City of Portland, Oregon

FIRE AND POLICE DISABILITY, RETIREMENT

AND DEATH BENEFIT PLAN

Administrative Rules

FPDR TWO AND THREE BENEFITS

SECTION 5.9 – MEDICAL BENEFITS

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5.9.01 – DEFINITIONS

"Aggravation." The term "Aggravation" means a Worsening of an approved service-connected injury/illness or occupational disability that occurs after the Member's condition has been deemed Medically Stationary.

"Ancillary Services." The term "Ancillary Services" means services that supplement the care provided by the Member's physician or other authorized healthcare provider (e.g., physical therapy, occupational therapy, etc.).

"Attending Physician." The term "Attending Physician" means:

(A) A medical doctor or doctor of osteopathy licensed under ORS 677.100 to 677.228 by the Oregon Medical Board, or a podiatric physician or surgeon licensed under ORS 677.805 to 677.840 by the Oregon Medical Board, an oral and maxillofacial surgeon licensed by the Oregon Board of Dentistry or a similarly licensed doctor in any country or in any state, territory or possession of the United States; or

(B) For a period of sixty (60) days from the first visit on the initial Claim or for eighteen (18) visits, whichever first occurs, a doctor or physician licensed by the State Board of Chiropractic Examiners for the State of Oregon or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States. All Members drawing disability benefits shall be examined at least once during each twelve-month period by the Member's identified physician or a physician appointed by the Director, unless otherwise determined by the Director.

(C) For a period of sixty (60) days from the first visit on the initial Claim or for eighteen (18) visits, whichever first occurs, a doctor of naturopathy or naturopathic physician licensed by the Oregon Board of Naturopathic Medicine under ORS chapter 685 or a similarly licensed doctor or physician in any country or in any state, territory or possession of the United States.

(D) For a period of 180 days from the first visit on the initial claim, a physician assistant licensed by the Oregon Medical Board in accordance with ORS 677.505 to 677.525 or a similarly licensed physician assistant in any country or in any state, territory or possession of the United States. A physician assistant may provide compensable medical services for 180 days from the date of the first visit on the initial claim and may also authorize the payment of disability benefits for a period not to exceed 180 days from the date of the first visit on the initial claim.

"Chart Note." The term "Chart Note" means a chronological documentation in a Member's medical record and includes subjective and objective findings, diagnosis, treatment rendered and proposed, status, and recovery and return-to-work objectives.

“Claim.” The term “Claim” means a written request to FPDR for a retirement, disability or death benefit and may be filed by an Active Member, their representative or legal beneficiary, or Surviving Spouse or other legal beneficiary of a deceased Member. This term may be used synonymously with the term “application.”

“CPT.” The term “CPT” means Current Procedural Terminology published by the American Medical Association.

“Curative Care.” The term “Curative Care” means Medical Services required to diagnose, heal or permanently relieve or eliminate a medical condition.

“Customary Fee.” The term “Customary Fee” means a fee that falls within the range of fees normally charged in Oregon for a given service.

“Date of Disability.” The term “Date of Disability” means the date that the Member’s Attending Physician establishes that the Member is first unable to perform the Member’s required duties as a result of a service-connected injury/illness or occupational disability that has been determined to arise out of and in the course of the Member’s employment in the Bureau of Fire or Police.

“Director.” The term “Director” where used in these Administrative Rules shall mean the Fund Director and/or Fund Administrator or their designee.

“Elective Surgery.” The term “Elective Surgery” is surgery which may be necessary in the process of recovery from an injury or illness but need not be done as an emergency to preserve life, function or health.

“Independent Medical Examination” (IME). The term “Independent Medical Examination” means an examination by one or more licensed medical providers in order to provide an opinion of findings in connection with a service-connected injury/illness or an occupational disability Claim. A Physical Capacity Evaluation (PCE) or a Work Capacities Evaluation (WCE) is considered an “IME” under these rules.

“Medical Service.” The term “Medical Service” means any medical treatment~~,~~ including:

(A) surgery
(B) diagnostic procedures
(C) chiropractic
(D) dental
(E) in-patient and out-patient hospitalization
(F) professional nursing
(G) ambulance transport
(H) prescription drugs
(I) medicine
(J) durable medical equipment
(K) crutches
(L) braces and supports
(M) prosthetic appliances
(N) physical Restorative Services

“Medical Treatment.” The term “Medical Treatment” means the management and care of a Member by a licensed medical provider for the purpose of combating disease, injury or disorder.

