 26</p> <ul style="list-style-type: none"> ▪ You or your spouse or domestic partner must be entitled to claim the child as an income tax exemption; or ▪ You or your spouse or domestic partner must be obligated to provide health insurance for the child by court decree or state order, and not be entitled to claim the child as an income tax exemption solely on the court decree <p>A disabled child may be covered beyond the limiting ages above if the child is continuously:</p> <ul style="list-style-type: none"> ▪ Incapable of self-sustaining employment because of intellectual disability or physical handicap; ▪ Has received a Determination of Disability under the Social Security Act; and ▪ Resides with you and is chiefly dependent upon you for support and maintenance

Coverage Amounts: Supplemental Life

If you die while covered by the Plan, your beneficiary(ies) will receive the benefit you choose. Your coverage options are:

For:	Supplemental Life Insurance Coverage Options
You	Any multiple of \$10,000, from \$20,000 to a maximum of \$500,000
Spouse/Domestic Partner	Any multiple of \$10,000, from \$10,000 to a maximum of \$300,000 (not to exceed the amount of life insurance for which you are insured)
Children	Any multiple of \$5,000, to a maximum of \$25,000 (not to exceed the amount of life insurance for which you are insured)

Note: Children may not be insured by more than one parent.

Cost

If you elect supplemental life insurance coverage for yourself, your spouse/domestic partner or children, you pay the full cost of coverage. *Remember, you must elect supplemental life for yourself in order to elect supplemental life for your spouse/domestic partner and/or children.*

Supplemental life insurance annual premiums (per family member) are as follows:

Your Age (as of July 1)	Rate	To calculate your monthly payroll deduction, use the formula indicated below:	
<30	\$0.025	1. Amount Elected:	Line 1: _____
30-34	\$0.038		
35-39	\$0.040		
40-44	\$0.050		
45-49	\$0.075	2. Line 1 divided by \$1,000 = Line 2.	Line 2: _____
50-54	\$0.115		
55-59	\$0.215		
60-64	\$0.310	3. Select your rate from the rate table and enter on Line 3.	Line 3: _____
65-69	\$0.500		
70	\$0.670		
71	\$0.685		
72	\$0.750		
73	\$0.815		
74	\$8.880		

Line 2 multiplied by Line 3 = Your monthly Cost

Life Insurance Plan Details

Coverage Effective Date

Basic Life Insurance

You are automatically enrolled in basic life insurance coverage if you are in a benefit-eligible job class and status as follows:

- If you are a permanent part-time employee represented by PPA, you become eligible on the first day of the calendar month following 174 hours of continuous service with the City of Portland

- If you are full-time PPA employee, you become eligible on the first day of the calendar month following 30 consecutive days of service with the City of Portland

Supplemental Life Insurance

You are eligible for supplemental life insurance on the date you become eligible for employer-sponsored benefit coverage.

For You...		
If you apply...	For coverage amounts of...	Coverage is effective...
Within 60 days of your initial waiting period <i>OR</i> Within 60 days of a marriage/domestic partner addition <i>OR</i> Within 60 days of birth or adoption of a child	Up to \$300,000 (including any previously "ported" amount of supplemental life insurance)	First day of the calendar month following the date you applied
	Between \$300,000 and \$500,000 (including any previously "ported" amount of supplemental life insurance)	First day of the calendar month following the date the insurance company approves your application (after approving your evidence of insurability)
After the end of your waiting period	Any amount, up to the limit of \$500,000 (including any previously "ported" amount of supplemental life insurance)	
For Your Spouse/Domestic Partner		
If you apply...	For coverage amounts of...	Coverage is effective...
Within 60 days after becoming eligible (must not exceed employee supplemental life amount)	Up to \$30,000 (including any previously "ported" amount of spouse/domestic partner supplemental life insurance)	First day of the calendar month following the date you apply
	Above \$30,000 (including any previously "ported" amount of spouse/domestic partner supplemental life insurance)	First day of the calendar month following the date the insurance company approves your spouse's/domestic partner's application (after approving your evidence of insurability)
More than 60 days after becoming eligible (must not exceed employee supplemental life amount)	Any amount up to the limit of \$300,000 (including any previously "ported" amount of spouse/domestic partner supplemental life insurance)	
For Your Children		
If you apply...	For coverage amounts of...	Coverage is effective...
Within 60 days after becoming eligible	Any amount, up to the limit of \$25,000	First day of the calendar month following the date you apply
More than 60 days after becoming eligible		

Notes:

- Evidence of Insurability is required for any increase to your or your spouse's/domestic partner's supplemental life coverage. It is not required for any newly insured or any increase to supplemental life for children.
- Supplemental life insurance coverage will end when you turn age 75, if you are still covered at that time. Your spouse's or domestic partner's supplemental life insurance will end on the earlier of the date you turn age 75 or he/she does. Supplemental life insurance for children ends when the child reaches age 26.
- When you leave the City, if you are not disabled and are under age 75, you may "port" up to \$150,000 in existing coverage for yourself (\$30,000 for your spouse/domestic partner) by paying the premiums directly to the insurance carrier.

Did You Know?

What is Evidence of Insurability (EOI)?

Plans, such as life insurance, may require you to complete a medical history statement in order to show how insurable you are, or how risky you would be to insure. EOI is requested if you increase your coverage amount or, in the case of a new employee, to elect a certain dollar amount in coverage. An EOI Form includes questions about your health and may require you to provide blood test results. Depending on the information you provide, you or your covered dependent may be asked additional questions and may have to have a physical exam. The insurance carrier must approve your EOI before coverage under the option you elected will begin. It will be much faster if you complete your Evidence of Insurability (Medical Health History) online! If you submit a paper form, the approval process is much longer, up to 90 days. Completing your Evidence on Insurability online will ensure your application is processed within 30 days.

Frequently Asked Questions about Evidence of Insurability for Applicants

Where do I get the Medical History Statements?

You are encouraged to use The Standard's Electronic Evidence of Insurability system (EEOI), which allows you to submit your application electronically, directly and securely to The Standard.

Please follow this link to The Standard's Electronic Evidence of Insurability system:

http://www.standard.com/mybenefits/mhs_ho.html

The information you are submitting through Standard's site and is protected by encryption technology to ensure your confidentiality. You may also access hardcopy MHS forms through this link:

<http://www.standard.com/forms/ebid/mhsonly/>

If my spouse and/or children are also applying, will they need to submit separate medical history statement(s)?

Yes, if they are applying for coverage that is subject to EOI (please check with your benefits administrator if unsure). Your spouse should complete and sign their own medical history statement.

What can I expect from Medical Underwriting?

Once an application is reviewed, Standard will either approve, decline, or request more information. You will be advised by mail of any request, the process involved, and the date by which the information must be received. Standard's 800 number will be provided in the letter requesting information in the event you have any questions.

How long does the underwriting process take?

It will be much faster if you complete your Evidence of Insurability (Medical Health History) online! If you submit a paper form, the approval process is much longer, up to 90 days. Completing your Evidence on Insurability online will ensure your application is processed within 30 days. Either way, you will need to know the City's Group Policy number. This number is 488980.

How will I know the decision?

You will receive a letter notifying you of the decision. In the event of a declination, you will be told the medical reason(s) for the decision, and be advised of the reconsideration process. The medical reason(s) for the declination will not be shared with anyone but you.

When is approved coverage effective?

Generally, coverage becomes effective the first of the month following your approval.

If my application is declined, do you take my existing coverage away?

No. If some amount of coverage is already in force through a guarantee issue provision or other means, any declination decision will apply only to the portion of coverage that is actually subject to EOI.

What happens if Standard doesn't get the information they need to make a decision?

In this case, your application will be closed due to Lack of Information (LOI). You will be advised that the application is closed, but Standard also let you know that if the needed information is received in a reasonable timeframe, your application will be re-opened. Remember, you can apply for Supplemental Life Insurance at any time. If you did not submit your EOI forms, Standard will not process any requests and the Benefits Office will reset your election before the next Annual Enrollment.

What do I do if I have a question regarding the status or decision on my application?

Call Standard's Medical Underwriting Department at 800-843-7979. They are happy to discuss any questions you might have. If your application was declined and if there is any information you could provide that might lead to a favorable decision, Standard will let you know.

Understanding the Importance of a Beneficiary

Your beneficiary—or beneficiaries—are those people who will receive your benefit if you die. So, let's take a minute to understand how to properly secure your benefits for the welfare of those you love.

You may name one or more individuals, trusts or legal entities as your primary beneficiary to receive your benefit in the event of your death. You may also name one or more individuals, trusts or legal entities as secondary (or "contingent") beneficiaries—the person or persons or entity, named to receive benefits if no primary beneficiary survives you. If you designate multiple primary or secondary beneficiaries, you can decide what percentage of your death benefit will go to each beneficiary. The total percentages for each category (primary and secondary designations) must equal 100%.

For example: If you are married, your spouse would be your primary beneficiary. If you have four siblings, you could choose to designate your siblings as contingent beneficiaries, assigning each of them a 25% share of your total benefit. They would each receive 25% of your life insurance benefit if your spouse was not alive to receive the benefit.

Making or Changing Your Beneficiary Designation

You may designate or change a beneficiary at any time for both basic and supplemental life insurance plans:

1. Log on to www.portlandoregon.gov/benefits
2. Choose the My Benefits option, and then Benefits
3. Scroll down and select Basic or Supplemental Life Insurance
4. Click View/Edit Information

You will need to enter beneficiary designations for each of the plans if you are covered by both basic and supplemental life insurance.

Remember to keep your beneficiary up to date! This is especially important when you experience a life event, such as divorce or marriage. You can make changes at any time online following the steps above.

If You Do Not Designate a Beneficiary

If you do not add a beneficiary online, your beneficiary will default to a “standard designation.” The standard designation directs the life insurance carrier to pay benefits in this order, as described in detail below: spouse, child, parents, siblings, estate—like this:

- The benefit is paid to your spouse at the time of your death. If you are not legally married, then to:
- Your child or children in equal shares. If any of your children are deceased, their portion is equally divided between *their* children who are alive at your death. If all of your children predecease you, their equal shares will be paid to *their* children. If there is no one in this group, then to:
- Your parents in equal shares. If one of them predeceases you, their share is paid to the other parent. If both parents predecease you, then to:
- Your siblings in equal shares. If any one of them predeceases you, their share will be paid to that sibling’s children equally. If all of your siblings predecease you, all of their children will share equally. If there is no one in this group, then:
- Payment will be made to your estate.

