



Health & Financial Benefits

HEALTHY LIVING. HEALTHY FUTURE.

2019-20

Summary Plan Description

Employee Benefits and Wellness Programs



CityBasic Health Plan

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 benefits. The Plan details are described in separate sections, with special boxes emphasizing key features and highlighting important points to remember.

Along with 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 benefits the City of Portland offers to active 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 active employees and Retirees. 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 107 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 wrap 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.

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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 a 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

	Health Benefits (Medical, Prescription Medication, Dental, Vision)
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.
Is the benefit automatic, or is enrollment required?	Enrollment is automatic for eligible employees. To include dependents, you must complete an enrollment form and return it to the Health & Financial Benefits Office
When does coverage begin?	<p>Coverage will begin as defined within the Labor Agreements between the City of Portland and Laborer’s Local 483 (Seasonal Maintenance Workers) effective January 1, 2015, and the Seasonal Park Rangers agreement effective November 19, 2014.</p> <p>The City of Portland is compliant with the federal Affordable Care Act (ACA) health reform and will provide medical, vision and dental coverage to Casual employees who may qualify for medical coverage under the ACA.</p> <p>More details can be found in the <i>Who Is Eligible?</i> section of this SPD.</p>
How do I enroll?	You will receive enrollment materials in the mail when eligible. To make changes, or to opt-out of coverage, you must complete the appropriate form and return it to the Health & Financial Benefits Office.
Who pays for coverage?	You and the City share the cost. Contributions are pre-tax.

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. (*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...
CityBasic Medical Plan	<ul style="list-style-type: none"> ▪ www.modahealth.com ▪ Network : <u>Connexus</u> ▪ 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 ▪
Prescription Medication Coverage	<ul style="list-style-type: none"> ▪ www.express-scripts.com or 1-855-889-7760 ▪ For specialty medications : www.Accredo.com
CityBasic Dental Plan	<ul style="list-style-type: none"> ▪ Customer Service : 503-265-5680 or 1-877-277-7280 ▪ Provider Directory: www.modahealth.com or 503-243-3974 Network : <u>Delta Dental Premier</u>
Vision Service Plan (VSP)	<ul style="list-style-type: none"> ▪ www.vsp.com or 1-800-877-7195 Network: <u>Signature Plan</u>

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

- **By phone:** Call the Benefits Information Line at **503-823-6031**. (Please leave a message with your name, your question, your daytime phone number, and the best time to reach you. A benefits team member will return your call.)
- **Via email:** Send an email to benefits@portlandoregon.gov

Glossary of Terms

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.

Chemical Dependency– 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, the plan requires that you pay a \$15 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.

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.

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 will reimburse providers under the 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 75th percentile of fees commonly charged for a given procedure in a given area, based on a national database. If a dollar value is not available in the national database, Moda Health will consider 75% of the billed charge as the MPA. In certain instances, when a dollar value is not available in the database, the claim is reviewed by 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.*

For end-stage renal disease facilities, MPA is the contracted amount for in-network facilities and 125% of the Medicare allowable amount for out-of-network dialysis facilities.

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 – All mental disorders covered by diagnostic categories listed in the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV or 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 only be partially covered after a higher deductible and coinsurance. 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 copays related to medical coverage. 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.

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.”

Prior Authorization – Approval by Moda Health for a member in the Medical 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 Medical plan is 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 City’s health fund.

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, WHEN COVERAGE IS EFFECTIVE

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> <ul style="list-style-type: none"> ▪ Laborer's Local 483 (Seasonal Maintenance Workers and Seasonal Park Rangers). 	<p>For initial eligibility:</p> <ul style="list-style-type: none"> ▪ You are eligible the first day of the month following 60 days of service in a position that is scheduled for a minimum of 28 hours per week <p>For continued eligibility</p> <ul style="list-style-type: none"> ▪ You must have been paid 112 hours in the prior month; hours are monitored month to month
<p>Employee</p> <p>The City complies with the Affordable Care Act in determining coverage for employees otherwise not covered by the City's benefit plans.</p>	<p>For initial eligibility:</p> <ul style="list-style-type: none"> ▪ You must average 30 working hours per week during a 6-month initial measurement period beginning on date of hire. Benefits begin on the first day of the month following *60 days from the end of the initial measurement period. <p>*60-days is determined to be an Administrative Period.</p> <p>For on-going employees:</p> <ul style="list-style-type: none"> ▪ You must average 30 working hours per week during a 6-month standard measurement period ▪ Standard measurement period: <ul style="list-style-type: none"> ○ October 4, 2018 to April 3, 2019 – for benefits beginning July 1, 2019 ○ April 4, 2019 to October 2, 2019 – for benefits beginning January 1, 2020
<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"> ○ As defined and declared in the City of Portland's Domestic Partner Affidavit, or ○ Who is a registered domestic partner as per the Oregon Family Fairness Act of 2007

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 they are <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. ▪ 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), or the Oregon Public Service Retirement Plan (OPSRP); and ▪ Have been covered under the active employee health plans on a City-paid basis in the month preceding retirement ▪ <i>Note: 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 or from private individual insurance providers. The option to return from an individual plan to the City's plans is limited to one time per participant.</i>

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

Initial Enrollment

When you become eligible for benefits:

1. You will automatically be enrolled in coverage for yourself.
2. You may add your eligible dependent(s) within 30 days from your initial eligibility date. If you add your dependents after the first of the month in which you were eligible for City-paid benefits, dependent coverage will be retroactive to the first of the month in which you were eligible.

Note: You must submit documentation for your spouse or domestic partner and children within 30 days of your coverage eligibility 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.

3. 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. **Any applicable premium share will be deducted from your paycheck on a pre-tax basis.**

Medical/Vision	Automatically enrolled in the CityBasic medical plan with vision coverage through Vision Service Plan (VSP)
Dental	Automatically enrolled in the CityBasic dental plan

Annual Enrollment

Each spring you will receive information at 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) provided you continue to be benefit-eligible.

To *change/review* your benefits during annual enrollment:

1. Review your current benefits and any benefit changes for the new plan year, and 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 have changes, complete the appropriate form provided to you in your benefit package and return it to the Health & Financial Benefits Office.

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.

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. The Benefits Office can accept scanned, faxed or mailed change forms. Instructions on how to get your information back to the Benefits Office will be included within the materials mailed to your home.

Retirees and other Self-Pay Continuation Participants (including COBRA)

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. The 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 two 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).
- 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.

If You Need to Make Changes During the Year

Once your benefits are effective for a new plan year or as a newly eligible employee, 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.

It is your responsibility to notify the City of a qualifying family status change. **You have 60 days to report a change to the Health & Financial Benefits Office.** 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 will be required to provide certain documentation. For example, a copy of your marriage certificate if adding your spouse, or child's birth certificate if adding your new dependent child. If the documentation is not received, changes you've requested 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 team at 503-823-6031.