"Medically Stationary." The term "Medically Stationary" means that no further material improvement can reasonably be expected from medical treatment or the passage of time.

“Nurse Case Manager.” A licensed nurse assigned by the Director to follow and monitor the progress of recovery of an injury/illness or occupational Claim.

“Nurse Practitioner.” A nurse practitioner licensed under ORS 678.375 to 678.390 may provide compensable medical services for 180 days from the date of the first visit on the initial claim and may also authorize the payment of disability benefits for a period not to exceed 180 days from the date of the first visit on the initial claim.

“Original Injury.” The term “Original Injury” means the period from the first occasion of medical treatment or disability resulting from a service-connected injury/illness or occupational disability through the date the Member reaches a Medically Stationary status.

“Palliative Care.” The term “Palliative Care” means post-Medically Stationary Medical Services required to reduce or temporarily moderate the intensity of an otherwise stable condition. It does not include those Medical Services needed to diagnose, heal or permanently alleviate a medical condition.

“Physical Capacity Evaluation.” The term “Physical Capacity Evaluation” means an objective, directly observed measurement of a Member’s ability to perform a variety of physical tasks combined with subjective analyses of abilities by Member and evaluator. Physical tolerance screening, Blankenship’s Functional Evaluation and Functional Capacity Assessment will be considered to have the same meaning as Physical Capacity Evaluation.

“Physical Restorative Services.” The term “Physical Restorative Services” means services prescribed by the Member’s physician that are designed to restore and maintain the Member to the highest functional ability consistent with the Member’s condition.

“Preponderance of the Evidence.” The term “Preponderance of the Evidence” means the greater weight of the evidence.

“Proximate Cause.” The term “Proximate Cause” means a cause that directly produces an event and without which the event would not have occurred.

“Recurrence.” The term “Recurrence” means an Aggravation of a service-connected injury/illness or occupational disability that requires Claim reopening for additional disability benefits and/or medical benefits after the Member has reached Medically Stationary status with respect to the approved service-connected injury/illness or occupational disability.

“Significant Factor.” The term a “Significant Factor” means an important Proximate Cause.

“Specialty Physician.” The term “Specialty Physician” means a licensed physician who qualifies as an “Attending Physician” who provides evaluation, diagnosis or temporary

specialized treatment at the request of the Member's Attending Physician on an approved Claim.

"Spouse." The term "Spouse" shall, on and after June 26, 2013, mean an individual to whom a member is lawfully married under state law, and shall be defined consistent with Rev. Rul. 2013-17 and Notice 2014-19, under which the terms "Spouse," "husband and wife," "husband," and "wife" include an individual married to another individual of the same sex if the individuals are lawfully married under state law, and the term "marriage" includes such a marriage between individuals of the same sex, provided that the marriage was validly entered into in a state whose laws authorize the marriage of two individuals of the same sex even if the married couple is domiciled in a state that does not recognize the validity of the same-sex marriages.

"Surviving Spouse." The term "Surviving Spouse" means the individual who, at the time of the Member's death, was the Spouse of the Member, had been the Member's Spouse throughout the 12-month period immediately preceding the Member's death and had not been judicially separated or divorced by interlocutory or final court decree at the time of death, unless otherwise provided in a domestic relations order that is enforceable with respect to the Member's Plan benefit. A same-sex domestic partner of a Member who filed an affidavit of domestic partner status form in accordance with Ordinance No. 176258 or a registered domestic partnership certificate with FPDR prior to June 26, 2013, is also considered a Surviving Spouse.

"Usual and Customary Fee." The term "Usual and Customary Fee" means a treatment service fee that falls within the range of fees normally charged for treatment of occupational injuries and illnesses in Oregon.

"Work Capacity Evaluation." The term "Work Capacity Evaluation" means a physical capacity evaluation with special emphasis on the ability to perform a variety of vocationally oriented tasks based on specific job demands. Work Tolerance Screening will be considered to have the same meaning as Work Capacity Evaluations.

"Worsening." The term "Worsening" means objective findings indicating a deterioration of the approved service-connected injury/illness or occupational disability based on expert medical opinion or an expert medical opinion explaining why the Member's symptoms indicate a deterioration of the approved service-connected injury/illness or occupational disability.