The default, “Standard Designation” does not provide automatic payment to your domestic partner. You must complete a beneficiary form online to add your domestic partner as a beneficiary to your benefit.

What’s Not Covered

Contributory life insurance benefits are not paid for suicide (while sane or insane) within two years of your coverage effective date.

If You Become Disabled

Waiver of Premium During Total Disability

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

If You Become Terminally Ill

Sometimes, the financial hardships of dealing with a terminal illness are greater than when dealing with the financial hardships of death. Bills pile up, you are unable to work, but your family's life must still go on.

To help you meet your health care needs and protect you from financial loss, the City offers an accelerated benefit option available to you once during your lifetime.

If you qualify for an accelerated death benefit (you are terminally ill with a prognosis of 12 months to live or less), you may receive up to 75% of your basic life insurance and supplemental life insurance, not to exceed \$300,000. The minimum accelerated benefit is \$5,000 or 10% of your basic life insurance and supplemental life insurance, whichever is greater.

Did You Know?

Accelerated benefits, also known as terminal illness benefits, are intended to qualify for favorable tax treatment under the Internal Revenue Code of 1986. However, tax laws relating to these benefits are very complex. You should consult with a qualified tax advisor before receiving payments under the accelerated benefit provision of your life insurance policy.

When Coverage Ends

Basic life insurance and your supplemental life insurance end automatically on the earliest of the following:

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

Supplemental life insurance for your spouse or domestic partner and supplemental life for dependents end automatically on the earliest of the following:

- The date your supplemental life insurance ends

- The last day of the last period for which you make a premium contribution
- For supplemental life insurance, the date your spouse or domestic partner becomes 75 years of age (or the date you become 75 years of age, if earlier)
- For supplemental life insurance, the date of your divorce or legal separation from your spouse, or the date of termination of your domestic partnership
- For supplemental life for dependents, the date your child ceases to qualify for coverage
- For Supplemental life for dependents, 90 days after the insurance company mails you a request for proof of a child's disabled status, if proof is not given
- For supplemental life for dependents, 5 months after you die (no premiums will be charged for your Dependents Life Insurance during this time)

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

Converting Life Insurance Coverage

You may be able to convert all or part of your life insurance coverage to an individual policy (unless coverage ends for non-payment of premiums) if your City employment ends, your life insurance amount is reduced, or you are no longer eligible to participate in the life insurance plan. You must submit an application within 60 days after your coverage ends. If you, your spouse or domestic partner, or your children die during this 60-day conversion period, the insurance company will pay the benefit amount the insured person *could have* converted.

Retirement and Savings

The City offers a full retirement package in an effort to support your (and your family's) financial health.

Fire & Police Disability & Retirement Fund and Oregon Public Service Retirement Plan

As part of your total compensation, and as a public employee, the City offers PPA Members generous retirement pension benefits through the Fire & Police Disability & Retirement Fund (FPDR). If you were hired before January 1, 2007 (FPDR One and FPDR Two), your retirement benefit is covered by the Fire and Police Disability and Retirement Fund (FPDR). Employees hired after January 1, 2007 (FPDR Three) will be enrolled in the Oregon Public Service Retirement Plan (OPSRP) following six months of employment with the City. OPSRP has two components: the pension program and the Individual Account Program (IAP).

For information about your pension benefits, please call FPDR at **503-823-6823** or call the PERS customer service number at **1-888-320-7377** or **503-598-7377** as appropriate.

457(b) Deferred Compensation Plan

A 457(b) Deferred Compensation Plan is an important retirement plan offered by the City, created to allow public employees, like you, to set aside money from each paycheck toward retirement. A deferred compensation plan can help bridge the gap between what you have in your pension and Social Security, and how much you'll need for retirement, or simply add additional funds to your retirement portfolio.

The City's Deferred Compensation plan (the Plan) is a voluntary plan available to eligible employees that helps you save for retirement on a tax-deferred basis. All amounts of compensation deferred under this Plan are held in trust, in annuity contracts or in custodial accounts, for the exclusive benefit of participants and beneficiaries under the Plan.

The Plan is managed by the Deferred Compensation Advisory Committee, by the Health & Financial Benefits Office within the Bureau of Human Resources. You may contact the Health & Financial Benefits Office at **503-823-6031**.

The City offers options for the 457(b) plan:

- Traditional pre-tax 457(b) deferred compensation plan
- Roth after-tax 457(b) deferred compensation plan

OR

- A combination of the two

Pre-tax or Roth: What's the Difference?

Your choice for retirement depends on your certain situation and savings objectives. The following chart will help you familiarize yourself with the options:

	Traditional Pre-tax 457(b) Plan	Roth After-tax 457(b) Plan
Eligibility	All benefits eligible full-time or part-time employees can participate in the plan. Electronic/paper election forms completed and received by the 15th of each month are effective the first payday of the next month. Online elections can be made with Employee Self Service (ESS) or you may contact the Health & Financial Benefits Office to request a paper form.	
Minimum contribution	1% of pay or \$10 per pay period (\$260/year based on 26 pay periods each year)	
Maximum annual contributions	\$19,500 in 2021* *If you make both pre- and after-tax contributions, this dollar limit applies to your total 457(b) contribution.	
Catch-up contributions	Age 50 and older can elect to save an additional \$6,000	
Three-year catch-up contributions	You are allowed to make up prior-year deferrals (subject to certain rules) during the three consecutive calendar years before your Normal Retirement Age. Please contact the Health & Financial Benefits Office for additional details.	
Investment providers	Voya Financial You can have pre-tax and Roth contributions. Only Voya has investment options you can choose from.	
Investment options	At Voya, you have access to a full portfolio of quality investment choices from a variety of funds (age-based funds, fixed accounts, aggressive fund options, etc.).	
Money going in	Pre-tax contributions are deducted from your salary before any applicable federal and state taxes are taken. Pre-tax contributions are subject to Social Security and Medicare taxes. Pre-tax contributions will reduce your taxable income.	After-tax contributions are subject to federal (and where applicable, state and local) income tax withholding
Earnings, if any	Are tax-deferred until withdrawn	Are tax-free as long as certain qualifying conditions are met
Money coming out	Distributions are taxable as current income when withdrawn	Tax-free distributions, as long as you've satisfied the five-year holding period and are age 59½ or older
Rollovers allowed?	Yes, amounts rolled over from other non-457(b) retirement plans remain subject to the 10% IRS early withdrawal rule	Roth IRAs are not eligible to be rolled into a Roth 457 plan
How do I stop my deferral?	You can make a change (or stop) your deferral amount at any time online, or by calling the Health & Financial Benefits Office for assistance at 503-823-6031 .	

No 10% Early Withdrawal Penalty for Pre-tax Contributions When You Retire or Terminate Employment!

An advantage of the 457(b) plan is that it is **not** subject to the IRS age 59½ withdrawal rule. That means if you retire early you can start withdrawing money from your account before you turn the age of 59½ without paying a 10% penalty to the IRS. Like other pre-tax retirement plans, taxes still apply to the money withdrawn as contributions were made on a pre-tax basis.

Which is Right for You?

After reviewing the chart above, think about how the retirement options offered by the City can meet your needs. Determining which 457(b) Deferred Compensation Plan is right for you depends on your personal situation, your investment goals, and your risk preference. It’s helpful to see how others weigh their options when considering investments. As you review the following examples and learn about your options, think about your own lifestyle and needs.

Meet Person #1

Age: 25
 Marital Status: Single
 Children: None

Person #1 just started working for the City and is excited to get a retirement plan underway. They aren’t worried about the tax deduction at their age and is confident their salary will increase over the years. By the time they are ready to retire, they will be in a higher tax bracket. Here is an overview of their options:

	Traditional Pre-tax 457(b) Plan	Roth After-tax 457(b) Plan
Gross income	\$35,000	\$35,000
Annual salary available to save	\$3,000	\$3,000
Less taxes at 25%	\$0	- \$750
Net yearly contributions	\$3,000	\$2,250
Total over 40 years	\$120,000	\$90,000
Value at retirement	\$478,200	\$358,700
Less taxes at 33%	\$159,500	----
After tax value	\$318,700	\$358,700

Conclusion for Person #1: Based on the savings shown in the chart, *Person #1* might want to consider the Roth after-tax 457(b) Deferred Compensation Plan.

Meet Person #2

Age: 45

Marital Status: Married

Children: 2

Person #2 considers themselves f at their “peak” earning years. They know they won’t make this kind of money with the City forever. However, they have two teenagers that need braces, are going to prom soon and, are just overall expensive. Person #2 doesn’t think they can afford to lose another tax deduction at this point so they aren’t sure participating is right for them. They expect they’ll be in a lower tax bracket when they retire (in the chart, we assume 15%). Here is an overview of her options:

	Traditional Pre-tax 457(b) Plan	Roth After-tax 457(b) Plan
Gross income	\$75,000	\$75,000
Annual salary available to save	\$10,000	\$10,000
Less taxes at 25%	\$0	- \$2,500
Net yearly contributions	\$10,000	\$7,500
Total over 40 years	\$200,000	\$150,000
Value at retirement	\$378,900	\$284,200
Less taxes at 15%	\$56,800	----
After tax value	\$322,100	\$284,200

Conclusion for Person #2: Based on the savings shown in the chart, Person #2 might want to consider the Traditional pre-tax 457(b) Deferred Compensation Plan.