Qualified Family Status Changes

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
Change in Marital or Relationship Status	
Marriage	<ul style="list-style-type: none"> ▪ Add spouse, children as applicable ▪ Change tier or cancel coverage
Domestic partner meets criteria, affidavit is approved	<ul style="list-style-type: none"> ▪ Add domestic partner, children as applicable ▪ Change tier or cancel coverage
Divorce, annulment or legal separation Note: 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
Termination of domestic partnership Note: 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
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
Increase or Decrease in Number of Family Members	
Birth, adoption or placement for adoption, custody, legal guardianship Note: 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
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
Change in hours to become eligible for benefits	Elect coverage/add eligible family members

Qualifying Event	Medical, Dental and Vision Plans
Change in Work Status	
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)
Change in Employment of Covered Family Member	
New job – gain coverage or eligibility	Cancel coverage for those enrolling in new/other plan
Job loss – loss of coverage	<ul style="list-style-type: none"> ▪ Elect coverage/add eligible family members ▪ Change coverage tier
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
Enrollment in Government Program	
Medicare, Medicaid, CHIP, TRICARE	Add or cancel coverage for person affected
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
Leave of Absence – FMLA Rules Apply	
Begin leave (unpaid)	Continue or cancel coverage
Return from leave (unpaid)	Reinstate prior coverage
Cost Change	
Significant cost increase	<ul style="list-style-type: none"> ▪ Continue current coverage ▪ Cancel coverage if no similar plan
Significant cost decrease	<ul style="list-style-type: none"> ▪ Continue current coverage ▪ If no prior coverage, may choose plan
Minor cost increase or decrease	<ul style="list-style-type: none"> ▪ Automatic increase or decrease ▪ No change of enrollment category allowed
Minor cost increase or decrease	<ul style="list-style-type: none"> ▪ Automatic increase or decrease ▪ No change of enrollment category allowed

IMPORTANT NOTE FOR RETIREES:

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.

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, then the dependent cannot be added until the next annual enrollment period.

When Coverage Ends

For Employees

Termination of City-paid coverage will occur if you do not meet the eligibility criteria or if you have received notification of termination or layoff. If you become ineligible for participation in the medical plan, you will have the right to continue coverage on a self-pay basis in accordance with state and federal law (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
- The date you (or your dependent) is no longer eligible
- The last day of the month in which:
 - Your employment ends
 - You are unable to meet the minimum requirements for your job class and/or standard hours designation
 - 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 your regularly scheduled work for the City
- As otherwise defined within your Labor Agreement (if represented)

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

Reinstatement of Coverage

If your coverage has been terminated due to loss of eligibility, coverage may be reinstated in accordance with federal Affordable Care Act (ACA) health reform or upon meeting the minimum requirements for City of Portland health coverage through ACA. See the eligibility requirements under the “Who is Eligible?” section of this SPD.

Contact the Health & Financial Benefits Office to resolve any questions concerning reinstatement of benefits.

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 of this SPD 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) primarily does two things if you need to take time off from work due to a birth, adoption, or serious medical condition—either your own or that of a family member—or the military service of family members, the law:

1. Protects your job while you are off work caring for either yourself or a family member (due to a birth, adoption, serious medical condition, or the military service of family members), so that your job or a similar job will be available when you can return to it; and
2. 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:

- While on approved FMLA, you may continue your benefits, provided you pay the required premium
 - As an alternative, you can pay the unpaid portion of your premium share upon your return to work
- If you and/or your enrolled dependents elect not to remain covered during an FMLA leave, you and/or your enrolled dependents will be eligible to be reinstated in the plans on the date you return from FMLA leave
- 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) is similar to FMLA in that it protects your job in the event you need to take some time off due to a birth, adoption, or serious medical condition (OFLA also applies if a family member has a serious medical condition). However, OFLA has some different rules. Please contact your Leave Coordinator for assistance and questions about eligibility; the information described here is not a full description of OFLA and/or its complex rules.

Here are a few of the ways OFLA is different from FMLA:

- OFLA has an expanded list of “family members” compared to FMLA. OFLA also extends to grandparents and grandchildren, parents-in-law, same-gender domestic partners and children and parents of same-gender domestic partners.

- OFLA has sick child leave (non-serious health condition requiring home care) and the additional allotment of leave following pregnancy disability leave and sick child leave following 12 weeks of parental leave.
- OFLA has bereavement leave which is the 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.

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 and dental coverage under certain circumstances, when coverage would otherwise end. Options include:

- Legally Separated, Divorced or Widowed Spouses Over 55
- COBRA continuation coverage when employment or eligibility ends

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

Under Oregon law (ORS 743.600-743.602), if you are a spouse 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 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: COBRA

Under certain circumstances, you 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 two group health components to the City's COBRA continuation coverage:

1. Medical/vision
2. Dental

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).

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 their 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, and dental 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 is eligible for Social Security disability benefits when you lose coverage (or within 60 days of loss of 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, and dental plans only.

** 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*. For example, 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 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 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.

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

Did You Know?

Any qualified beneficiary for whom COBRA continuation coverage is not elected within the 60-day election period will lose their right to elect continuation coverage in the future.

Cost

When you are no longer an active employee 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.) Participants on COBRA will pay 102% of the full cost of active coverage (the full cost plus a 2% administrative fee). 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 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.

CityBasic COBRA

Plan	TOTAL Monthly Benefit Costs		
	Employee Only	Employee + 1	Family
CityBasic Medical & VSP Vision	\$484.25	\$903.12	\$1,277.40
CityBasic Dental	\$44.33	\$76.54	\$135.99

When Payment Is Due

If your first full payment is not received within the first 45 days of your 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). 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 in writing to the Health & Financial Benefits Office. Written notices must be mailed or hand-delivered to:

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

Effective during the Fall of 2017, the Benefits & Financial Benefits Office moved to the Columbia Square Building, while our mailing address stayed the same, our physical address is 111 SW Columbia St., Portland, OR 97201. The Health & Financial Benefits Office is located on the 5th floor.

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 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 states that don't offer an exchange including Oregon, 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 health care exchange.

HEALTH

Medical Plan

This section describes the medical coverage available to you and your eligible dependents. (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.

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

Good news! Preventive care (like an annual physical, age-appropriate screenings, etc.) that you receive from an in-network doctor is covered 100%.

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. Copays apply to emergency and urgent care, most 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 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. *Not all services are subject to the deductible. There is no deductible to satisfy when you visit your primary care doctor.* Check the Medical Plan Coverage chart for the details.