5.9.02 – RECIPIENTS OF DISABILITY BENEFITS

All Members drawing disability benefits of whatever nature shall identify a physician as defined in and under the conditions prescribed for under "Attending Physician" in Section 5.9.01 of this Administrative Rule.

5.9.03 – MEDICAL SERVICES

(A) Reimbursement for actual, reasonable and necessary expenses, as determined by the Director, paid for or incurred by a Member as a result of a service-connected or occupational injury or illness shall be paid as provided below:

(1) Members shall be reimbursed for the actual, reasonable and necessary medical expenses they have paid for or incurred. Payment directly to the medical care provider shall be deemed to be reimbursement of the Member.

(2) Actual, reasonable and necessary costs for travel, prescriptions and other necessary expenses paid by the Member will be reimbursed upon request by the Member.

(3) All requests for reimbursement shall be made on forms provided by the Director and accompanied by itemized documentation which supports the request. For example, requests for reimbursement for prescriptions must be accompanied by a receipt from the provider identifying the prescription and its price and requests for mileage reimbursement must be accompanied by a statement reflecting the actual mileage traveled.

(4) Reimbursement for the cost of meals, lodging, public transportation or use of a private vehicle shall be at the rate of reimbursement paid to City employees when incurring such expenses.

(5) Reimbursement for the cost of meals, lodging or travel exceeding 50 miles will be paid only if such expenses are pre-approved by the Director.

(6) Expenses incurred for public transportation or the use of a private automobile will be reimbursed based on the most direct route between the Member's home and the facility where the service is to be performed.

(7) All requests for reimbursement for expenses paid by the Member must be submitted to and received by the Director within sixty (60) days of making payment for or incurring the expense for which reimbursement is sought.

(8) Initial determinations regarding actual, reasonable and necessary medical and other expenses shall be made by the Director. Members shall be advised in writing of any denials. In the event that a denial is issued by the Director, the Member may appeal such determination by filing with the Director a written notice of appeal requesting reconsideration before a hearings officer. However, the reconsideration shall not be granted unless the notice of appeal is received by the Director within sixty (60) days after the mailing of the determination, unless the Member can establish good cause why the notice of appeal was not received until after the required sixty (60) days.

(9) Medical or hospital service providers that have fee agreements with the Director. Notwithstanding the provisions of subsection (1) above, Members receiving disability benefits must obtain hospital and Medical Services for service-connected or occupational disability injuries or illnesses from providers or organizations that have fee agreements with the Director, except in those circumstances described in subsection (10) below. A listing of such providers shall be on file in and available from the Director's office.

Medical or hospital service providers or organizations that have a fee

agreement with the Director shall provide Medical Services to Members that are subject to the terms and conditions of said agreement.

(10) Medical or hospital service providers that do not have a fee agreement with the Director. Members may obtain and will be reimbursed for the actual and reasonable costs of necessary medical or hospital services received from providers who do not have fee agreements with the Director in the circumstances described below. Payment directly to the provider will be considered to be reimbursement to the Member.

(a) The Member has a life-threatening emergency requiring immediate medical care at the nearest emergency facility. Life-threatening emergencies include, but are not limited to, situations such as profuse bleeding, loss of consciousness, breathing difficulty or sudden severe head trauma.

(b) The Member is traveling in an area in which there are no providers who have a fee agreement with the Director and a service-connected injury or illness or occupational disability requires immediate medical treatment.

(11) Medical treatment and services provided by approved health care providers must be consistent with the nature of the approved service-connected injury or illness or occupational disability, and care that is reasonable and necessary to promote recovery.

(B) The Director reserves the right to request of the Member's Attending or Specialty Physician, evidence of the frequency, extent and efficacy of treatment and services.

(C) Ancillary Services provided by a health care provider other than the Member's Attending Physician will not be reimbursed unless prescribed by the Member's Attending or Specialty Physician. These services must be according to a treatment plan that has been provided to the Member's Attending or Specialty Physician within a reasonable time of when the ancillary treatment begins. The treatment plan must include the following:

(1) objectives of planned treatment;

(2) description of modalities to be provided;

(3) frequency of treatments; and

(4) duration of treatments.

The Member's Attending or Specialty Physician shall sign off on the ancillary treatment plan and send a copy to the Director.