Meet Person #3

Age: 55

Marital Status: Divorced

Children: 1

Person #3 has been working for the City for too many years to count. They like the idea of a tax-free retirement income, but also likes their current tax deduction. They are getting closer to retirement and don’t want to change their retirement nest egg now. But, they are considering the flexibility to optimize their tax strategy year to year as they withdraw their retirement income. Here is an overview of their options:

	Traditional Pre-tax 457(b) Plan	Roth After-tax 457(b) Plan
Gross income	\$60,000	\$60,000
Annual salary available to save	\$6,000	\$6,000
Less taxes at 25%	\$0	- \$1,500
Net yearly contributions	\$6,000	\$4,500
Total over 40 years	\$60,000	\$45,000
Value at retirement	\$81,500	\$61,100
Less taxes at 25%	\$20,400	----
After tax value	\$61,100	\$61,100

Conclusion for Person #3: Based on the savings shown in the chart, Person #3 might want to consider a combination of the Traditional pre-tax and Roth after-tax 457(b) Deferred Compensation Plans.

Traditional, Roth, Maybe Both!

Maybe you, like the examples above, could benefit from a retirement strategy that combines the traditional pre-tax and Roth after-tax 457(b) options. It might be right for you if you:

- Like the idea of tax-free retirement income, but also like the current tax deduction on your pre-tax contributions
- Believe your taxes in retirement will be about the same or are unsure where taxes are headed in the future
- Would like the flexibility to optimize your tax strategy year to year as you withdraw your retirement income

Enroll and Manage Your Account

The City partners Voya Financial - Voya offers varying investment options to give you flexibility over your retirement. Both plans offer automatic payroll deductions so it's easy to contribute each month. After 30 days of employment, you are eligible to enroll. Here are the steps to enroll:

Step 1: Decide How Much You Want to Contribute

Contribution amounts will vary depending on your income now and the income you will need to live an active and eventful retirement. If you need help figuring out what contribution amount makes sense for you, please contact either Voya Financial. Call Voya at **503-937-0378** or toll free **1-800-238-6281** to have their information and enrollment guide mailed to you.

Get One-on-One Support

If investments and determining your retirement path isn't your strong suit, you can have a one-on-one meeting with a Voya representative to go over the materials in person. To schedule a meeting, email Voya at deferredcomp@lewis-stefani.com or visit their online scheduling website at www.booknow.so/CityofPortland.

Step 2: Understand Investing

You may be ready to study and understand how to build your own portfolio or you may want help. The City offers monthly informational sessions downtown. And, Voya offers regular service days at various downtown locations and also as needed at various outlying locations, where they come on site and help you elect your coverage options. The Voya sessions are free to Voya current and future participants.

Step 3: Enroll

- Using a **City Computer** you can enroll using the Employee Self Service (ESS) system available through the [CityLink Employee Portal](#). In ESS you will want to access the Employee Programs tab/Deferred Compensation Enrollment. If you are electing Voya, you will be defaulted into a Target Date Fund depending on your year of birth.. You can then complete a Fillable Beneficiary Form and submit it electronically to the Health & Financial Benefits Office. Or,
- You can use the Voya [EZ Enroll](#) form from located online. You will be defaulted into a Target Date Fund depending on your year of birth. Or,
- You can enroll using the 3 City forms (participation agreement, beneficiary and acknowledgement forms). An additional enrollment needs to be completed for those enrolling with Voya (503) 937-0378). Your completed City forms must be received in the Health & Financial Benefits Office by the 15th of the month to be effective the first paycheck of the following month.

Once you are enrolled, you can make changes to your contribution once each month from a City computer by completing a participation agreement online through Health & Financial Benefits Office at www.portlandoregon.gov/ep.

Step 4: Manage Your Account

It's important to keep an eye on your account to help ensure that your financial future is on track. Use the following tools to help yourself along the way:

- Obtain account information and initiate transactions by visiting:
 - *Voya Financial* at: <https://primebeready2retire.com> or call **503-937-0378** or **1-800-238-6281**
- Visit our educational website: <https://prime.beready2retire.com> then click on Resource Center to access a variety of interactive financial planning tools
- Review your quarterly retirement account statement that is mailed to your home (and can be found online) for detailed account activity
- Employees can sign-up for paperless quarterly statements by logging into their Voya account

Distribution of Benefits

The Internal Revenue Service (IRS) and the City's Plan allow distributions from your account only upon your retirement, employment separation, unforeseeable emergency, Qualified Domestic Relations Order (QDRO), your death, or a voluntary in-service distribution for small account balances.

Retirement/Separation of Employment

The earliest you may start drawing on your account is the day following the date you leave City employment. Your separation from City employment *does not* include the status of "working retiree." You are not required to take a distribution upon retirement or separation of employment; you may choose to defer payments to a later time. You must begin to take distributions from your account by the time you attain age 70-½ if you are not actively employed. For active employees who are 70-½ no distribution is required until you separate employment. You can also make changes (increase, decrease, stop, or start) to your payout schedule as often as you like. The only exception to that rule would be if you had initially selected an annuity payment option.

Unforeseeable Emergency Withdrawal

Sometimes, things happen that we never saw coming! There are provisions within the Deferred Compensation Plan that allow you to apply for an Emergency Withdrawal and seek relief from events beyond your control, including:

- Accident or illness involving you, your spouse, or your dependent (as defined by the IRS)
- Loss of property due to casualty (including damage not otherwise covered by homeowner's insurance)
- Other similar extraordinary and unforeseeable circumstances beyond your control

It is important that you exhaust all other options before you seek an unforeseeable emergency withdrawal. Distributions will be limited to the amount reasonably necessary to satisfy the emergency need, which may include any amounts necessary to pay federal, state, or local income taxes or penalties

anticipated from the distribution. Voya participants must contact Voya at **1-800-584-6001** or the Health & Financial Benefits Office at **503-823-6031** for additional information.

Qualified Domestic Relations Order (QDRO)

If you and your spouse divorce or legally separate, your spouse cannot receive any portion of your account unless the court enters a Domestic Relations Order. The rules are established by the IRS, and any applicable taxes are the responsibility of the divorced/legally separated spouse. The recipient can take an immediate distribution or elect any of the payout options available to participants in the Plan.

Death

Upon your death, the named beneficiary(ies) (or Standard Default Designation) as allowed is entitled to receive the balance of your account. Your beneficiary(ies) may select any payout option allowed by the Plan provided that it meets the Internal Revenue Code minimum required distribution. The IRS may require other distribution rules depending on your age.

Voluntary In-Service Distribution

While you are still working for the City, you may receive a lump sum distribution if you meet all three of the following requirements:

- Your total account balance does not exceed \$5,000; and
- You have not previously received an in-service distribution of the total amount of your account; and
- You have not deferred any salary to the Plan during the two-year period ending on the date of the in-service distribution.

Frequently Asked Questions About the 457(b) Plan

1. **What sets a 457(b) plan apart from other retirement plans?** A 457(b) plan offers benefits that other retirement plans can't, like penalty-free withdrawals once you stop working for the City.
2. **What does tax-deferred mean?** Basically, you don't pay income taxes on your deferred compensation plan contributions or earnings until you retire and/or begin to take payments from your account. This may lower your taxable income now and in retirement. Withdrawals taken in retirement are taxed as regular income.
3. **Who regulates a 457(b) plan?** The Internal Revenue Service created and continues to regulate the plan.

If You Need Help

For more information on investment opportunities with *Voya Financial*, please review the website at <https://prime.bereadytoretire.com> or call **503-937-0378** or **1-800-238-6281**.

How Much Do the Benefits Cost?

2021-22 Benefit Costs and Employee Premium Shares

For *full-time employees*, the City of Portland will pay 95% of the cost of the CityNet medical/VSP vision and Delta Dental Plan of Oregon coverage and you will contribute 5% of the cost for this coverage. This is called your “premium share.” If you elect the Kaiser plan, your premium share will depend on the cost of the Kaiser plans in relation to the cost of the CityNet/VSP/Delta Dental Plan of Oregon plans. If the cost is less than 95% of the CityNet plans, then you will not have a premium share for the Kaiser plans. If the cost is greater than the CityNet plans, then you will pay the difference. The CityHDP High Deductible Medical (with VSP) is paid 100% for full-time employees. You only pay a 5% premium share on the cost of dental coverage.

For *part-time employees*, the City of Portland contributes 50% of your medical/vision and dental premium costs. You will contribute 50% of the cost. This 50% “premium share” will apply to all medical, dental and vision coverage.

Full-time and part-time employees who did not meet the preventive care initiative will pay an additional 5 percentage points premium share for the 2021-22 plan year. Please refer to the Preventive Care Initiative Section of this SPD.

The following table shows the total cost of these benefits and provides employee premium amounts per-pay-period for the current plan year.

Note: Table does not include costs for supplemental life insurance coverage. Costs for this optional benefit is based on your age and is included in the *Cost* section of the supplemental life insurance section.

PPA Full-Time Rates

Cost per pay period	Employee Only	Employee + 1	Family
CityNet, VSP and Delta Dental	\$18.41	\$35.45	\$48.56
CityNet, VSP and Kaiser Dental	\$18.56	\$36.15	\$48.93
CityHDP, VSP and Delta Dental	\$1.44	\$2.48	\$4.41
CityHDP, VSP and Kaiser Dental	\$1.59	\$3.18	\$4.78
Kaiser Medical, Vision, Dental	\$0.00	\$0.00	\$0.00
Kaiser Medical, Vision, Delta Dental	\$0.00	\$0.00	\$0.00
Delta Dental Buy-Up (add this to your total cost)	\$4.44	\$7.69	\$13.66
VSP Buy-Up (add this to your total cost)	\$5.11	\$9.28	\$12.38
Opt-Out Dollars	\$25.00	\$45.00	\$62.50

PPA Part-Time Rates

Cost per pay period	Employee Only	Employee + 1	Family
CityNet, VSP and Delta Dental	\$185.19	\$355.58	\$486.67
CityNet, VSP and Kaiser Dental	\$186.76	\$362.62	\$490.37
CityHDP, VSP and Delta Dental	\$142.13	\$268.73	\$369.20
CityHDP, VSP and Kaiser Dental	\$143.70	\$275.77	\$372.90
Kaiser Medical, Vision, Dental	\$164.12	\$314.84	\$465.56
Kaiser Medical, Vision, Delta Dental	\$162.55	\$307.80	\$461.86
Delta Dental	\$14.35	\$24.80	\$44.06
Kaiser Dental	\$15.92	\$31.84	\$47.76
Delta Dental Buy-Up (add this to your total cost)	\$4.44	\$7.69	\$13.66
VSP Buy-Up (add this to your total cost)	\$5.11	\$9.28	\$12.38
Opt-Out Dollars	\$12.50	\$22.50	\$31.25

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

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

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

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

The taxable value of the domestic partner coverage will depend on the benefit plan and level of coverage in which the employee and domestic partner are enrolled and on the number of enrolled eligible dependents of the employee and/or the number of enrolled eligible dependents of the domestic partner. The City recommends that you consult with your tax adviser to determine your tax liability. Please refer to the tables below to assist in identifying the taxable income

Employee + Domestic Partner	For Employee + 1 coverage, with no other family members covered under the Plan, the taxable value to the employee should be calculated by subtracting the difference of the Employee Only rate from the Employee + 1 rate listed below
Employee + 1 dependent + domestic partner	If the employee has one enrolled eligible dependent child in addition to a domestic partner (with or without children of the domestic partner also included) the taxable value to the employee should be calculated by subtracting the difference of the Employee + 1 rate from the Family rate listed below
Employee + 2 dependents + domestic partner	If the employee has two or more enrolled eligible dependent children in addition to a domestic partner (with or without dependent children of the domestic partner) there is no taxable value to the employee.
Employee + domestic partner + 1 or more domestic partner dependent(s)	If the employee has a domestic partner and one or more dependent children of the domestic partner and the employee does not have other eligible dependents enrolled, the taxable value to the employee should be calculated by subtracting the difference of the Employee + 1 rate from the Family rate listed below.