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 Summary

Medical Plan Feature	CityBasic Medical Plan	
	In-Network	Out-of-Network
Network	The Medical 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	
Maximum Plan Allowance (MPA)	After the deductible, the plan pays benefits based on negotiated rates	After the deductible, the plan pays benefits based on MPA limits
Plan Year Deductible	\$200/person; \$600/family maximum	\$750/person; \$2,250/family maximum
	Notes: 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	
Plan Year Out-of-Pocket Maximum	\$1,800/person; \$5,400/family maximum (excludes out-of-network expenses)	\$3,000/person; \$9,000/family maximum (excludes in-network expenses)
	Note: Charges over MPA do not apply to annual maximum.	
Lifetime Maximum	No lifetime maximum benefit limit	
Prior Authorization	Required for hospitalization and certain other services. See <i>Services Requiring Prior Authorization</i> .	
Physician Office Visits		
Office Visit (for primary care, and other medically necessary exam) Allergy shots and other injections	\$15 copay (preventive care services are not subject to the office visit copay). \$10 per injection	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Urgent Care	\$15 copay	50% up to plan year out of pocket maximum, plus amount in excess of MPA, no deductible

Medical Plan Feature	CityBasic Medical Plan	
	In-Network	Out-of-Network
Specialist Office Visit	30% after the deductible up to plan year out of pocket maximum.	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Pregnancy	\$15 per visit for prenatal care; 30% after deductible up to plan year out of pocket maximum for all other care	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Preventive Care (including, but not limited to: routine visits, lab work, diagnostic medical procedures, immunizations, health/education or tobacco cessation counseling, screenings)		
Wellness – Routine Exams and Immunizations (except travel-related immunizations) 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. Preventive services are covered as required under the Affordable Care Act.	\$0 (Plan pays 100%)	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
	Preventive care is subject to these limits: Routine physical exam maximum: <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 12 months ▪ Routine vision screening for age 3 to 5 ▪ Newborn hearing screening Cancer screenings: <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 maximum: 1 per 12 months (365 days) ▪ 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 (more frequent 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 	
Outpatient Services		

Medical Plan Feature	CityBasic Medical Plan	
	In-Network	Out-of-Network
Diagnostic Laboratory and X-rays (including ultrasound and other radiology services)	30% up to the plan year out of pocket maximum, after the deductible	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Advanced Imaging (including CT Scans, MRIs and PET Scans)	30% up to the plan year out of pocket maximum, after the deductible	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Outpatient Hospital (including in-hospital diagnostic x-rays and lab work, surgery, anesthesia and miscellaneous services)	30% up to the plan year out of pocket maximum, after the deductible	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Inpatient Hospital Services		
Inpatient Hospital (including semi-private room and board, in-hospital diagnostic x-rays and lab work, surgery, anesthesia and miscellaneous services)	30% up to the plan year out of pocket maximum, after the deductible	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Emergency Services		
Emergency Room (copay waived if admitted as inpatient following emergency)	30% up to the plan year out of pocket maximum, after \$50 copay (not subject to deductible)	30% up to the in-network plan year out of pocket maximum, plus amount in excess of MPA, after \$50 copay (not subject to deductible)
Other Services		
Ambulance	30% of MPA, up to plan year out of pocket maximum, no deductible	
Skilled Nursing Facility	30% up to the plan year out of pocket maximum, after you meet deductible (limited to 30 days per plan year)	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA (limited to 30 days per plan year)
Home Health Care	30% up to the plan year out of pocket maximum, after you meet deductible (limited to 60 visits per plan year)	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA (limited to 60 visits per plan year)

Medical Plan Feature	CityBasic Medical Plan	
	In-Network	Out-of-Network
Hospice	30% up to the plan year out of pocket maximum, after you have met your deductible	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Durable Medical Equipment	30% up to the plan year out of pocket maximum, after you have met your deductible	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
	Note: Precertification required if rental exceeds 30 days or cost exceeds \$500.	
Alternative Care (includes chiropractic, acupuncture, and naturopathic services)	30% up to the plan year out of pocket maximum, after you have met your deductible	50% up to plan year out of pocket maximum after you meet deductible, plus amount in excess of MPA
	Chiropractic care has a 35-visit annual maximum.	
Physical Therapy	30% up to the plan year out of pocket maximum, after you have met your deductible	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
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
Behavioral Health and Mental Health Treatment Note: Prior authorization is required for all inpatient and residential treatment programs.	<ul style="list-style-type: none"> ▪ Outpatient office visits: \$15 copay ▪ Inpatient and residential treatment programs: 30% up to plan year out of pocket maximum, after you meet deductible Note: Intensive outpatient treatment requires prior authorization	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Chemical Dependency Treatment Note: Prior authorization is required for all inpatient and residential treatment programs	<ul style="list-style-type: none"> ▪ Outpatient office visits: \$15 copay ▪ Inpatient and residential treatment programs: After meeting the \$200 deductible, cost of co-insurance is waived for members 	50% up to plan year out of pocket maximum, after you meet the deductible, plus amount in excess of MPA
Prescription Medication Coverage		

Medical Plan Feature	CityBasic Medical Plan	
	In-Network	Out-of-Network
<p>Prescription Medications</p> <p>Network retail pharmacy (up to 30-day supply, or a 90-day supply of maintenance medications at Smart 90 Program participating pharmacies)-</p> <p>Specialty medications are subject to a 2x copay for a 90-day supply</p> <p>Out-of-network pharmacy (up to 30-day supply)</p> <p>Mail order pharmacy Up to a 90-day supply at 2x stated coinsurance or maximum at participating retail pharmacies and Mail Order</p>	<p>In-network pharmacy 30-day supply:</p> <ul style="list-style-type: none"> ▪ Generic: 10% of medication cost <ul style="list-style-type: none"> ○ Subject to \$3 minimum, \$25 maximum copay ▪ Preferred brand-name: 20% of medication cost <ul style="list-style-type: none"> ○ Subject to \$10 minimum, \$50 maximum copay ▪ Non-preferred brand-name: 30% of medication cost <ul style="list-style-type: none"> ○ Subject to \$25 minimum, \$75 maximum copay <p>Voluntary Smart 90 pharmacy 90-day supply (see eligible locations below):</p> <ul style="list-style-type: none"> ▪ Generic: 10% of medication cost \$3 minimum/\$50 maximum copay ▪ Preferred: 20% of medication cost \$10 minimum/\$100 maximum copay ▪ Non-preferred medication (generic or brand): 30% of medication cost \$25 minimum/\$150 maximum copay <p>Voluntary Smart 90 Program This program allows employees to receive 90-day supplies of medication at the following pharmacy retailers:</p> <ul style="list-style-type: none"> - Costco - Fred Meyer - Safeway - Rite Aid - QFC - Walmart <p>Note: CVS and Walgreens pharmacies are not part of this network, however, members can still receive a 30-day supply of medication</p>	<p>Out-of-network pharmacy: You pay the full cost at the pharmacy, then submit claims to Moda Health.</p> <p>You pay 50% after you meet the out-of-network deductible (Plan reimburses 50%).</p>

Medical Plan Feature	CityBasic Medical Plan	
	In-Network	Out-of-Network
	<p>Mail order: Same as in-network retail pharmacy benefit levels shown above.</p> <p>Note: Deductible does not apply.</p> <p>Be sure to go online at www.express-scripts.com to compare pricing and pharmacy availability.</p>	

Note: Prior authorization is required for all inpatient hospital care, surgery, and several outpatient procedures. To obtain prior authorization, contact Moda Health before services are received or within 48 hours of an emergency.