5.9.04 – MEDICAL SERVICES GUIDELINES

Medical Services provided to the injured Member must not be more than is reasonable and necessary to treat the approved service-connected injury/illness or occupational disability. The Director may deny services that are shown to be more than the nature of the approved service-connected injury/illness or occupational disability or the process of recovery requires. Accepted professional standards will be relied upon in making these determinations.

(A) The utilization and treatment standard for physical therapy included in any fee agreement with a medical or hospital service provider will be followed. If none exists, the number and duration of therapy visits covered will not exceed what is medically reasonable and necessary under accepted professional standards. The Member's Attending or Specialty Physician will be required to provide the Director with a written explanation for visits exceeding this standard.

(B) Attending Physicians may prescribe treatment or services to be carried out by persons not licensed to provide a Medical Service or treat independently only when such services or treatment is rendered under the Attending or Specialty Physician's direction.

(C) Massage therapy not administered under the direct oversight of an Attending Physician must comply with the requirements for "Ancillary Services" in these rules.

(D) Prescription drugs may be purchased by the Member at a pharmacy of the Member's choice. The Director may ask that the Member access the services of providers that the Director has made fee agreements with. Except in an emergency, drugs and medicine for oral consumption supplied by an Attending Physician must not exceed that which is medically necessary to treat the Member.

(E) Post-Medically Stationary medical care may fall into one of the following categories:

(1) Curative Care: Medical care necessary to stabilize a temporary and acute flare up of symptoms of the Member's condition; or

(2) Palliative Care: Medical care that is reasonable and necessary to reduce or temporarily moderate the intensity of an otherwise stable condition and/or is reasonable and necessary to enable the Member to continue current employment or a vocational training program.

In both cases, the Member's Attending Physician will be required to submit to the Director a written request that provides the following:

(1) a description of the objective findings;

(2) the diagnosed medical condition for which the care is being requested, to include the appropriate ICD-9-CM diagnosis code;

(3) provide an explanation of how and why requested care is reasonable and

necessary and will improve the Member's condition; and/or is reasonable and necessary to enable the Member to continue current employment or a vocational training program; and

(4) a description of how the care is medically reasonable and necessary to treat the approved Claim.

5.9.05 –NONCOVERED SERVICES

(A) Medical treatment that is excessive, unscientific, unproven as to its effectiveness, outmoded, inappropriate or experimental in nature is not reimbursable. Accepted professional standards will be relied upon in making these determinations.

(B) Dietary supplements, unless prescribed by the Member's Attending or Specialty Physician specifically as medical treatment for an approved dietary deficiency condition are not reimbursable.

(C) Articles including but not limited to beds, hot tubs, chairs, Jacuzzis and gravity traction devices are not covered unless a need is clearly justified by a report which establishes that the nature of the injury or the process of recovery requires the item be furnished. The report must specifically set forth why the Member requires an item not usually considered necessary in the great majority of workers with similar impairments.

(D) Trips to spas, resorts or retreats, whether prescribed or in association with a holistic medicine regimen, are not reimbursable unless special medical circumstances are shown to exist that render such treatment medically reasonable and necessary.

(E) Physical Restorative Services may include but are not limited to a regular exercise program, gym membership or swim therapy. Such services are not compensable unless the nature of the Member's limitations requires specialized services to allow the Member a reasonable level of social and/or functional activity. The Attending Physician must justify by report why the Member requires services not usually considered necessary for the majority of injured workers.

(F) The Director may deny services that are shown to be more than the nature of the approved service-connected injury/illness or occupational disability or the process of recovery requires. Accepted professional standards will be relied upon in making these determinations.

5.9.06 – INDEPENDENT MEDICAL EXAMINATIONS

(A) If requested by the Director, any Member potentially eligible to receive benefits under this program is required to undergo an Independent Medical Examination (IME) by one or more licensed physician or psychologist. Should the Member fail to submit to the examination, or obstructs the same, the Member's rights to benefits may be suspended or reduced by the Director until the examination has taken place.

(B) The Director is not required to schedule an IME appointment during a Member's work hours. Members will be required to attend an IME during off-work hours, as

well as work hours, if so scheduled, and unless there is good cause for not attending the IME. An IME scheduled during a Member's off-work hours is not considered good cause, of and by itself, for not attending an IME.