Monthly Rates for Determining the Domestic Partner Taxable Benefit

Domestic Partner	Employee Only	Employee + 1	Family
CityNet, VSP and Delta Dental	\$670.57	\$1,289.15	\$1,767.07
CityNet, VSP and Kaiser Dental	\$676.54	\$1,315.91	\$1,781.16
CityHDP, VSP and Delta Dental	\$538.87	\$1,021.14	\$1,403.84
CityHDP, VSP and Kaiser Dental	\$544.60	\$1,047.43	\$1,417.20
Kaiser Medical, Vision, Dental	\$664.76	\$1,281.02	\$1,767.07
Kaiser Medical, Vision, Delta Dental	\$658.48	\$1,252.86	\$1,767.07

Monthly Value is the amount of the Bureau Contribution and does not include the value paid by the employee as a premium share.

The first and second pay period of each month the taxable value of the benefit as identified above (on a monthly basis) will be reflected on the employee's paycheck as income for federal tax purposes because the federal government considers these benefits as taxable income. The City will withhold federal tax from the taxable amount of the benefits. The City will also withhold state tax from your paycheck for the cost of the benefits provided to domestic partners not registered in the state of Oregon.

Retirees & COBRA Rates

If you elect to continue your coverage as a retiree or with COBRA coverage, you pay 100% of the premium costs after-tax as follows.

If you do not elect to continue coverage upon retirement, or terminate coverage under City plans prior to age 65, you may only return to the City's medical and dental plans in which you were previously enrolled *IF* you are not Medicare-eligible and you maintain continuous medical and dental group (employer-sponsored) coverage between the time you leave the City plans and the date you want to return. An independent election to dental coverage is not allowed if you maintain other group medical coverage. Written verification from the other employer-sponsored plan will be required.

Total Monthly Cost	Employee Only	Employee + 1	Family
CityNet, VSP Vision*	\$683.37	\$1,323.15	\$1,770.45
CityNet, VSP Buy-Up	\$693.59	\$1,341.71	\$1,795.20
Kaiser Medical, Vision*	\$592.84	\$1,132.02	\$1,671.22
CityHDP, VSP Vision	\$511.15	\$975.74	\$1,300.58
CityHDP, VSP Buy-Up	\$521.37	\$944.30	\$1,325.33
Delta Core Dental Plan	\$57.42	\$99.20	\$176.23
Delta Dental Buy-Up	\$66.30	\$114.57	\$203.55
Kaiser Dental	\$63.70	\$127.36	\$191.06
Kaiser Medicare Senior Advantage Plan	One-Party \$357.54 Two-Party \$661.44		
Kaiser NW Medicare Sr. Advantage Retiree & Kaiser NW Medical Spouse/Dependent	\$896.72		
Kaiser NW Medical Retiree & Kaiser NW Medicare Sr. Advantage Spouse/Dependent	\$896.74		
Employee Assistance Program (EAP)	\$6.40 per month (same for all tiers)		

Important Plan Information

Employer Tax ID No.:	93-6002236
Agent for Legal Process:	City Attorney 1221 SW 4 th Avenue, Room 430 Portland, OR 97204
Funding Process:	Funded through a combination of employee payroll deductions and employer benefit dollar allocations and self-pay contributions.
Type of Administration:	The Plan is administered by the Human Resources/ Health & Financial Benefits Office of the City of Portland.
Plan Administrator:	Benefit Program Manager City of Portland Bureau of Human Resources 1120 SW 5 th Avenue, Room 987 Portland, Oregon 97204

IMPORTANT NOTICE

ACTIVE EMPLOYEES: Any falsification, misrepresentation, misleading statements or omission of the employee when enrolling in these plans may be cause for immediate termination from the City benefit plans and may subject the employee to discipline, including discharge, from City employment, regardless of when or how discovered. If an employee fails to report family status change events within 60 days of the date eligibility would cease, such as divorce or cessation of dependent eligibility requirements, it will be the employee's obligation to reimburse the City of Portland any monies that are paid by a City of Portland Health Plan for claims incurred. If an employee or the employee's dependent fraudulently obtains any health care benefits under the City of Portland Health Plan, the employee and/or dependent will be prosecuted to the full extent of the law.

IMPORTANT NOTE FOR RETIREES:

Any falsification, misrepresentation, misleading statements or omission of the retiree when enrolling in these plans may be cause for immediate termination from the City benefit plans. If a retiree fails to report family status change events within 60 days of the date eligibility would cease, such as divorce or cessation of dependent eligibility requirements, it will be the retiree's obligation to reimburse the City of Portland any monies that are paid by a City of Portland Health Plan for claims incurred. If a retiree or the retiree's dependent fraudulently obtains any health care benefits under the City of Portland Health Plan, the retiree and/or dependent will be prosecuted to the full extent of the law.

The terms within this Benefits handbook are valid on a year-to-year basis. Therefore, the provisions within this document apply to FY 2021-22 only.

This summary is written to provide a reference to your City of Portland benefits. Each component is created by a contract or a plan document, which governs the plan's provisions and administration. Except to the extent that this summary or any of its component plans are governed by federal law, this summary and all of its component plans shall be construed, administered, enforced and governed by and in accordance with the laws of the State of Oregon, where applicable, even if Oregon's choice of laws otherwise would require application of the law of a different jurisdiction. In the case of a dispute regarding your benefits, the contract or plan document will determine your actual benefit. If you would like to read a contract or plan document, please contact the Health & Financial Benefits Office at **503-823-6031**.

Coordination of Benefits (COB)

Did You Know?

Coordination of Benefits (COB) occurs when you have coverage under more than one plan. There are special rules that determine which plan is primary, and who will pay for what. The benefit plans work together to coordinate your care so that, in total, the two plans pay benefits equal to the amount you would have received if the City of Portland's plan had been primary.

The following sections describe the specific details for how benefits will be coordinated under the plans.

CityNet PPO and CityHDP Medical Plan and Delta Dental Plans

The same Coordination of Benefits rules apply to both plans (the CityNet PPO and CityHDP Medical Plan administered by Moda Health, the Delta Dental Plan of Oregon, and the Delta Dental Buy-Up Plan), except where discrepancies are noted.

Definitions

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

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

Plan includes:

- Group or individual insurance contracts and group-type contracts
- HMO (Health Maintenance Organization) coverage
- Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan
- Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
- Other arrangements of insured or self-insured group or group-type coverage
- **For the CityNet and CityHDP Medical Plan only:** Medical care components of group long-term care contracts, such as skilled nursing care;

Plan does not include:

- Hospital indemnity coverage or other fixed indemnity coverage
- Accident-only coverage
- Specified disease or specified accident coverage
- School accident coverage
- Medicare supplement policies
- Medicaid policies
- Coverage under other federal governmental plans, unless permitted by law
- **For the CityNet and CityHDP Medical Plan only:** Benefits for non-medical components of group long-term care policies

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

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

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

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

Claimant means the enrollee for whom the claim is made.

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

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

- The amount of the reduction by the primary plan because a claimant has failed to comply with the plan provisions concerning second surgical opinions or prior authorization of admissions or services, or because the claimant has a lower benefit because that claimant did not use an in-network provider.
- Any amount in excess of the highest reimbursement amount for a specific benefit, if a claimant is covered by two or more plans that compute their benefit payments on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology.
- Any amount in excess of the highest of the negotiated fees, if a person is covered by two or more plans that provide benefits or services on the basis of negotiated fees.
- If a person is covered by one plan that calculates its benefits or services on the basis of usual and customary fees or relative value schedule reimbursement methodology or other similar reimbursement methodology and another plan that provides its benefits or services on the basis of negotiated fees, the primary plan's arrangement shall be the allowable expense for all plans. However, if the provider has contracted with the secondary plan to provide the benefit or service for a specific negotiated fee or payment amount that is different than the primary plan's payment arrangement and if the provider's contract permits, the negotiated fee or payment shall be the allowable expense used by the secondary plan to determine its benefits.
- ***For the CityNet and CityHDP Medical Plan only:***
 - 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.
 - If a plan is advised by a covered person that all plans covering the person are high-deductible health plans and the person intends to contribute to a health savings account established in accordance with Section 223 of the Internal Revenue Code of 1986, the primary high-deductible health plan's deductible is not an allowable expense, except for any health care expense incurred that may not be subject to the deductible as described in Section 223(c)(2)(C).

This Plan is the part of this group contract that provides benefits for health care expenses (*or dental expenses, in the Delta Dental Plan of Oregon and Delta Buy-Up Dental Plan*) 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 health care (*or dental*) benefits is separate from this Plan. A contract may apply one COB provision to certain benefits, coordinating only with similar benefits, and may apply another COB provision to coordinate other benefits.