Medical 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.

Medical Plan Network

Moda Health is the claims administrator for the 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) who 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 in-network copay, or your coinsurance amount after you’ve met the deductible). 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—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 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.

- 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.
- **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 match the in-network benefits 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, your benefit from the medical plan is lower, at the “out-of-network” level described in this section. 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.

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 and acupuncturists) provide 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 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. Chiropractic treatment is subject to a 28 visit annual maximum.**

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.

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.

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.

Medical Plan: More Details

Annual Deductible

The medical plan applies a deductible each calendar 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 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 Summary* chart for details concerning copays and coinsurance amounts for various services.

For example: Aaron is admitted to an in-network hospital for appendicitis. They spend two days in the hospital, and incurs fees for room and board, lab work, surgery, anesthesia, medication, etc. Aaron pays the full cost of applicable services until they have paid \$200 (the in-network deductible in the Medical Plan). Then, the plan will share the cost of any additional covered services at the appropriate coinsurance level for each service. (Generally speaking, Aaron will pay 30% of remaining charges and the plan will pay 70% while they are an inpatient in the in-network hospital.)

Assuming Aaron’s hospital stay, procedure and all associated lab work and medication for appendicitis costs a total of \$12,000, they would pay:

\$200 (deductible)
+
\$1,600 (30% of the remaining total up to the plan year out of pocket maximum of \$1,800)
=
\$1,800

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 Summary* 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.

Allowable Charges, Maximum Plan Allowance

In-network services: To reduce the cost of in-network care, the Claims Administrator (Moda Health) negotiates charges with providers in the Connexus network. 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 Claims Administrator’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 50% 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, the medical plan begins paying benefits—sharing the cost of eligible covered services with you. This is the medical 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 70% of eligible reduced charges in-network (you pay 30%), and the plan covers 50% of MPA charges out-of-network (you pay 50% plus any amount billed over the MPA).

Copays

A copayment, or copay, is a fixed dollar amount you must pay for certain standard services. (For example, in the Medical plan, you would pay a \$15 copay for an office visit with your in-network primary care doctor.) Generally, there is no further charge to you for an office visit, unless other services are performed (and those expenses would go toward your out-of-pocket maximum for the plan year).

Annual Out-of-Pocket Maximums

To protect you and your family from very high medical expenses in a single year, the plan includes an annual out-of-pocket maximum. When amounts you pay during the year as co-pays, deductibles and coinsurance reach your out-of-pocket maximum amount, 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.

Benefits for Special Medical Situations

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

In this medical situation...	The Medical plan pays the following:
You live in the network service area, but a	<ul style="list-style-type: none"> ▪ You’ll need to request prior authorization from Moda to see an out-of-network provider.

In this medical situation...	The Medical plan pays the following:
<p>specialist or type of treatment is not provided in your network service area</p>	<ul style="list-style-type: none"> ▪ If approved, you meet the in-network deductible (if you haven't already) then the plan pays 70% for medically necessary covered services. ▪ You'll need to see an out-of-network provider. ▪ You meet the in-network deductible (if you haven't already), then the plan pays 70% for medically necessary covered services. ▪ Eligible charges are subject to the maximum plan allowance (MPA) limits. ▪ You pay 30% coinsurance, and any amounts over the 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 out of pocket 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 Medical plan members</p> <p>Note: This section does not apply to urgent care.</p>	<p>Network providers: You pay 30% of charges after \$50 Emergency Room copay for an emergency. (Copay is waived if admitted; not subject to deductible.)</p> <p>Out-of-network providers: You pay 30% of charges, 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 (subject to MPA) when the covered member has no control over the choice of provider for these services.</p> <p>The out-of-pocket expenses (except for those charges in excess of MPA) will apply to the in-network out-of-pocket maximum.</p>

In this medical situation...	The Medical plan pays the following:
You live outside the Connexus network service area	<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. <i>If you do not see a Connexus or First Health network provider</i>, 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><i>For urgent and emergency situations</i>, 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>

Medical 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 the Connexus 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.

What Is Covered: 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 Summary 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.** Medically necessary chiropractic, acupuncture and naturopathic services are covered subject to maximums outlined in the *Medical Plan Summary* chart. 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 third-party administrator. *Appliances do not include dental appliances and braces, supporting devices such as corsets, eye glasses or contact lenses.*
- **Artificial Limbs.** The first extremity prosthesis after loss of a body part is covered, including artificial eyes and post-mastectomy bra and prosthetic. An additional prosthesis may be authorized if the attending physician provides documentation to the plan that a new prosthetic device is medically necessary because of changing fit or poor function. *Testicular prostheses are not covered.*
- **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 their professional license.
- **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.** Comprehensive lactation support and counseling is covered 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).
- **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.
- **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 (CityCore) and no cost share after deductible (CityHD)
 - In-Network male contraception, including sterilization. Is covered at no cost share (CityCore) and no cost share after deductible (CityHD)
 - Out-of-Network service may be paid at no cost share (CityCore) or no cost share after deductible (CityHD) 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.** Dental and orthodontic services are covered when medically necessary to treat congenital craniofacial anomalies including (but not limited to) cleft palate and cleft lip. Dental Services are also covered when medically necessary for mouth appliances related to a diagnosis of sleep apnea.
 - **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 their 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.

- **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. 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 any 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 **1-800-258-2073**.

- **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
- **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.
- **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
- **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 service provider.
- **Maternity Care for the employee, spouse, domestic partner, and dependent children.** Coverage for the newborn, beyond the initial nursery care, will be allowed if the child meets the City's definition of an eligible dependent. 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** that have been prior authorized.
- **Nonprescription Enteral Formula for Home Use and Inborn Errors of Metabolism.** When medically necessary, and ordered by the doctor for the treatment of severe intestinal malabsorption, and must comprise the sole source (or an essential source) of nutrition.
- **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 **1-800-258-2073**. 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.

- **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* 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.

- **Professional Services.** Medically necessary services of a professional provider (see the *Medical 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.*
- **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.

- **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 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. Inpatient care related to the mastectomy and post-mastectomy services are also covered 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. The City of Portland Health Plan and/or Moda Health are not liable for any adverse effects of the clinical trials. Qualified clinical trials are limited to those:
 - Funded or supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for 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 required solely for the prevention, diagnosis or treatment of complications arising from the provision 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 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 and 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.*
- **Surgical Benefits.** All inpatient elective procedures and some outpatient surgeries require prior authorization. Covered medically necessary surgical services include:
 - Primary surgeon
 - Assistant surgeon (as requested by the surgeon and only to the extent that hospital staff assistance is not available or appropriate)
 - Anesthesiologist (only as required by the surgeon)
 - Radio-active therapy
 - Iodine therapy
 - Super-voltage therapy
 - Deep x-ray therapy
 - Burn treatment, fractures and dislocations
 - Surgeon consultation while an inpatient, as required in the diagnosis or treatment of an illness or injury
 - Outpatient surgical and related services on the day of the surgery
 - Second surgical opinions
 - Medically necessary inpatient lab and x-ray expenses

Telemedicine Health 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.