(C) The Member may request a change in the IME appointment date, time or place for good cause.

(D) FPDR will mail a written notice to the Member by certified and regular mail at least fourteen (14) calendar days prior to the IME appointment date. If the Member has an attorney, the Member's attorney shall be simultaneously notified in writing of a scheduled medical examination under these Administrative Rules. FPDR may provide fewer than fourteen (14) days notice if Member agrees.

(E) The Member's notification of the medical examination shall include the following information:

(1) the name of the examiner and facility;

(2) a statement of the specific purpose for the examination and, identification of the medical specialties of the examiners;

(3) the date, time and place of the examination; and

(4) the first and last name of the Member's Attending Physician and verification that the Member's Attending Physician was informed of the examination.

(F) The Member must cooperate with a scheduled IME by arriving at the date and time of the scheduled appointment and cooperating with the examination unless the Member can show good cause for non-cooperation.

(G) Suspension or reduction of benefits may result from non-cooperation in participation with an IME.

(H) When necessary, the following expenses associated with the Member's attending the medical examination will be considered by the Director:

(1) reimbursement of reasonable cost of public transportation or use of a private vehicle; and

(2) reimbursement of reasonable cost of child care, meals, lodging and other related services.

(I) Requests for reimbursement must be accompanied by a sales slip, receipt or other evidence necessary to support the request. Should an advance of these costs be necessary for attendance, a request for advancement must be made in sufficient time to ensure a timely review and consideration prior to the date of the examination. Mileage reimbursement will be based on City of Portland rates in effect at the time of incurred expense.

(J) When Elective Surgery is recommended by the Member's Attending or Specialty Physician, the Member may be required to attend an IME with an independent consultant prior to approval of the surgery.

(1) The Director will notify the Attending or Specialty Physician within seven (7) days of receiving a request to approve surgery that an IME will be required prior to approval of the surgery.

(2) The Director will arrange the IME as soon as possible, but no later than thirty (30) days following the request for surgery by the Member's Attending Physician or Specialty Physician.

(3) The Director will issue a decision to approve or deny the request for surgery as soon as possible, but no later than twenty-one (21) days, following the date of the IME.

5.9.07 – MEDICAL MANAGEMENT PROGRAMS

(A) Clinical Case Management: Clinical case management is the use of a combination of medical professionals (nurses and physicians) to manage or assist in managing the medical and disability aspects of service-connected injury/illness and occupational disability Claims.

(1) Typical clinical case management providers and services may include telephonic and field nurse case management services, utilization management and physician advisor.

(2) A Nurse Case Manager may be assigned to monitor and track recovery of a Member's approved Claim when deemed appropriate by the Director.

(a) Members are required to cooperate with the Nurse Case Manager assigned to their Claim. Cooperation includes submitting to personal and/or phone contact and answering relevant medical and vocational questions posed to them by the Nurse Case Manager.

(b) Members may decline to allow the Nurse Case Manager to accompany them to their medical appointments.

(c) Members may request a change of Nurse Case Manager. However, it is at the discretion of the Director to assign a new Nurse Case Manager.

(B) Utilization Review: FPDR may require the use of utilization review services to provide pre-certification of surgical and specialty care prior to approval of the Medical Service. The Director may deny a Medical Services request if utilization review services deny precertification of such request.

5.9.08 – MEDICAL FEES AND PAYMENTS

(A) The Director may contract with medical or hospital service providers or groups of providers for medical or hospital services and enter into fee agreements with such to reimburse medical fees of approved Claims under these rules.

(B) Health care providers will submit their fees for services rendered pursuant to current Charter and FPDR Administrative Rules. Billings must be itemized and include Chart Notes, and must be submitted directly to FPDR, no later than ninety (90) days from the date of service or in accordance with the terms of their provider panel agreement with whom FPDR is contracted. A health care provider must establish good cause if billing is submitted later than 90 days from the date of service or in accordance with the terms of their provider panel agreement with whom FPDR is contracted. Failure to show good cause may result in a reduction or nonpayment of allowable charges. Members will be held harmless by the health care provider for any costs that, if not for late submission, would have been covered by FPDR.

(C) Medical fees will be reimbursed according to the fee agreements made between the medical providers and FPDR.