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

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

How COB Works

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

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

The **Secondary Plan** (the plan(s) that pay(s) benefits after the primary plan) **will reduce the benefits it pays so that payments from all plans do not exceed 100% of the total allowable expense.**

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

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

- If this Plan is primary, it will provide its benefits first.
- If this Plan is secondary and the non-complying plan does not provide its primary payment information within a reasonable time after it is requested to do so, this Plan will assume that the benefits of the non-complying plan are identical to this Plan’s benefits. This Plan will provide its benefits first, but the amount of the benefits payable shall be determined as if this Plan were the secondary plan.
- If the non-complying plan reduces its benefits so that the enrollee receives less in benefits than 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 Moda Health (*Delta Dental Plan of Oregon and the Delta Dental Buy-Up Plan, for the dental plan*) will not pay any more than it would have paid if it had been the

primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the enrollee against the non-complying plan.

Which Plan Pays First?

The *first* of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a plan covers the claimant as other than a dependent, for example—an employee, member, subscriber, or retiree—then that plan will determine its benefits before a plan which covers the person as a dependent.

For the CityNet and City HDP Medical Plan and/or Delta Dental Plans Only: 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 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:
 - o If a court decree states that one of the parents is responsible for the health care 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.
 - o If a court decree states that both parents are responsible for the health care expenses of the child, or that the parents have joint custody without specifying that one parent has responsibility for the health care expenses of the child, the "birthday rule" described above applies.
 - o If there is not a court decree allocating responsibility for the dependent child's health care expenses, the order of benefits is as follows:
 - The plan covering the custodial parent;
 - The plan covering the spouse or partner of the custodial parent;
 - The plan covering the non-custodial parent; and then
 - The plan covering the spouse or partner of the non-custodial parent.

This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

4. **Dependent Child Covered by Individual Other Than Parent.** For a dependent child covered under more than one plan of individuals who are not the parents of the child, the first applicable provision (court decree or no court decree) 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. **Dependent Child Covered by Parent and Spouse.** For a dependent child covered under the plans of both a parent and a spouse/domestic partner, the length of coverage provision below shall determine the order of benefits. If coverage under either or both parents' plans and the spouse's/domestic partner's plan began on the same day, the birthday rule will apply.
6. **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.
7. **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.
8. **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.
9. **None of the Above.** If the preceding rules do not determine the order of benefits, the allowable expenses shall be shared equally between the plans. In addition, this Plan will not pay more than it would have paid had it been the primary plan.

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

Effect on the Benefits of This Plan

When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a plan year are not more than the total allowable expenses. In determining the amount to be paid for any claim, the secondary plan will calculate the benefits it would have paid in the absence of other health care 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 health care coverage.

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

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

Medical: Moda Health'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. Moda Health 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. Moda Health need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Moda Health any facts it needs to apply those rules and determine benefits payable.

Dental: Moda Health's Right to Collect and Release Needed Information

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

Certain facts about dental coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans. Moda Health 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. Moda Health need not tell, or get the consent of, any person to do this. Each person claiming benefits under this Plan must give Moda Health any facts it needs to apply those rules and determine benefits payable.

Facility Correction of Payment

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

Right of Recovery

If the amount of payments made by this Plan is more than it should have paid under this COB provision, this Plan may recover the excess payment from one or more of the persons it has paid or for whom it has paid; or any other person, insurance company, service plan, 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.

Claims and Appeals

Did You Know?

If at any time you disagree with a health plan's decision regarding whether or not a claim should be covered, you have the right to file an appeal. There are time limits for filing appeal, and special rules around who makes the decisions and the timing of those decisions. Each plan handles the appeals process slightly differently—please see the appropriate section below for details about the applicable plan or contact the health plan directly if you have any questions.

Medical

CityNet PPO and CityHDP Medical Plan: Appeals and External Review

If you disagree with the decision to deny a claim, you may appeal the decision. The Plan has a two level formal appeal process. Your appeal must be made within 180 days of the date of the Plan's action on your claim. You may also call the Plan's Medical Customer Service at **503-243-3974** or toll-free at **1-877-337-0649** to discuss the issue, as it may be possible to resolve it without filing a formal appeal.

Definitions

For purposes of this section, the following definitions apply:

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

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

Authorized Representative means an individual who by law or by the consent of a person may act on behalf of the person.

Claim Involving Urgent Care means any claim for medical care or treatment in which the application of the regular time period to review a denial of a pre-service claim could seriously jeopardize a member's life or health or ability to regain maximum function, or, in the opinion of a physician with knowledge of a member's medical condition, would subject the member to severe pain that cannot be adequately managed without the requested care or treatment.

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

Post-service claim means any claim for a benefit under the Plan for care or services that have already been received by a member.

Pre-service claim means any claim for a benefit under the Plan for care or services that require prior authorization.

Utilization Review means a system of reviewing the medical necessity, appropriateness, or quality of medical care services and supplies using specified guidelines, including preadmission certification, the application of practice guidelines, continued stay review, discharge planning, prior authorization of ambulatory procedures, and retrospective review. An adverse benefit determination that the item or service is not medically necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a medical judgment is a utilization review decision.

Time Limit for Submitting Appeals

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

The Review Process

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

The member will be allowed to receive continued coverage of an approved and ongoing course of treatment pending conclusion of the internal appeal process.

Note: The timelines addressed in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise).

First Level Appeals

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service. Otherwise, an appeal must be submitted in writing to Moda Health. If necessary, Customer Service can provide assistance filing an appeal. The member may review the claim file and present evidence and testimony as part of the appeal process, and may appoint a representative to act on his or her behalf.

Appeals related to an urgent care claim will be entitled to expedited review upon request. Expedited reviews will be completed within 72 hours in total for the first and second level appeals combined after receipt of those appeals by Moda Health, not counting the lapse between the first level appeal determination and receipt of the second level appeal by Moda Health. If the member fails to provide sufficient information for Moda Health to make a decision at each appeal level, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision. The member must provide the specified information as soon as possible.

Investigation of a pre-service appeal will be completed, and a notice of resolution will be sent within 15 calendar days. Investigation of a post-service appeal will be completed and a notice of resolution will be sent within 30 calendar days. When an investigation has been completed, Moda Health will notify the

member in writing of the decision, the basis for the decision, and if applicable, information on the right to a second level appeal.

Second Level Appeals

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. The second level appeal must be submitted in writing within 60 days of the date of Moda Health's action on the first level appeal.

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

External Review

If the dispute meets the criteria below, a member may request that it be reviewed by an independent review organization appointed by the Oregon Insurance Division.

- a. The dispute must relate to an adverse determination based on a utilization review decision; whether a course or plan of treatment that a member is undergoing is an active course of treatment for purposes of continuity of care; or cases in which Moda Health fails to meet the internal timeline for review or to the federal requirements for providing related information and notices.
- b. The request for external review must be in writing no more than 180 days after receipt of the final internal adverse benefit determination.
- c. The member must sign a waiver granting the independent review organization access to his or her medical records.
- d. The member must have exhausted the appeal process described in the First Level Appeals and Second Level Appeals sections. However, Moda Health may waive this requirement and have a dispute referred directly to external review with the member's consent. For an urgent care claim or when the dispute concerns a condition for which a member received emergency services and is still hospitalized, a request for external review may be expedited or simultaneous with a request for internal appeal review.
- e. The member shall provide complete and accurate information to the independent review organization in a timely manner.

Moda Health will notify the Oregon Insurance Division of a member's request for external review no later than the second business day after receipt of the request and will pay the cost of the external review. The member may submit additional information to the independent review organization no later than 5 business days after the appointment of the review organization or 24 hours in the case of an expedited review. The independent review organization will complete their review within:

- a. 3 days for expedited reviews (notification is immediate)
- b. 30 days when not expedited (notification is within 5 days)
- c. The decision of the independent review organization is binding except to the extent other remedies are available to the member under state or federal law. If Moda Health fails to comply with the decision, the member may initiate a suit against Moda Health.

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

Additional Member Rights

Members have the right to file a complaint or seek other assistance from the Division of Financial Regulation.

Phone: 503-947-7984 or toll-free 888-877-4894
Mail: Division of Financial Regulation
P.O. Box 14480
Salem, Oregon 97309-0405
Internet: www.cbs.state.or.us/ins/consumer/consumer.html
email: cp.ins@state.or.us

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

Complaints

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

- a. Availability, delivery or quality of a health care service
- b. Claims payment, handling or reimbursement for health care services that is not disputing an adverse benefit determination
- c. Matters pertaining to the contractual relationship between a member and Moda Health.

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

Kaiser HMO Medical Plan – Claims and Appeals

For information about the process Kaiser follows for claims and appeals, please see the *Grievances, Claims, Appeals, and External Review* section of this SPD, or contact Kaiser directly.

Definitions

For purposes of this section, the following definitions apply:

Adverse Benefit Determination means a written notice from Moda Health, in the form of a letter or an Explanation of Benefits (EOB), of any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for a benefit, including one based on a determination of a member's eligibility to participate in the Plan and one resulting from the application of any utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted dental practice for the prevention or treatment of oral disease or accidental injury.

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

Utilization Review means a system of reviewing the dental necessity, appropriateness, or quality of dental care services and supplies using specific guidelines, including certification, the application of practice guidelines, and retrospective review. An adverse benefit determination that the item or service is not dentally necessary or appropriate, is investigational or experimental, or in which the decision as to whether a benefit is covered involved a dental judgment is a utilization review decision.

Time Limit for Submitting Appeals

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

The Review Process

The Plan has a 2-level internal review process consisting of a first level appeal and a second level appeal. Moda Health's response time to an appeal is based on the nature of the claim as described below.

The timelines addressed in the sections below do not apply when the member does not reasonably cooperate, or circumstances beyond the control of either party prevents that party from complying with the standards set (but only if the party who is unable to comply gives notice of the specific circumstances to the other party when the circumstances arise).