If telemedical 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.

- **Tobacco Cessation.** This benefit provides reimbursement to **certain providers** to assist enrollees to stop using tobacco. This coverage allows reimbursement for prescription medications 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 service provider.

Important note: Keep in mind that 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: Medical Plan Limitations and Exclusions

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

Charges specifically excluded from coverage or limited in any way are as follows:

General Exclusions and Limitations

- Services that are not provided
- Services received before your effective date of coverage
- Services that are not a covered service or relate to complications resulting from a non-covered service, even if such service was previously covered under the plan
- Services that are not furnished by a 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 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 considered medically necessary by the plan.
- 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.
 - Telemedical Health Services Charges including telephone visits or consultations and telephone psychotherapy except as provided for in the paragraph titled "Telemedical Health Services" in the *What Is Covered* section.
 - 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 their spouse or domestic partner.
- **Temporomandibular Joint Disease (TMJ).** Surgical treatment of TMJ
- Third party liability claims. Services and supplies for treatment of illness or injury for which a third party is or may be responsible, to the extent of any recovery received from or on behalf of the third party. Includes benefits payable under any automobile medical, personal injury protection (PIP), automobile no fault, underinsured or uninsured, homeowner, commercial premises coverage, or similar contract or insurance, when such contract or insurance is issued to, or makes benefits available to, a member—whether or not such benefits are requested. More information can be found in the *Third Party Liability for CityBasic Medical and Dental Plan* 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; 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.

Exclusions Related to Miscellaneous Services and Items

- Support Education including Level 0.5 educational programs related to Driving Under the Influence (DUI); voluntary mutual support groups, such as Alcoholics Anonymous; or family education or support groups except for support groups rated A or B by the United States Preventive Services Taskforce
- Behavior modification, psychological enrichment or self-help programs for mentally healthy individuals. These include assertiveness training, image therapy, sensory movement groups, marathon group therapy, and sensitivity training.
- Routine optometric eye examinations, including the fitting, provision, or replacement of eyeglasses or contact lenses, and any charges for orthoptics, vitamin therapy, vision therapy, eye exercises, or fundus photography. Vision benefits may be available through the City's vision 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 - Maternity services related to conception, pregnancy, delivery or postpartum care incurred by a covered person acting as a surrogate mother.
 - For the purpose of this plan, the child of a surrogate mother will not be considered a dependent of the surrogate mother or her spouse if the mother has entered into a contract or other understanding pursuant to which they relinquish the child following its birth.
 - Members who enter into a surrogacy agreement must reimburse Moda Health for covered services related to conception, pregnancy, delivery or postpartum care that are received in connection with the surrogacy agreement, regardless of whether those payments are characterized as being for medical expenses. Moda Health 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 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 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. 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
- 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
- Charges incurred for telephone consultations with or between medical providers
- 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 the plan will not cover services and supplies that do so by treating the obesity directly, even if morbid obesity is present. Services specifically excluded from this plan include, but are not limited to:
 - Surgical: Gastric restrictive procedures with or without gastric bypass, or the revision of the same.
 - 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) made of high impact plastics or other materials, designed to be inserted into shoes
- Temporomandibular joint (TMJ) treatment and surgery.
- Orthognathic surgery and services or supplies to add to or reduce the upper or lower jaw.
- Genetic testing or counseling unless medically necessary and prior authorized through the City's contracted Utilization Review provider. Genetic testing for family members not covered under the Plan is excluded.
- Counseling related to family, marriage, sex and career, in the absence of medical necessity/illness
- Vocational, pastoral or spiritual counseling
- Dance, poetry, music or art therapy, except as part of a treatment program in an inpatient setting
- Non-organic therapies including, but not limited to, bioenergetics therapy, confrontation therapy, crystal healing therapy, educational remediation, guided imagery, marathon therapy, primal therapy, rolfing, sensitivity training, training psychoanalysis, transcendental meditation and Z therapy
- Organic therapies including, but not limited to, aversion therapy, carbon dioxide therapy, environmental ecological treatment or remedies, herbal therapies, hemodialysis for schizophrenia, vitamin or orthomolecular therapy, narcotherapy with LSD, and sedative action electrostimulation therapy
- Routine foot care services that are not medically necessary, including the following services unless required by the member's medical condition (e.g., diabetes):
 - Paring or cutting of benign hyperkeratotic lesion (e.g., corn or callus)
 - Trimming of dystrophic and non-dystrophic nails
 - Debridement of nail by any method
- Routine physical exams for employment, licensing, insurance coverage or 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 (including, but not limited to, doulas or birthing coaches.) This exclusion does not pertain to medically necessary mental health treatment as otherwise defined within Covered Services.

Frequently Asked Questions about the 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 Medical 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**.
2. **Do I need to designate a primary care physician (PCP) under the Medical 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 professional provider.

Medical Plan Prescription Medication Program

When you enroll in the Medical plan 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, , and many independent pharmacies. For a complete list, go to www.express-scripts.com.

What Is Covered

The Medical plan's pharmacy coverage pays benefits based on the type of prescription medication you receive and whether or not 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 formulary list is revised at least annually; Express Scripts will continually review and update the formulary on recommendation by a panel of pharmacists and physicians. And, because formularies vary by prescription medication program manager, be sure to verify whether the medications you are taking are on Express Script’s formulary each time you fill a prescription that is not a generic. 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 formulary at www.express-scripts.com or by calling **1-855-889-7760**.

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. **Prior authorization does not necessarily mean the medication will not be covered; your doctor will work with the plan to approve the prescription or find an acceptable alternative that will treat your condition.**

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	You pay 10% of the cost (\$3 minimum, \$25 maximum); Plan pays 90%	You pay full cost, then file claim for reimbursement of up to 50%

Preferred Brand-Name on the Express Scripts Formulary (including Specialty)	You pay 20% of the cost; (\$10 minimum, \$50 maximum); Plan pays 80%	(after you meet out-of-network medical plan deductible)
Non-preferred Brand-Name not on the Express Scripts Formulary (including Specialty)	You pay 30% of the cost (\$25 minimum, \$75 maximum); Plan pays 70%	
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.	Not applicable
Voluntary Smart 90 Program	<p>Voluntary Smart 90 Program This program allows employees to receive 90-day supplies of medication at the following pharmacy retailers:</p> <ul style="list-style-type: none"> - Costco - Fred Meyer - Safeway - Rite Aid - QFC - Walmart <p>Note: CVS and Walgreens pharmacies are not part of this network, however, members can still receive a 30-day supply of medication</p>	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 after your second fill. 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.

Guide to Your Preferred Drug List

Your preferred drug list, sometimes called a formulary, is a list of brand-name and generic medications that are preferred by the Plan. These medications are selected because they can safely and effectively treat most medical conditions while helping to contain costs for you and the Plan.

