City of Eugene

Employee Benefits Handbook

City Hybrid Plan

Point of Service (POS) Plan

IATSE- and Non-Represented Employees Only

City Hybrid Plan Medical Insurance
Dental & Vision Insurance
Employee Assistance Program
Flexible Spending Account Program
Life and Long Term Disability Insurance

Effective June 1, 2016

This edition of the Employee Benefits Handbook for employees on the City Hybrid Plan supersedes all previous benefit handbooks distributed to employees with City Hybrid Plan Point of Service (POS) coverage.

CONTACT INFORMATION

PacificSource Health Plans

Medical, Vision and Pharmacy Claims Administrator
www.pacificsource.com

Customer Service
Phone: 541-225-1950 or
Toll-free Phone: 888-532-5332
Spanish: Toll-Free: 800-624-6052 ext 1009
Fax: 541-225-3658
Email: asocustomerservice@pacificsource.com

Claims Address - Medical, Vision, Pharmacy
Attn: City of Eugene PSA Claims
PacificSource Administrators
PO Box 70088
Springfield, OR 97475
Medical/Vision Fax: 541-225-3632
Pharmacy Fax: 541-225-3665
Email: asocustomerservice@pacificsource.com

Delta Dental Plan of Oregon

A Moda Health Affiliated Company
Dental Claims Administrator
www.modahealth.com

Dental Customer Service
Toll-Free Phone: 888-217-2365
Spanish Toll-Free 877-299-9063
Email: dental@modahealth.com

Claims Address - Dental
Delta Dental Plan of Oregon
601 SW Second Avenue
Portland, Oregon 97204

BenefitHelp Solutions

COBRA/Retiree and Flexible Spending Account Administrator
www.benefithelpsolutions.com

COBRA/Retiree Administrator
PO Box 5817
Portland OR 97228-5817
COBRA Toll-Free Phone: 877-664-4760
Retiree Toll-Free Phone: 855-289-6313
Toll-Free Fax: 888-393-2943
Email: contactbhs@benefithelpsolutions.com

Flexible Spending Account Administrator
Attn: FSA
PO Box 67230
Portland OR 97268-1230
FSA Toll-Free Phone: 877-664-4761
TRA Toll-Free Phone: 888-398-8057
Toll-Free Fax: 888-249-5058
Email: fsa@benefithelpsolutions.com

City of Eugene

Employee Benefits Program

www.eugene-or.gov/employeebenefits

City of Eugene Risk Services
Employee Benefits
940 Willamette St, Suite 200
Eugene OR 97401
Phone: 541-682-5062
Fax: 541-682-5211
Email: BenefitsStaff@ci.eugene.or.us

INTRODUCTION

About Your Benefits Handbook

The City of Eugene maintains the Employee Benefits Plan for its benefitted employees. This handbook is designed to inform you about your health, life and long-term disability insurance as well as other benefits provided by the City. With this information, you will be able to take advantage of these important benefits.

This handbook serves as an integral part of your benefit plan document, and describes your entitlements and obligations under each of the plan's benefit programs. This handbook is a summary of your benefits and is not a contract. Any of the benefits provided under the plans may be changed, replaced or terminated by the City of Eugene and the affected bargaining units at any time.

If you have questions about any of the benefits outlined in this handbook, you can contact the City of Eugene Risk Services Benefits Program at 541-682-5062.

Health Care Reform

The City of Eugene will comply with the Federal Patient Protection and Affordable Care Act, commonly referred to as Health Care Reform. Not all of the changes outlined in the legislation will happen at once. Many of the changes are set to occur in future years. See the Important Notices section of this handbook for more information.

Frequently Asked Questions

1. **How do I make changes to my health plan enrollment?**

   You can submit a new health plan enrollment form electronically from home or work at www.eugene-or.gov/healthenroll. Paper copies of the form can be downloaded from the same link or are available in the Risk Services Employee Benefits office.

2. **When will I get my new wallet cards?**

   You will normally receive your wallet cards within 2 weeks after your enrollment information has been processed. Contact the Claims Administrator (either PacificSource or Delta Dental) if you have questions about your wallet card. Be sure to show your new wallet card to your pharmacy and provider to take advantage of contracting discounts.