First Level Appeals

Before filing an appeal, it may be possible to resolve a dispute with a phone call to Customer Service. Otherwise, an appeal must be submitted in writing. If necessary, Customer Service can provide assistance filing an appeal. Written comments, documents, records, and other information relating to the claim for benefits may be submitted. Upon request and free of charge, the member may have reasonable access to, and copies of, all documents, records, and other information relevant to the claim for benefits. Moda Health will acknowledge receipt of the written appeal within 7 days and conduct an investigation by persons who were not previously involved in the original determination. The investigation will be completed within 30 days of receipt of the appeal.

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

When an investigation has been completed, Moda Health will send a written notice of the decision to the member, including the basis for the decision. If applicable, the notice will include information on the right to a second level appeal.

Second Level Appeal

A member who disagrees with the decision regarding the first level appeal may request a review of the decision. A second level appeal must be submitted in writing within 60 days of the date of Moda Health's action on the first level appeal. Investigations and responses to a second level appeal will be by persons

who were not involved in the initial determinations. The member will have the option to submit written comments, documents, records and other information related to the case that were not previously submitted.

Investigations and responses to a second level appeal will follow the same timelines outlined in the First Level Appeals section. Moda Health will notify the member in writing of the decision, including the basis for the decision.

Kaiser Dental Plan

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

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

Important Notices

What Is Included?

In the following section, you will find these important notices that describe your rights and protections. Included are:

- Patient Protection Act
- Health Insurance Portability and Accountability Act (HIPAA) Notice of Privacy Rights
- Medicare Part D – Notice of Creditable Coverage
- Newborns' and Mothers' Health Protection Act
- Women's Health and Cancer Rights Act
- Children's Health Insurance Program (CHIP)

Patient Protection Act

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

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

Enrollees have the right to:

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

Members have the responsibility to:

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

Members may call the Moda Health's Customer Department for questions about these rights and responsibilities.

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

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

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

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

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

You can file an appeal by contacting Moda Health's Customer Service or by writing a letter to Moda Health (P.O. Box 40384, Portland, Oregon 97240). See the booklet section titled "Appeals" for complete information. You may also contact the Oregon Insurance Division:

By phone: **503-947-7984** or **1-888-877-4894**
By mail: Division of Financial Regulation
P.O. Box 14480
Salem, Oregon 97309-0405
By internet: www.cbs.state.or.us/ins/consumer/consumer.html
By email: cp.ins@state.or.us

5. What are Moda Health's prior authorization and utilization review criteria?

Prior authorization is the process Moda Health uses to determine whether a service is covered under the Plan (including whether it is medically necessary) prior to the service being rendered. Members may contact Moda Health's Customer Service Department, visit myModa, or review the CityNet **and CityHDP**

prior authorization section in this booklet to request information on the list of services that require prior authorization. Many types of treatment may be available for certain conditions; the prior authorization process helps determine which treatment is covered under the Plan.

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

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

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

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

Moda Health protects your information in several ways:

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

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

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

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

Moda Health
601 S.W. Second Avenue
Portland, Oregon 97204
www.modahealth.com

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

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

9. What additional information can I get upon request?

The following documents are available by calling Moda Health's Customer Service:

- A copy of Moda Health's annual report on complaints and appeals
- A description of Moda Health's efforts to monitor and improve the quality of health services
- Information about procedures for credentialing network providers and how to obtain the names, qualifications, and titles of the providers responsible for a member's care

- Information about Moda Health's prior authorization and utilization review procedures

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

The following information regarding the Moda Health benefit plans is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys
- A summary of Moda Health's health promotion and disease prevention activities
- An annual summary of appeals
- An annual summary of utilization review policies
- An annual summary of quality assessment activities
- An annual summary of scope of network and accessibility of services

Contact:

Oregon Insurance Division

P.O. Box 14480

Salem, Oregon 97309-0405

503-947-7984 or toll-free at 1-888-877-4894

HIPAA and Plan Information

HIPAA NOTICE OF PRIVACY PRACTICES

Health Insurance Portability and Accountability Act (HIPAA)

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

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

Effective September 23, 2013

INTRODUCTION

The Plan has a health care component (the “Health Plan”) subject to HIPAA. The Health Plan includes medical (including prescription coverage), dental, vision, and certain employee assistance programs. This Notice of Privacy Practices (“Notice”) is required by HIPAA.

If you are enrolled in any of the Health Plan’s insured coverage options, you may receive a separate privacy notice from your insurer or HMO. The privacy of your personal health information (“PHI”) that is created, used, or disclosed by the Health Plan is protected by HIPAA. By law, the Health Plan is required to:

- Maintain the privacy of your protected health information;
- Provide you with this Notice of the Health Plan’s legal duties and privacy practices with respect to your protected health information;
- Notify you if there is a breach of your unsecured protected health information; and
- Abide by the terms of this Notice

Protected health information is information that identifies you and either relates to your physical or mental health condition, the provisions of health care, or relates to the payment of your health care expenses health information and is created, received, or maintained by the Health Plan. However, protected health information does not include all health information that may be maintained by the City or its benefit plans. For example, protected health information does not include health information that is used or maintained by the City’s non-health benefit plans, such as life insurance. Protected health information also does not include any health information that was obtained by the City in its capacity as an employer (e.g., through an FMLA or leave of absence request). If health information is not protected health information, then the health information is not protected by HIPAA and is not covered by this Notice.

The City and the Health Plan understand that your protected health information is personal and private, and both are committed to maintaining the privacy of your protected health information. This Notice summarizes the Health Plan’s and City’s privacy practices and those of any third party that assists in the administration of the Health Plan. In particular, this notice describes how the Health Plan may use or disclose your protected health information. It also describes the Health Plan’s obligations to you and your

individual rights regarding the use and disclosure of your protected health information. Please review it carefully.

The Health Plan reserves the right to change, at any time, its privacy practices and the terms of this notice and to make the new notice effective for all protected health information. Once revised, information about any material revision (or a revised copy of the Notice) will be delivered to you, within 60 days of the revision and the notice will be posted on the City's Web site at <http://www.portlandoregon.gov/bhr/26588>. You may also request the new notice be mailed to you.

HOW THE CITY USES OR SHARES INFORMATION

The City acquires limited protected health information about you in order to enroll, maintain, change and terminate your participation in the Plans. Those in the City performing these functions include City payroll employees in your bureau, employees in the Bureau of Technology Services (BTS), and employees assigned to the Health & Financial Benefits Office in the Bureau of Human Resources. They will obtain the following information from you to perform these functions: The names, dates of birth, addresses, phone numbers, social security numbers, and employment data with the City, enrollment in other medical benefit plans if any, of yourself and any dependents and/or domestic partners that participate in the Plans. Other authorized City employees may also use this information to conduct quality assessment and improvement activities, other activities relating to the creation, renewal or replacement of health benefits and budget creation and analysis.

The City may also acquire information from the Plans that has been de-identified – that is medical information that cannot be linked to any individual participant, for purposes of utilization review, cost studies, and review of appeals decisions made by the Health Plan with respect to any Plan benefit.

HOW THE HEALTH PLAN USES AND SHARES INFORMATION

The Health Plan use protected health information and may share it with others as part of your treatment, payment for treatment, and Plan operations. The following are ways the Health Plan may use or share information about you:

- The Health Plan will use the information to administer your plan benefits and help pay your medical bills that have been submitted to the Health Plan by doctors and hospitals for payment
- The Health Plan may share your information with your doctors or hospitals to help them provide medical care to you. For example, if you are in the hospital, the Health Plan may provide access to any medical records sent to the Health Plan by your doctor.
- The Health Plan may use or share your information with others to help manage your health care. For example, the Health Plan might talk to your doctor to suggest a disease management or wellness program that could help improve your health.
- The Health Plan may share your information with individuals who perform business functions for the City. The City will only share your information if there is a business need to do so and if our business partner agrees to protect the information, in accordance with this privacy notice.
- The Health Plan may give you information about treatments and programs or about health related products and services that may be to your benefit. For example, the Health Plan sometimes send out letters to notify you about chronic conditions, tobacco cessation or nutrition programs.
- The Health Plan may use and disclose your protected health information for administration and operations, including quality assessment and quality improvement activities; underwriting (excluding any protected health information that is genetic information), premium rating and other activities relating to the creation, renewal or replacement of a health insurance or health benefits contract or a stop-loss or excess-loss insurance contract; conducting or arranging for medical assessments, legal services and auditing functions (including fraud and abuse detection and

compliance programs), and other general administrative activities such as customer service and HIPAA compliance. For example, the Health Plan may disclose your health information to potential health insurance carriers in order to obtain a premium bid from the carrier.

There are other situations in which the Health Plan may disclose your protected health information without your authorization.

- The Health Plan may disclose your protected health information to you or your personal representative
- The Health Plan may disclose protected health information to a close friend or family member involved in or who helps pay for your health care. The Health Plan may also advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death, unless other laws would prohibit such disclosures. If you are present or otherwise available before the use or disclosure, the Health Plan may make the use or disclosure if the Health Plan obtains your agreement; provides you with an opportunity to object and you do not object; or reasonably infers from the circumstances, through the exercise of professional judgment, that you do not object. If you are not present or the opportunity to agree or object to the use or disclosure of your protected health information is not practical due to your incapacity or an emergency situation, the Health Plan may, through the exercise of professional judgment, determine whether the disclosure is in your best interest. Any disclosure made under these circumstances will be limited to the protected health information which is directly related to the person's involvement with your care or payment for your health care or need for notification.
- The Health Plan, or an insurer of benefits provided under the Health Plan, may disclose your protected health information without your written authorization to designated personnel at your employer for plan administration purposes. The employer agrees not to use or disclose your health information other than as permitted or required by the plan document(s) for the Health Plan and by applicable law. In particular, your health information that is protected health information will not be used for employment decisions.
- Certain services are provided to the Health Plan by third-party administrators known as "business associates." For example, the Health Plan may place information about your health care treatment into an electronic claims processing system maintained by a business associate so that your claim may be paid. In so doing, the Health Plan will disclose your protected health information to its business associates so that the business associates can perform their claims payment functions. However, the Health Plan will require its business associates, through written agreements, to appropriately safeguard your health information.