How are medications on the preferred drug list chosen?

A national panel of physicians and pharmacists continually reviews and compares prescription drugs to ensure your preferred drug list includes proven medications in every drug category.

What's the difference between preferred and nonpreferred drugs?

You will almost always have a lower copayment for preferred drugs. They will also save the Plan money to keep your benefits affordable. Ask your doctor to consider prescribing a generic or preferred brand-name drug if they think it would be right for you.

Is there a difference between a non-preferred drug and an excluded drug?

Yes, an important difference. If you fill a prescription for a non-preferred drug, you will usually have a higher copayment than for a preferred drug. But if you try to fill a prescription for a drug that is excluded or not covered on the 2018 drug list, you may pay the full, non-discounted retail price. A section of the preferred drug list shows excluded drugs, along with preferred alternatives for each that you and your doctor may consider.

How do I know which drugs are preferred?

Your preferred drug list contains thousands of commonly prescribed drugs. To see if a medication is covered on your 2018 drug list, log on at Express-Scripts.com and click on "Price a medication." If your drug is not preferred, talk with your doctor to identify an appropriate alternative that will effectively treat your condition. For more information, call the toll-free number on your Express Scripts member ID card.

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 certain retail pharmacies or use the mail order pharmacy services through Express Scripts. For a list of pharmacies participating in the 90-day maintenance medication program, go to www.Express-Scripts.com

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 **1-855-889-7760**.

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: Medical Plan Prescription Medication Program Exclusions

- Medications purchased or obtained without a physician's written prescription
- Over-the-counter products (with the exception of diabetes supplies and some over-the-counter products as required under the Affordable Care Act (ACA))
- Nose drops or nasal preparations that do not require a physician's written prescription
- Immunization agent
- 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: Medical Plan Limitations and Exclusions* section of this SPD
- Non-legend or over-the-counter (OTC) medications except as required under the ACA
- Non-sedating antihistamines
- Prescriptions that are covered by Workers' Compensation laws, the Fire and Police Disability Retirement Fund, or other county, state, or federal programs
- Compounded medications that include ingredients that can be purchased over the counter
- 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"

Special Programs

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 **503-243-3974** 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 registered nurses 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, please call Moda Health at **503-948-5561** or **1-800-592-8283** (or 711 for Relay Service for the deaf or hard of hearing).

Maternity Care Program

The Medical plan includes free support throughout your pregnancy with the Moda Health Maternity Care Program. The program is available to any pregnant covered individual, including a pregnant dependent who participates in the medical plan. This program offers prenatal education, obstetric check-up planning and lifestyle awareness—the key factors in helping pregnant women have healthy pregnancies and deliver healthy babies. When you enroll in this program you'll receive:

- Monthly one-on-one coaching by phone or e-mail
- Personal support throughout your pregnancy.
- Educational materials about prenatal care
- Extra support for high-risk pregnancies
- A baby monitor for your active participation

For more information or to enroll, contact Moda Health at **503-948-5561** or **1-800-592-8283** (or 711 for Relay Service for the deaf or hard of hearing). Or, send an email to maternity@modahealth.com.

Medical and Behavioral Management Services

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

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

Using these services will ensure you receive the maximum benefits under the 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 their 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 by calling Moda Health Customer Service at **503-243-3974** or **1-877-337-0649** or by going to MyModa at www.modahealth.com/members .

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

Emergency Procedure Authorization

Authorization for emergency hospital admission must be obtained by calling 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.
- **Chemical Dependency and Mental Health Services Review.** Review of recommended treatment plans.
- **High Risk Pregnancy.** Prenatal screening.

Continuity of Care

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

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 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.

Tobacco Cessation Programs

Notes:

- For **Medical** participants, the Legacy, Adventist and Providence programs listed in this chart are paid as in-network, no deductible. To receive reimbursement for your expenses, you must submit your claim to Moda Health

	Legacy	Adventist	Providence
Program	Stop Smoking 4-session class over four weeks.	Becoming Smoke-Free, Staying Smoke-Free 2-session program and ongoing aftercare support group.	Smoking Cessation 11-session class on smoking cessation at either Providence Portland Medical Center or Providence St. Vincent Medical Center. Quit for Life Telephone based program offers 12 months of stop-smoking support.
Locations	Class rotates at Legacy Hospitals	Adventist Medical Center 10123 SE Market St Portland, OR	Providence Portland Medical Center and Providence St. Vincent Medical Center
Frequency	Four, 1-hour sessions over a four-week period.	Two, 2-hour sessions over two weeks. Ongoing support group meets once a week.	Eleven, 90-minute sessions various evenings.
Contact	503-335-3500	503-256-4000	Smoking Cessation: 503-574-6595 Quit for Life: 1-800-292-2336

Fees

All fees are subject to change. Please contact the provider for current fees.

Diabetes Education Programs

For **Medical** participants, see Medical Plan benefit information for details. You are eligible for the Legacy, Portland Adventist and Providence programs listed in the chart. To receive reimbursement for your expenses, you must submit your claim to Moda Health.

	Legacy	Portland Adventist	Providence
Program	Programs include: classes and individual self-management training; nutrition counseling; special programs for Type I and pump patients; combining diabetes education and exercise sessions	Programs include: information sessions; hands-on activities; self-care techniques, including eating in restaurants; blood glucose self-monitoring; coping with diabetes; exercise; oral and insulin administration review	Classes and individual self-management training for adults and seniors. Nutrition management and gestational diabetes management classes. Individual consultations in insulin pump training, insulin administration, blood glucose monitoring, and other services can be offered for patients with barriers to class settings.
Locations	Legacy hospitals (Good Samaritan, Emanuel, Mount Hood, Meridian Park and Legacy Clinic, St. Helens. and Woodburn)	Adventist Medical Center 10000 SE Main Professional Bldg. 1 Suite 214 Portland, OR 97216	Providence Portland Medical Center, Sunset Business Park, Providence Milwaukie Hospital, Providence Newberg Hospital, Gresham
Frequency	Varies from site to site. Typically, two group classes per month for Type II, more extensive available for Type I and individual sessions.	Day classes: 3 mornings per month, generally from 8:30 a.m. to noon. Evening classes: Either three classes from 6:00 p.m. – 9:30 p.m. OR Four classes from 6:00 pm – 8:30 p.m. Classes include a pre-class visit and follow-up visit.	Classes offered on an ongoing basis: 9:30 a.m. – 11:30 a.m. OR 1:30 p.m. – 3:30 p.m. OR 6:30 p.m. – 8:30 p.m. Individual consultations are scheduled daily Monday through Friday.
Contact	General Education is 10 hours of instruction. Medical Nutrition Services are charged in 15-minute increments. Call 503-413-7227	Call 503-261-6003 for current pricing information.	Self-management class (9 hours) includes a one-hour individual appointment with an RN or RD and four, 2-hour classes. Call 503-215-6265

Fees

All fees are subject to change. Please contact the provider for current fees.