3. **Can I make changes to my benefit elections during the year?**

   You can only make changes to your health plan enrollment and flexible spending account elections during the City's annual open enrollment periods or if you have a qualifying status change. See the Open Enrollment, Special Enrollment, and Flexible Spending Accounts sections for more information.

4. **What impact does it have on my health insurance if I don't report a family status change to the Benefits Program within 60 days of the event?**

   - ***If adding a dependent:*** If you miss the 60-day initial eligibility period, you will not be able to be add your dependent to your plan until the City's next Open Enrollment period if it causes an increase to your Payroll Deduction or contribution for health insurance coverage. Please see the Eligibility and Enrollment section for more information.
   - ***If dropping a dependent:*** Coverage for your ex-dependent will end on the last day of the month in which they are eligible for benefits. Please see the Eligibility and Enrollment and the Continuation of Coverage sections for more information.

5. **How can I calculate my out of pocket costs for health insurance coverage?**

   - Information on health insurance rates, including Active Employee payroll deductions and COBRA/Retiree rates, is available in the Benefit Premium Ratesdocument on the Employee Benefits website at www.eugene-or.gov/employeebenefits. COBRA/Retirees can also contact BenefitHelp Solutions for additional information.
   - For other possible health insurance costs, including copays or coinsurance, deductibles, and out of pocket maximums, please see the Benefit Summaries and the Medical Coverage General Information sections of this handbook.

6. **Where can I find a listing of in-network providers?**
   - ***Medical, Vision, and Pharmacy:*** Participating provider information is available on the PacificSource website at http://www.pacificsource.com/provider-networks.aspx or by contacting PacificSource. Please see the Using the Provider Network section for more information.
   - ***Dental:*** Information on participating Delta Dental providers is available on the Moda website at www.modahealth.com or by contacting Delta Dental, a Moda Health affiliated company.

7. **How can I find out if my prescription drug is covered by the plan?**

   The Preferred Drug List (PDL) is available on the PacificSource website at www.pacificsource.com\pdl.

8. **How do I submit a claim for reimbursement?**
   - ***Medical, Dental and Vision Coverage*:** Submit claims using a City of Eugene Quick Claim Form available on the Employee Benefits website. See the health insurance Claims Administration and Payments section of this handbook for detailed information.
   - ***Flexible Spending Accounts*:** Submit claims using a City of Eugene FSA Claim Form or TRA Claim Form available on the Employee Benefits website. See the Flexible Spending Account and Transportation Reimbursement Account sections of this handbook for detailed information.

9. **Who is eligible for coverage under my plan?**

   For regular employees, dependents eligible to be added to your health plan include your spouse, domestic partner, children, step-children and children of domestic partners. For a more comprehensive list of eligible dependents see the Eligibility and Enrollment section. For temporary employees, dependents are biological and adopted children.

10. **Is there a way to continue health insurance coverage after termination of employment?**

    Yes, you and your covered dependents may be entitled to COBRA Continuation or Retiree Health Insurance coverage once your coverage through the City ends. See the Continuation of Coverage section for more information.

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CITY HYBRID PLAN

Point of Service (POS)
Medical, Dental and Vision Insurance

Effective June 1, 2016

WELCOME

The City of Eugene maintains a health care program designed to provide you and your dependents with financial assistance toward maintaining your good health. This plan helps pay your medical expenses, hospitalization costs, and doctors' fees. It also helps pay the cost of dental care, from routine examinations to orthodontic treatment.

The City of Eugene's health plans are self-funded, which means the City directly pays the costs of eligible expenses incurred under this plan. The City contracts with Claims Administrators to process the claims. This plan's medical, pharmacy and vision coverage is administered by PacificSource Health Plans, and the dental coverage is administered by Delta Dental Plan of Oregon, a Moda Health affiliated company.

This handbook will help you understand how your plan works and how to use it. Please read it carefully and thoroughly. If anything is unclear to you, either PacificSource Customer Service or Delta Dental Customer Service is available to answer your questions. Contact information is at the front of this handbook.