There are also state and federal laws that may require the Health Plan to release your health information to others. The Health Plan may be required by law to provide information to others for the following reasons:

- The Health Plan may have to give information to law enforcement agencies. For example, the Health Plan is required to report when child abuse or neglect or domestic violence is reasonably believed to have occurred.
- The Health Plan may be required by a court or administrative agency to provide information because of a search warrant or subpoena

- The Health Plan may report health information to public health agencies to report births or deaths or if the Health Plan believes there is a serious health or safety threat
- The Health Plan may report health information on job-related injuries because of requirements of state or other workers' compensation laws
- The Health Plan may report information to the Food and Drug Administration. This agency is responsible for investigating or tracking prescription medications and medical device problems.
- The Health Plan may have to report information to state and federal agencies that regulate the City, such as the U.S. Department of Health and Human Services to enable the Secretary to investigate and determine the Health Plan's compliance with HIPAA.
- The Health Plan may disclose your protected health information to a coroner or medical examiner for identification purposes, for determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. The Health Plan may also disclose protected health information to a funeral director, as necessary to allow the funeral director to carry out his or her duties.
- If you are an organ donor, the Health Plan may disclose your protected health information as necessary to facilitate organ or tissue donation, including transplantation
- The Health Plan may disclose your protected health information to researchers without your authorization if their research has been approved by an institutional review board or privacy board that has reviewed the research proposal and established protocols to ensure the privacy of your protected health information and the researchers have provided certain necessary representations regarding the research.
- When the appropriate conditions apply and if you are a member of the Armed Forces, the Health Plan may disclose your protected health information (1) for activities deemed necessary by appropriate military command authorities, (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to a foreign military authority if you are a member of that foreign military service. The Health Plan may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities for the conduct of lawful intelligence, counter-intelligence and national security activities. The Health Plan may also disclose protected health information to authorized federal officials for the provision of protective services to the President or others that are authorized by law.
- If you are an inmate of a correctional institution or in the custody of a law enforcement official, the Health Plan may disclose your protected health information to the institution or official if the information is necessary for (1) the provision of health care to you, (2) your health and safety or the health and safety of other inmates, the officers, employees, or others at the correctional institution, (3) law enforcement on the premises of the correctional institution, or (4) the safety and security of the correctional institution.
- The Health Plan may disclose your protected health information, in certain situations, to law enforcement officials, including: (1) when directed by a court order, subpoena, warrant, summons or similar process; (2) if necessary to identify or locate a suspect, fugitive, material witness or missing person; and (3) if necessary to report information about the victim of a crime in limited circumstances where the victim is unable to provide consent.
- The Health Plan will disclose your protected health information where required to do so by federal, state or local law

If the Health Plan uses or discloses your information for any reasons **other than the above**, your written authorization will be obtained first. The Health Plan is required to obtain your written authorization as a condition for:

- Any use or disclosure of your protected health information for marketing purposes, except if the communication is in the form of face-to-face communications with you or a promotional gift of nominal value;
- Any use or disclosure of your protected health information that is in the form of a sale of protected health information; or
- Any use or disclosure of psychotherapy notes, except to carry out certain treatment, payment or health care operations, or as otherwise required by law

If you give the Health Plan written permission and change your mind, you may revoke your written authorization at any time. The Health Plan will honor the revocation except to the extent that the Health Plan has already relied on your authorization.

Note: If the Health Plan discloses information as a result of your written authorization, it may be re-disclosed by the receiving party and may no longer be protected by state and federal privacy rules. However, federal or state law may restrict re-disclosure of additional information such as HIV/AIDS information, mental health information, genetic information and drug/alcohol diagnosis, treatment, or referral information.

What Are Your Rights

You have certain rights with respect to your protected health information. These include:

- **You have the right to ask the Health Plan to restrict** how your information is used or disclosed for treatment, payment, or health care operations. You also have the right to ask the Health Plan to restrict information provided to persons involved in your care. While the Health Plan may honor your request for restrictions, *they are not required to agree* to these restrictions.
- **You have the right to submit special instructions** to the Health Plan regarding how information is sent to you that contains protected health information. For example, you may request that your information be sent by a specific means (for example, U.S. mail only) or to a specific address. The Health Plan will accommodate reasonable requests by you as explained above. The Health Plan may require that you make your request in writing.
- **You have the right to inspect and obtain a copy** of information that the Health Plan maintain about you in a designated record set. *However*, you may not be permitted to inspect or obtain a copy of information that is:
 - Contained in psychotherapy notes;
 - Compiled in reasonable anticipation of, or for use in a civil, criminal, or administrative action or proceeding; and
 - Subject to the Clinical Laboratory Improvements Amendments of 1988, 42 U.S.C. 263a, to the extent the provisions of access to the individual would be prohibited by law or exempt from the Clinical Laboratory Improvements Amendments of 1988, pursuant to 42 CFR 493.3(a)(2)
- **You also have the right to request that a copy of your protected health information that the Health Plan maintains electronically be provided to you** in a specified electronic form and format. If the requested electronic form and format is not readily producible, the Health Plan will

provide the copy in a readable electronic form and format to which you agree. You may request an electronic copy of your health information if it is maintained in an electronic health record. You may also request that such electronic health information be sent to another entity or person, so long as that request is clear, conspicuous and specific. Any charge that is assessed to you for these copies, if any must be reasonable and based on the Health Plan's cost.

Additionally, in certain situations the Health Plan may deny your request to inspect or obtain a copy of your information. If the Health Plan denies your request, the Health Plan will notify you in writing. Any denial will explain your right to have the denial reviewed.

The Health Plan may require that your request be made in writing. The Health Plan will respond to your request no later than 30 days after it is received. If the information you request is not maintained or accessible to the Health Plan on-site, the Health Plans will respond to your request no later than 60 days after it is received. If additional time is needed, the Health Plan will inform you of the reasons for the delay and the date that the Health Plan's action on your request will be completed.

If you request a copy, a reasonable fee based on copying and postage costs will be required. You may request a copy of the portion of your enrollment and claim record related to an appeal free of charge.

- ***You have the right to ask the Health Plan to amend*** information maintained about you in a designated record set. The Health Plan will require that your request be in writing and that you provide a reason for your request. The Health Plan will respond to your request no later than 60 days after it is received. If a response cannot be made within 60 days, the time may be extended by no more than an additional 30 days. If additional time is needed you will be notified of the delay and the date by which action on your request will be completed.

If an amendment is made you will be notified that it was made, and the Health Plan will obtain your authorization to notify the relevant persons you have identified with whom the amendment needs to be shared. The Health Plan will notify these persons, including their business associates, if any, of the amendment.

If your request to amend is denied, you will be notified in writing of the reasons for the denial. The denial will explain your right to file a written statement of disagreement. The Health Plan has a right to rebut your statement. However, you have the right to request that your written request, the Health Plan's written denial, and your statement of disagreement be included with your information for any future disclosures.

- ***You have the right to receive an accounting*** of certain disclosures of your information made by the Health Plan during the six years prior to your request. The accounting may not include certain disclosures, including:
 - For treatment, payment, and health care operations purposes;
 - Made for you;
 - Made in connection with a use or disclosure otherwise permitted;
 - Made pursuant to your authorization;
 - For a facility's directory or to persons involved in your care or other notification purposes;
 - For national security or intelligence purposes;
 - To correctional institutions, law enforcement officials; or
 - Made as part of a limited data set for research, public health, or health care operations purposes

Additionally, if the Health Plan discloses your information for research purposes pursuant to an authorization, the Health Plan may not account for each disclosure of your information. Instead, the

Health Plan will provide for you: (1) the name of the research protocol or activity; (2) a description of the research protocol or activity including the purpose for the research and the criteria for selecting particular records; (3) a description of the type of Protected Health Information that was disclosed; (4) the date or period of time when such disclosure occurred; and (5) the name, address, and telephone number of the entity that sponsored the research and researcher to whom the information was disclosed.

The Health Plan will act on your request for an accounting within 60 days. Additional time may be needed to act on your request, and may therefore take up to an additional 30 days. Your first accounting will be free, and you will be entitled to one free accounting upon request every 12 months. However, if you request an additional accounting within 12 months of receiving a free accounting, you will be charged a fee. You will be informed of the fee in advance and you will be provided with an opportunity to withdraw or modify your request.

Exercising Your Rights

You have a right to receive a paper copy of this notice upon request at any time. You can also view a copy of the notice on our Web site at <http://www.portlandoregon.gov/bhr/26588>.

If you have any questions about this notice or privacy practices of the City or the Health Plan, please contact the HIPAA Program Coordinator at **503-823-3506**. Our office is open Monday through Friday from 8 a.m. to 5 p.m.

If you believe your privacy rights have been violated by the Health Plan you may file a complaint with the City by writing the City at the address as follows:

Cathy L. Bless
City of Portland Privacy Officer
Bureau of Human Resources
City of Portland, Oregon
1120 SW 5th Avenue, Room 987
Portland, Oregon 97204
Phone: **503-823-3572**
Fax: 503-823-3522
Email: Cathy.Bless@portlandoregon.gov

You may also notify the Office of Civil Rights, U.S. Department of Health and Human Services of your complaint. The City cannot and will not take any action against you for filing a complaint. You may contact the Office of Civil Rights at

Office for Civil Rights
U.S. Department of Health and Human Services
Room 509F, HHH Building
200 Independence Avenue, S.W.
Washington, DC 20201
OCR Hotlines-Voice: **1-800-368-1019**
Ocrmail@hhs.gov

The complaint should generally be filed within 180 days of when the act or omission complained of occurred.

Prescription Coverage and Medicare

Important Notice From the City of Portland About Your Prescription Medication Coverage and Medicare

Please read this notice carefully and keep it where you can find it. This notice has information about your current prescription medication coverage with the City of Portland and about your options under Medicare's prescription medication coverage. This information can help you decide whether or not you want to join a Medicare medication plan. If you are considering joining, you should compare your current coverage, including which medications are covered at what cost, with the coverage and costs of the plans offering Medicare prescription medication coverage in your area. Information about where you can get help to make decisions about your prescription medication coverage is at the end of this notice.