Filing a Claim for Medical Plan Benefits

. If you see an in-network provider (part of the Connexus network), the provider will directly bill Moda Health. 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 Claims Administrator. 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

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.

Third Party Liability for CityBasic Medical and Dental Plan

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 their 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 their 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 their 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 their 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.
- 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.

Vision Plan

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 plan available from the City of Portland encourages preventive eye care by offering coverage for comprehensive eye exams and allowances for lenses and frames or contact lenses.

Vision coverage is included when you enroll in the CityBasic medical plan. The coverage tier (one-party, two-party, family) you choose for medical coverage will apply to vision coverage.

The following chart outlines the benefits available under the vision plan.

Vision Plan Feature	Vision Service Plan (VSP)	
	VSP Provider	Non-VSP Provider
Enrollment	Automatic enrollment with election of Medical Plan.	
Exams <ul style="list-style-type: none"> ▪ adults: 1 visit/ 24 months ▪ children: 1 visit/ 12 months 	\$15 copay for exam and materials	Plan pays up to \$50, you may any additional costs. Claims must be filed within 12 months of the date of service.
Eyeglass frames (1 pair/24 months)	Plan allows up to \$150 towards the cost of frames and provides a 20% discount for costs in excess of the \$150 allowance.	Plan pays up to \$80 per Costco equivalent frame, you pay any additional costs. Claims must be filed within 12 months of the date of service.
Eyeglass lenses (1 pair/24 months)	You pay \$15 combined copay for exam and glasses Plan pays 100% of prescribed lenses (1 pair every 24 months) <ul style="list-style-type: none"> ▪ Single lenses (pair) ▪ Lined bifocals (pair) ▪ Lined trifocals (pair) (See "Special notes" below).	You pay all costs in excess of Plan allowances. Plan pays up to: <ul style="list-style-type: none"> ▪ Single lenses (pair): \$50 ▪ Bifocals (pair): \$75 ▪ Trifocals (pair): \$100 Claims must be filed within 12 months from date of service.
Elective contacts	Plan pays up to \$130 every 24 months in lieu of glasses plus 15% discount on the contact lens exam (fitting and evaluation)	Plan pays up to \$105 Claims must be filed within 12 months of the date of service.
Medically necessary contacts* (1 pair/24 months)	Plan pays 100% after applicable copays	Plan pays up to \$210 after applicable copay; you pay any additional costs. Claims must be filed within 12 months from date of service.
Special notes	Special cosmetic items, such as tinted or coated lenses, UV protected lenses, blended lenses, color contacts, etc., are not covered by VSP.	

Your Vision Plan Benefits – More Details

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

- City of Portland Health & Financial Benefits Office at **503-823-6031** or benefits@portlandoregon.gov
- VSP: **1-800-877-7195**, or www.vsp.com ([VSP Network : Signature](#))

Vision Service Plan (VSP) for Medical Plan Participants

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

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

In-network

Go to an 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 12 months of receiving the service.

VSP Affiliated Providers

VSP also gives you the option of using Costco, 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:

Benefits Through a VSP Affiliate Provider	
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
Lens Options	Subject to Costco pricing at Costco; 20% off at other affiliate locations
Frames	Frame allowance is \$80 at Costco and up to \$120 at other affiliate locations less applicable copay

What Is Not Covered: VSP Exclusions and Limitations of Benefits

The VSP plan is designed to cover visual needs rather than cosmetic materials. When you select any of the following extras, the plan will pay the basic cost of the allowed lenses, and you will pay the additional costs for the options:

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

VSP Exclusions

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

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than a +/- .38 diopter power); or two pair of glasses in lieu of bifocals
- Replacement of lenses and frames furnished under this Plan which are lost or broken, except at the normal intervals when services are otherwise available
- Medical or surgical treatment of the eyes

- Any eye examination, or any corrective eyewear, required by an employer as a condition of employment
- Corrective vision treatment and/or surgeries
- Any treatments considered to be of an experimental nature
- Out-of-network claims submitted more than 12 months from the date of service

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

Filing a Claim for VSP Vision Plan Benefits

Vision claims covered by VSP must be submitted within 12 months of the date the charges were incurred; send to:

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

Dental Plan

This section describes the dental coverage available to you as an eligible employee. 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.

The City offers the CityBasic Dental Plan administered by the Delta Dental Plan of Oregon through Moda Health. You contribute to the cost of coverage with pre-tax dollars. You may opt out of coverage if you also opt-out of the medical plan.

Please note: the cost sharing and the plan year out of pocket maximum benefit do not apply for children under age 19.

Dental Plan Feature	CityBasic Dental Plan
Am I required to use a network dentist?	No
Plan Year Deductible	\$25/member; \$75/family of three or more
Plan Year Maximum Benefit	\$2,000/person age 19 and older
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 Delta Dental Plan of Oregon network
Diagnostic and Preventive Care	Class I* – \$0 (Plan pays 100%, no deductible for eligible services)
Routine Services	Class II* – You pay 20%, after you meet deductible
Major Services <i>Note:</i> Includes inlays, onlays, crowns, and permanent prosthetics.	Class III* – You pay 50%, after you meet deductible Occlusal guards (nightguard) covered once every two years at 100% up to a \$150 maximum benefit. Over-the-counter nightguards are excluded.

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

Your Dental Plan Benefits – More Details

The dental plan has specific rules about what services are covered and how the plan pays benefits. These are described in detail in the following section. If you have questions about the information presented, please contact:

- Moda Health Customer Service: **503-265-5680** or **1-877-277-7280**, or www.modahealth.com
- City of Portland Health & Financial Benefits Office at **503-823-6031** benefits@portlandoregon.gov

CityBasic Dental Plan (administered by Delta Dental Plan of Oregon through Moda Health Plans)

The CityBasic Dental plan covers 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 Health before treatment is received.

Annual Deductible

Before the CityBasic Dental Plan pays its 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 CityBasic Dental Plan begins 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). 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 applies to all members age 19 and older, and 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.

CityBasic Dental Plan: 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 CityBasic Dental Plan...

- **Use participating, network providers.** They have agreed to charge individuals enrolled in the CityBasic 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 CityBasic plan 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

Preventive services

- Prophylaxis (cleanings) or periodontal maintenance, once every six months for the core plan (every four months for the buy-up plan Additional periodontal maintenance is covered for members with periodontal disease, up to a total of 2 additional per year).
- 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 of this SPD 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 teeth
- Composite (tooth-colored) fillings to treat decay on 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.

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
- Pulp capping, when there is exposure of the pulp
- 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: 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 Core or Buy-up Dental Plans offers orthodontic services to straighten or realign teeth. This benefit is available to adults and children enrolled in the Plan. You do not need to satisfy your deductible before benefits begin.

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

The lifetime maximum amount the Plan 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 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 Core and Buy-up Dental Plans: What Is NOT Covered

The following exclusions apply to individuals enrolled in the Delta Dental 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
- Replacement of a stainless steel crown by the same dentist within 24 months of placement. The replacement is included in the charge for the original crown.
- 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 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, premedication's, 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 their 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 her or himself.
- 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 page 84).