Your Responsibility in this Plan

In a Point-of-Service plan you need to select a Primary Care Provider (PCP) from within the network in order for your benefits to be paid at the highest level. You also need to actively consult with your PCP and any other treating provider to ensure that all care is being provided within the provider network. You may be responsible for part or all of the charges associated with services provided out of network or without a referral.

Membership Card

After enrolling, you and your covered dependents will receive identification cards from our Claims Administrators, PacificSource and Delta Dental, which will include your group number and identification number. Your medical card will also have the name of each covered person's primary care provider. Please review these cards carefully. You will need to present your card each time you receive services from a participating physician or provider. When calling for an appointment, identify yourself as a member of the PacificSource medical network or the Delta Dental network. If you lose your identification card, you can request a replacement by either calling the Claims Administrator or by requesting them via your member website.

Member Access Websites

The ability to access personal information online has become increasingly important. Both PacificSource and Delta Dental have helpful online services for members which provide powerful tools for managing your healthcare. After a simple registration process, you will be able to view benefit information tailored specifically for you. For example, you can:

- Order ID cards
- Review benefit coverage levels
- Track deductibles and out of pocket information
- Change personal information
- Review claims information or check the status of an open claim
- Print an Explanation of Benefits

You can access the member websites at:

PacificSource – InTouch: www.pacificsource.com

Delta Dental (a Moda Health affiliated company) – myModa: www.modahealth.com

MEDICAL BENEFIT SUMMARY

This is only a summary of your benefits; other sections of the handbook discuss the services covered under the plan, as well as applicable benefit limitations, exclusions from coverage, and conditions of service.

Payment to providers is based on the contracted reimbursement rate for covered services. Although in-network participating providers accept the contracted rate as payment in full, nonparticipating providers may not. To receive the maximum benefits under this plan, members should use an in-network participating provider and first seek treatment from their Primary care provider (PCP).

The City Hybrid plan requires either a co-pay for services or a deductible and co-insurance amount as the member's contribution to the cost of services under the plan. Services requiring a co-insurance amount are paid after the deductible has been met. The deductible does not apply for services requiring a co-pay.

General Information	**Medical Coverage Administered by PacificSource Health Plans.**
Eligibility	Regular Non-Represented full-time and part-time employees scheduled to work at least 20 hours per week. IATSE-represented employee eligibility specified in most recent labor agreement between IATSE and the City of Eugene. Temporary employees meeting the definition of full-time under the Affordable Care Act (ACA). Former IATSE- and Non-Represented employees and/or their dependents who are eligible for COBRA or the Retiree health insurance continuation.
When Coverage Begins	Regular Active employees: First of the month following date of hire (following date of eligibility for IATSE-represented employees). Temporary Active employees: First of the month after the Administrative Period following ACA date of eligibility. COBRA/Retirees: First of the month following the last day of employment with the City of Eugene, provided timely election of coverage and premium payment.
Benefit Levels	The City Hybrid Plan uses the PacificSource Prime PSN Network. Benefit levels for *most* services referred by your PCP: • In-Network provider: The co-pay **or** co-insurance and deductible as specified in this Medical Benefit Summary • Non-Network provider: Normally, 50% plus co-pay **or** 50% plus co-insurance and deductible as specified in this Medical Benefit Summary
Choice of Physician/Hospital	For most services, you must go to an in-network physician or hospital and have a referral from your primary care provider to receive in-network benefits. However, if you are willing to pay more for the cost of health care you may go to any qualified provider.
Service Area	Worldwide for emergencies. Benefits are paid at the highest rate when using a provider in the PacificSource service area. PacificSource contracts with participating providers throughout the Oregon, Idaho, and Montana service areas and in bordering communities in southwest Washington. They also have agreements with certain nationwide networks whose providers outside the PacificSource service area are considered participating providers under your plan. Contact PacificSource for details. PacificSource contracts with the Life Flight Network for air ambulance services.
Required Premiums	Employees may be required to contribute to the cost of coverage under this plan. Retiree and COBRA Continuees pay the full cost of the premium. Information on rates is available on the City of Eugene Benefits website at www.eugene-or.gov/employeebenefits.