There are two important things you need to know about your current coverage and Medicare's prescription medication coverage:

1. Medicare prescription medication coverage became available in 2006 to everyone with Medicare. You can get this coverage if you join a Medicare Prescription Medication Plan or join a Medicare Advantage Plan (like an HMO or PPO) that offers prescription medication coverage. All Medicare medication plans provide at least a standard level of coverage set by Medicare. Some plans may also offer more coverage for a higher monthly premium.
2. The City of Portland has determined that the prescription medication coverage offered by the CityNet CityHDP and Kaiser Plans is, on average for all plan participants, expected to pay out as much as standard Medicare prescription medication coverage pays and is therefore considered Creditable Coverage. Because your existing coverage is Creditable Coverage, you can keep this coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare medication plan.

When Can You Join a Medicare Medication Plan?

You can join a Medicare medication plan when you first become eligible for Medicare and each year from October 15 through December 7.

However, if you lose your current creditable prescription medication coverage, through no fault of your own, you will also be eligible for a two-month Special Enrollment Period (SEP) to join a Medicare medication plan.

What Happens to Your Current Coverage if You Decide to Join a Medicare Medication Plan?

If you decide to join a Medicare medication plan, your current City of Portland coverage will not be affected. The City of Portland plan's coverage will be primary and pay before Medicare.

For retirees and spouses of retirees: if you do decide to join a Medicare medication plan and drop your current City of Portland coverage, be aware that you and your dependents will not be able to get this coverage back.

For active employees and spouses of active employees: if you do decide to join a Medicare drug plan and drop your current City of Portland coverage, be aware that you and your dependents will not be able to get this coverage back until the next open enrollment period (unless you experience a qualified family status change).

When Will You Pay A Higher Premium (Penalty) to Join a Medicare Medication Plan?

You should also know that if you drop or lose your current coverage with the City of Portland and don't

join a Medicare medication plan within 63 continuous days after your current coverage ends, you may pay a higher premium (a penalty) to join a Medicare medication plan later.

If you go 63 continuous days or longer without creditable prescription medication coverage, your monthly premium may go up by at least 1% of the Medicare base beneficiary premium per month for every month that you did not have that coverage. For example, if you go 19 months without creditable coverage, your premium may consistently be at least 19% higher than the Medicare base beneficiary premium. You may have to pay this higher premium (a penalty) as long as you have Medicare prescription medication coverage. In addition, you may have to wait until the following October to join.

For More Information About This Notice or Your Current Prescription Medication Coverage

Contact the Health & Financial Benefits Office at **503-823-6031** for further information.

Note: You'll get this notice each year. You will also get it before the next period you can join a Medicare medication plan, and if this coverage through the City of Portland changes. You also may request a copy of this notice at any time.

For More Information About Your Options Under Medicare Prescription Medication Coverage

More detailed information about Medicare plans that offer prescription medication coverage is in the "Medicare & You" handbook. You'll get a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare medication plans.

For more information about Medicare prescription medication coverage:

- Visit www.medicare.gov
- Call your State Health Insurance Assistance Program (see the inside back cover of your copy of the "Medicare & You" handbook for their telephone number) for personalized help
- Call **1-800-MEDICARE** (1-800-633-4227). TTY users should call **1-877-486-2048**.

If you have limited income and resources, extra help paying for Medicare prescription medication coverage is available. For information about this extra help, visit Social Security on the web at www.socialsecurity.gov, or call them at **1-800-772-1213** (TTY 1-800-325-0778).

Remember: Keep this Creditable Coverage notice. If you decide to join one of the Medicare medication plans, you may be required to provide a copy of this notice when you join to show whether or not you have maintained creditable coverage and, therefore, whether or not you are required to pay a higher premium (a penalty).

Date:	July 1, 2021
Name of Entity/Sender:	City of Portland
Contact--Position/Office:	Health & Financial Benefits Office
Address:	1120 SW Fifth Ave., Room 987
Phone Number:	503-823-6031

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

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

Federal Women's Health and Cancer Rights Act of 1998

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

Women's Health Act Frequently Asked Questions

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

Premium Assistance Under Medicaid and the Children’s Health Insurance Program (CHIP)

If you or your children are eligible for Medicaid or CHIP and you’re eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren’t eligible for Medicaid or CHIP, you won’t be eligible for these premium assistance programs but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial **1-877-KIDS NOW** or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren’t already enrolled. This is called a “special enrollment” opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call **1-866-444-EBSA (3272)**.

If you live in one of the following states, you may be eligible for assistance paying your employer health plan premiums. The following list of states is current as of January 31, 2017. Contact your State for more information on eligibility –

ALABAMA – Medicaid	GEORGIA – Medicaid
Website: http://myalhipp.com/ Phone: 1-855-692-5447	Website: http://dch.georgia.gov/medicaid - Click on Health Insurance Premium Payment (HIPP) Phone: 404-656-4507
ALASKA – Medicaid	INDIANA – Medicaid
Website: http://health.hss.state.ak.us/dpa/programs/medicaid/ Phone (Outside of Anchorage): 1-888-318-8890 Phone (Anchorage): 907-269-6529	Healthy Indiana Plan for low-income adults 19-64 Website: http://www.hip.in.gov Phone: 1-877-438-4479 All other Medicaid Website: http://www.indianamedicaid.com Phone 1-800-403-0864
COLORADO – Medicaid	IOWA – Medicaid
Medicaid Website: http://www.colorado.gov/hcpf Medicaid Customer Contact Center: 1-800-221-3943	Website: http://www.dhs.state.ia.us/hipp/ Phone: 1-888-346-9562
FLORIDA – Medicaid	KANSAS – Medicaid
Website: http://flmedicaidplrecovery.com/hipp/ Phone: 1-877-357-3268	Website: http://www.kdheks.gov/hcf/ Phone: 1-785-296-3512

KENTUCKY – Medicaid	NEW HAMPSHIRE – Medicaid
Website: http://chfs.ky.gov/dms/default.htm Phone: 1-800-635-2570	Website: http://www.dhhs.nh.gov/oii/documents/hippapp.pdf Phone: 603-271-5218
LOUISIANA – Medicaid	NEW JERSEY – Medicaid and CHIP
Website: http://dhh.louisiana.gov/index.cfm/subhome/1/n/331 Phone: 1-888-695-2447	Medicaid Website: http://www.state.nj.us/humanservices/dmahs/clients/medicaid/ Medicaid Phone: 609-631-2392 CHIP Website: http://www.njfamilycare.org/index.html CHIP Phone: 1-800-701-0710
MAINE – Medicaid	NEW YORK – Medicaid
Website: http://www.maine.gov/dhhs/ofi/public-assistance/index.html Phone: 1-800-442-6003 TTY: Maine relay 711	Website: http://www.nyhealth.gov/health_care/medicaid/ Phone: 1-800-541-2831
MASSACHUSETTS – Medicaid and CHIP	NORTH CAROLINA – Medicaid
Website: http://www.mass.gov/MassHealth Phone: 1-800-462-1120	Website: http://www.ncdhhs.gov/dma Phone: 919-855-4100
MINNESOTA – Medicaid	NORTH DAKOTA – Medicaid
Website: http://mn.gov/dhs/ma/ Phone: 1-800-657-3739	Website: http://www.nd.gov/dhs/services/medicalserv/medicaid/ Phone: 1-844-854-4825
MISSOURI – Medicaid	OKLAHOMA – Medicaid and CHIP
Website: http://www.dss.mo.gov/mhd/participants/pages/hipp.htm Phone: 573-751-2005	Website: http://www.insureoklahoma.org Phone: 1-888-365-3742
MONTANA – Medicaid	OREGON – Medicaid
Website: http://dphhs.mt.gov/MontanaHealthcarePrograms/HIPP Phone: 1-800-694-3084	Website: http://www.oregonhealthykids.gov http://www.hijossaludablesoregon.gov Phone: 1-800-699-9075
NEBRASKA – Medicaid	PENNSYLVANIA – Medicaid
Website: http://dhhs.ne.gov/Children_Family_Services/AccessNebraska/Pages/accessnebraska_index.aspx Phone: 1-855-632-7633	Website: http://www.dhs.pa.gov/hipp Phone: 1-800-692-7462

NEVADA – Medicaid	RHODE ISLAND – Medicaid
Medicaid Website: http://dwss.nv.gov/ Medicaid Phone: 1-800-992-0900	Website: http://www.eohhs.ri.gov/ Phone: 401-462-5300
SOUTH CAROLINA – Medicaid	VIRGINIA – Medicaid and CHIP
Website: http://www.scdhhs.gov Phone: 1-888-549-0820	Medicaid Website: http://www.coverva.org/programs_premium_assistance.cfm Medicaid Phone: 1-800-432-5924 CHIP Website: http://www.coverva.org/programs_premium_assistance.cfm CHIP Phone: 1-855-242-8282
SOUTH DAKOTA - Medicaid	WASHINGTON – Medicaid
Website: http://dss.sd.gov Phone: 1-888-828-0059	Website: http://www.hca.wa.gov/medicaid/premiumpymt/pages/index.aspx Phone: 1-800-562-3022 ext. 15473
TEXAS – Medicaid	WEST VIRGINIA – Medicaid
Website: http://gethipptexas.com/ Phone: 1-800-440-0493	Website: http://www.dhhr.wv.gov/bms/Medicaid%20Expansion/Pages/default.aspx Phone: 1-877-598-5820, HMS Third Party Liability
UTAH – Medicaid and CHIP	WISCONSIN – Medicaid and CHIP
Website: Medicaid: http://health.utah.gov/medicaid CHIP: http://health.utah.gov/chip Phone: 1-877-543-7669	Website: https://www.dhs.wisconsin.gov/publications/p1/p10095.pdf Phone: 1-800-362-3002
VERMONT– Medicaid	WYOMING – Medicaid
Website: http://www.greenmountaincare.org/ Phone: 1-800-250-8427	Website: https://wyequalitycare.acs-inc.com/ Phone: 307-777-7531

To see if any other states have added a premium assistance program since January 31, 2017, or for more information on special enrollment rights, contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Menu Option 4, Ext. 61565

City of Portland

Health & Financial Benefits

1120 SW 5th Ave. Room 987

Portland, OR 97204

503-823-6031

portlandoregon.gov/bn

Interoffice: 106/987

Text “city benefits” to 31996 to join our text club



City of Portland
Bureau of

Human Resources

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