(D) If no fee agreement has been made with the medical provider, and the service complies with these Administrative Rules in all other respects, FPDR will reimburse at the "Usual and Customary Fee" for the Medical Service.

(E) FPDR payment shall be considered payment in full. Members will be held harmless by the medical provider for any costs above the usual and customary rate, as defined in 5.9.01 of these Administrative Rules, or an agreed upon fee agreement amount payable by FPDR on an otherwise approved billing.

(F) FPDR will date stamp each medical bill received. Bills for services rendered on approved Claims will be adjudicated within thirty (30) days of receipt. Payments will be in accordance with adopted fee schedules.

(G) If there is a dispute concerning the amount of a bill, the appropriateness of the service rendered or the relationship of the services to the approved Claim, FPDR must pay any undisputed portion of the bill and notify the provider of the specific reasons for nonpayment or reduction of the remainder of the bill.

5.9.09 – MEDICAL PAYMENT LIMITATIONS

(A) Member shall not pay for any Medical Service that is related to an approved service-connected or occupational disability or any amount that has been reduced by the FPDR in accordance with these Administrative Rules. A medical provider shall not attempt to collect payment for any Medical Service from a Member, except as follows:

(1) when the Member seeks treatment for conditions not related to the approved Claim; or

(2) when the Member seeks treatment that has not been prescribed by the

Attending Physician, or a Specialty Physician upon referral of the Attending Physician; or

(3) when the Member seeks treatment outside the provider panels which FPDR has contracted with, and said treatment was not pre-authorized by FPDR; or

(4) when the Member seeks treatment after being notified that such treatment has been determined to be unscientific, unproven, outmoded, or experimental, or has been notified that the treatment is not approved or outside of these Administrative Rules.

5.9.10 – POST-RETIREMENT MEDICAL BENEFITS

(A) Retirement from Disability: Medical and hospital expenses arising from an approved service-connected injury/illness or occupational disability shall be reimbursable, if the Member's disability benefits continued until the Member reached Disability Retirement Age.

(B) Retirement from active service: For Members who are retired as of January 1, 2007, medical and hospital expenses arising from an approved service-connected injury/illness or occupational disability shall not be reimbursable.

(C) Retirement from active service: For Members who are not retired before January 1, 2007, medical and hospital expenses arising from an approved service-connected injury/illness or occupational disability shall be reimbursable.

(D) The Director shall deny the Claim for medical or hospital expense if the Director determines by a Preponderance of the Evidence that a Claim under subsection (C) from a retired Member is due to the following:

(1) medical or hospital expenses related to an injury/illness that was based upon fraud, misrepresentation, an omission, or illegal activity by the Member,; or

(2) medical or hospital expenses related to an injury/illness that was accepted in good faith, in a case not involving fraud, misrepresentation, an omission, or illegal activity by the Member, and within two (2) years of the initial acceptance the Director obtains evidence that the Claim is not a service-connected or occupational illness/injury or FPDR is not responsible for the injury/illness; or

(3) Medical or hospital expenses are not related to the service-connected injury/illness or occupational disability.

5.9.11 – DISABILITY RETIREMENT AGE

(A) Service-connected injury/illness or occupational disability benefits payable to a FPDR Two Member shall cease at Disability Retirement Age except as provided in Section C hereof. A Member receiving service-connected injury/illness or occupational disability benefits shall be eligible to receive a retirement benefit at Disability Retirement Age, which shall be the earlier of the dates the Member is (1)

credited with 30 Years of Service for retirement benefit purposes or (2) the date the Member attains Social Security retirement age. For purposes of this rule, “Social Security retirement age” means the retirement age provided in 42 USC § 416(l)(1).

(B) Service-connected injury/illness or occupational disability benefits payable to a FPDR Three Member shall cease at Normal Retirement Age under PERS except as provided in Section C hereof.

(C) If the Director determines the service-connected injury/illness or occupational disability to be temporary, benefits may continue after Disability Retirement Age for a FPDR Two Member or PERS Normal Retirement Age for a FPDR Three Member up to two (2) years from the date of such disability. A Member, who is actively employed and suffers a service-connected injury/illness, or occupational disability after attaining Disability Retirement Age for a FPDR Two Member or PERS Normal Retirement Age for a FPDR Three Member, shall be eligible to receive disability benefits for a period of up to two (2) years from the date of such disability if the Director determines the disability to be temporary.