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 Core and Buy-up Dental Plans: 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 Delta 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 Plans

1. **Does Delta Dental 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 Delta Dental at **503-265-5680** or **1-877-277-7280**. 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 Delta Dental.
2. **What dentist can I see?** The City of Portland's service agreement with Delta Dental 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 Delta Dental. 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 Delta Dental Customer Service at **503-265-5680** or **1-877-277-7280** (toll free) and Delta Dental will review your claims history to determine how much in benefits you have remaining. Or, visit Delta Dental'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 Delta Dental 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 Delta Dental directly at **503-265-5680** or **1-877-277-7280**. Or, reach out to the City of Portland Benefit Information Line at benefits@portlandoregon.gov or **503-823-6031**.

COST OF COVERAGE

How Much Do the Benefits Cost?

2019-2020 Benefit Costs and Employee Premium Shares

The City of Portland contributes 90% of your medical, dental and vision premium costs. You will contribute 10% of the cost. This 10% “premium share” will apply to all medical, dental and vision coverage, unless you opt-out.

Plan	Total Monthly Benefit Costs			Your Semi-Monthly Contribution		
	Employee Only	Employee + 1	Family	Employee Only	Employee + 1	Family
CityBasic Medical, Dental and Vision plan	\$501.02	\$934.16	\$1,321.22	\$27.22	\$50.46	\$72.73

IMPORTANT PLAN INFORMATION

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 404 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.

The terms within this Benefits handbook are valid on a year-to-year basis. Therefore, the provisions within this document apply to FY 2019-2020 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 Employee Health & Financial Benefits Office at **503-823-6031**.

COORDINATION OF BENEFITS, CLAIMS AND APPEALS

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.

CityBasic Medical Plan and Dental Plan

The same Coordination of Benefits rules apply to both plans (the Medical Plan and Dental Plan administered by Moda Health), 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:

- Individual and group insurance contracts and group-type contracts
- HMO (Health Maintenance Organization) coverage
- Coverage under a labor-management trustee plan, a union welfare plan, an employer organization plan or an employee benefits plan
- Medicare or other government programs, other than Medicaid, and any other coverage required or provided by law
- Other arrangements of insured or self-insured group or group-type coverage
- **For the 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 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 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 CityBasic 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 CityBasic dental 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 will not pay any more than it would have paid if it had been the primary plan. In consideration of such an advance, this Plan shall be subrogated to all rights of the enrollee against the non-complying plan.

Which Plan Pays First?

The *first* of the following rules that applies will govern:

1. **Non-dependent/Dependent.** If a plan covers the claimant as other than a dependent, for example—an employee, member, subscriber, or retiree—then that plan will determine its benefits before a plan which covers the person as a dependent.

However, if the claimant is a Medicare beneficiary and, as a result of federal law, Medicare is secondary to the plan covering the person as a dependent and primary to the plan covering the person as other than a dependent (e.g., a retired employee), then the order of benefits between the two plans is reversed so that the plan covering the person as an employee, member, subscriber, or retiree is the secondary plan and the other plan covering the person as a dependent is the primary plan.

2. **Dependent Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together.** If the claimant is a dependent child whose parents are married, registered under the Oregon Family Fairness Act, or living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the plan of the parent whose birthday falls earlier in the calendar year is the primary plan. If both parents' birthdays are on the same day, the plan that has covered the parent the longest is the primary plan. (This is called the “Birthday Rule.”) This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.

3. **Dependent Child/Parents Separated or Divorced or Not Living Together.** If the claimant is a dependent child of divorced or separated parents, or parents not living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, then the following rules apply:

- If a court decree states that one of the parents is responsible for the 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.
- 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.
- 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 (#2 or #3) above shall determine the order of benefits as if those individuals were the parents of the child. This rule does not apply if the Non-dependent/Dependent rule can determine the order of benefits.
5. **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.

CityBasic Dental Plan 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.

CityBasic 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 preexisting condition exclusion or utilization review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not necessary and customary by the standards of generally accepted practice for the prevention or treatment of disease or accidental injury, 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 their 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 two-level internal review process consisting of a first level appeal and a second level appeal. If a member is not satisfied with the outcome of the second level appeal, and the dispute meets the specifications outlined in the External Review section, the member may request external review by an independent review organization. The first and second levels of appeal will need to be exhausted to proceed to external review, unless the Plan agrees otherwise.

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 when 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 Moda Health's Customer Service. Otherwise, an appeal must be submitted in writing to Moda Health. If necessary, Moda Health's 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 their behalf. Moda Health will acknowledge receipt of the written appeal within seven days and conduct an investigation by persons who were not involved in the original determination.

An appeal related to an urgent care claim will be entitled to expedited review upon request. An expedited review will be completed no later than 72 hours after receipt of the appeal by Moda Health, unless the member fails to provide sufficient information for Moda Health to make a decision. In this case, Moda Health will notify the member within 24 hours of receipt of the appeal of the specific information necessary to make a decision.

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.

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 their 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

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

Within six business days following receipt of a request, Moda Health will send a written notice to the member if the request is incomplete or ineligible for external review. Otherwise, the independent review organization will provide a written notice of the final external review decision within 45 days after its receipt of the request. For claims involving urgent care, the independent review organization will expedite the review and provide notice within 72 hours after its receipt of the request. The decision of the independent review organization is binding, except to the extent other remedies are available to the member under state or federal law.

Additional Member Rights

Members may contact the Department of Health and Human Services Health Insurance Assistance Team (HIAT) at **1-888-393-2789** or the Oregon Insurance Division. Assistance for questions about their appeal rights or for assistance:

By phone: **503-947-7984** or toll-free **1-888-877-4894**
By mail: Oregon Insurance Division
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

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

Members may also contact the Health & Financial Benefits Office at 503-823-6031 for other consumer assistance through the Group.

CityBasic Plan: Appeals

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 their 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. 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.

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.

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.
- Obtain free language assistance services, including verbal interpretation services, when communicating with Moda Health
- 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 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: Oregon Insurance Division
 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 CityBasic Medical plan 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 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 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>. 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 medication 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 their 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>.

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:

Serilda Summers-McGee
City of Portland Privacy Officer
Bureau of Human Resources
City of Portland, Oregon
1120 SW 5th Avenue, Room 404
Portland, Oregon 97204
Phone: **503-823-3572**
Fax: 503-823-3522

Serilda.Summers-McGee@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.

Medication 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 this Medical plan 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 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, 2018
Name of Entity/Sender:	City of Portland
Contact--Position/Office:	Health & Financial Benefits Office
Address:	1120 SW Fifth Ave., Room 404
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, 2016. 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://flmedicaidprecovery.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.hijosaludablesoregon.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, 2016, 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

111 SW Columbia St. Suite 550

Portland, OR 97201

503-823-6031

portlandoregon.gov/bn

Interoffice: 122/550

Text “city benefits” to 31996 to join our text club



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