Calendar Year Medical Deductible (only applies to services requiring co-insurance as outlined below)	
IATSE and Non-Represented	Per Person: $200 Per Family: $600

Calendar Year Out-of-Pocket Maximum Expense per Person	
Non-Represented	Medical: $1,000 per person Retail Pharmacy: $1,300 per person Deductibles, fixed dollar copays and mail order prescription drug co-pays do not count toward the Out of Pocket Maximum
IATSE-Represented	Medical: $1,200 per person, including deductible. (No more than three deductibles apply per family per year) Retail and Mail-Order Pharmacy: $1,300 per person Fixed dollar copays do not count toward the Out of Pocket Maximum

Service/Treatment/Supply	Co-pay	In-Network PCP or Referred Benefit After Co-pay	Out of Network or Nonreferred Benefit After Co-pay
Preventative Services *Note: IATSE-Represented employees have certain women's preventative care services covered with no co-pay as outlined by the Affordable Care Act as it applies to non-grandfathered health plans. Please contact PacificSource for details.*			
Routine Physical Exams	No co-pay – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Annual Gynecological Exams	No co-pay – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Routine Mammograms	No co-pay	100%	50%
Cancer Screenings - including Colorectal and Prostate screening (subject to exam frequency limits)	No co-pay – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Immunizations	No co-pay	100%	50%
Hearing/Eye Exams - Children (1 exam every 24 months for children through age 18)	No co-pay – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Well-Baby Care	No co-pay – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Professional Services			
Alternative care Per calendar year for all alternative care combined: IATSE- up to 12 visits / Non-Represented - up to 15 visits	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	100%
Home and Office Visits	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Outpatient Diabetic Instruction	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Physician Hospital Visits	No co-pay	80% after deductible	50% after deductible
Surgery - Physician Services at a Facility	No co-pay	80% after deductible	50% after deductible
Surgery - Physician Services in the Physician's Office	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Therapeutic Injections - Physician Services	No co-pay	80% after deductible	50% after deductible

Service/Treatment/Supply	Co-pay	In-Network PCP or Referred Benefit After Co-pay	Out of Network or Nonreferred Benefit After Co-pay
Hospital / Inpatient Services			
Inpatient Room and Board*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Skilled Nursing Facility Care*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Outpatient Services			
Outpatient Surgery Facility Charges These services require pre-authorization	No co-pay	80% after deductible	50% after deductible
X-ray and Lab - Diagnostic/Therapeutic	No co-pay	80% after deductible	50% after deductible
Imaging procedures (CT/MRI)	No co-pay	80% after deductible	50% after deductible
Emergency and Urgent Care			
Ambulance Transportation	No co-pay	80% after deductible	80% after deductible
Emergency Room Facility (co-pay waived if covered hospitalization immediately follows emergency room use). PacificSource contracts with the Life Flight Network for air ambulance services.	$100 per visit	100%	100% - IATSE-Represented 50% - Non-Represented
Urgent Care Office Visit	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Rehabilitation			
Inpatient Rehabilitation*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Outpatient Rehabilitation	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Physical Therapy, Speech Therapy and Occupational Therapy	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Other Services and Supplies			
Diabetic Supplies (other than insulin and syringes)	No co-pay	80%	50%
Durable Medical Equipment	No co-pay	80% after deductible	50% after deductible
Hearing Aid - Adults $1000 maximum in a 36-month period	No co-pay	50% after deductible	50% after deductible
Hearing Aid - Children	No co-pay	80%	80%
Home Healthcare	No co-pay	80% after deductible	50% after deductible
Home Infusion Therapy	No co-pay	100%	50%

Service/Treatment/Supply	Co-pay	In-Network PCP or Referred Benefit After Co-pay	Out of Network or Nonreferred Benefit After Co-pay
Hospice Care	No co-pay	80% after deductible	50% after deductible
Infertility**	No co-pay	50%	Not Covered
Injectable Medication			
Self-administered	See Pharmacy Benefit Summary		
Provider-administered	No co-pay	100%	50%
Maternity / Pregnancy			
Physician services	No co-pay – IATSE-Represented $15 per visit – Non-Represented	80% after deductible - IATSE-Represented 100% - Non-Represented	80% after deductible - IATSE-Represented 50% - Non-Represented
Facility charges*	$100 per day	80% after deductible	50% after deductible
Mental Health and Chemical Dependency			
Inpatient*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Residential*	$100 per day	100% for first five days, then 80% after deductible	50% for first five days, then 50% after deductible
Outpatient	$25 per visit – IATSE-Represented $15 per visit – Non-Represented	100%	50%
Prosthetic Devices	No co-pay	80% after deductible	50% after deductible
Temporomandibular Joint Syndrome (TMJ) **	No co-pay	50%	Not Covered
Tobacco Cessation Eligible expenses for members age 15 or older participating in a tobacco cessation program	No co-pay	100%	100%

*Co-pay subject to five day maximum
**Subject to limitations

PHARMACY BENEFIT SUMMARY

Pharmacy coverage is administered by PacificSource Health Plans, and uses the PacificSource Health Plans Retail Pharmacy Network and offers mail-order pharmacy through your choice of Caremark or Wellpartner.

This health plan includes coverage for prescription drugs and contraceptives, subject to the limitations and exclusions. Please review the Covered Services, Supplies and Treatments - Prescription Drug Program section of this handbook for more information. IATSE-Represented employees have certain women's preventative care services covered with no co-pays as outlined by the Affordable Care Act as it applies to non-grandfathered health plans. Please contact PacificSource for details.

The City of Eugene uses the PacificSource Preferred Drug List (PDL), which is available on the PacificSource at: http://www.pacificsource.com/pdl/.

	Retail Co-pay ***Copay charged for each 34-day supply***	**Mail-Order Co-pay**
IATSE-Represented	Up to 34-day supply* (30-day supply for self-injectables)	Up to 90-day supply* (30-day supply for self-injectables)
	$1,300 Out of Pocket Maximum retail and mail order combined.	
Generic (Tier 1): Preferred (Tier 2): Non-Preferred (Tier 3):	50% 50% $40 or 50%, W*hichever is greater*	$15 $35 $70
Non-Represented	Up to 34-day supply* (30-day supply for self-injectables)	Up to 90-day supply* (30-day supply for self-injectables)
	$1,300 Out of Pocket Maximum	No Out of Pocket Maximum
Generic (Tier 1): Preferred (Tier 2): Non-Preferred (Tier 3):	50% 50% $40 or 50%, W*hichever is greater*	$15 $35 $70

**If a 3-month supply of contraceptives is initially prescribed, a 12-month refill of the same contraceptive will be covered, regardless if the initial prescription was covered under this plan.*

VISION BENEFIT SUMMARY

Former Employees: Vision Coverage is optional for former employees continuing coverage, and is only available if you selected this benefit level and pay the additional required premium.

Vision coverage is administered by PacificSource Health Plans.

See the Vision Plan Coverage section of this handbook for additional information about your benefits.

VISION GENERAL INFORMATION	
Deductible	None
Covered Vision Services	Exams, lenses and frames, contact lenses, medically necessary subnormal vision aids
BENEFIT – Children under the age of 19	
Eye Exams (once every 12 months)	80%
Prescription frames and lenses **OR** contacts (once every 12 months). Contacts limited to the following per year: Standard (one pair annually): 1 contact lens per eye (2 lenses total); Monthly (six month supply) or Biweekly (3 month supply): 6 lenses per eye (12 lenses total); Dailies (one month supply): 30 lenses per eye (60 lenses total)	100%
BENEFIT - Adults	**IATSE-Represented**
Eye Exams (once every 12 months)	80% up to $60
Lenses (per lens)* Single Vision Bifocal Trifocal Lenticular	 $20 $30 $40 $60
Frames* (one pair, once every 24 months)	$50
Contacts* (per lens, once every 24 months) After cataract surgery To correct extreme visual acuity problems (20/70) Cosmetic Contacts (both lenses)	 $60 $60 $70
*Adult IATSE plan members are eligible for prescription lenses and frames **OR** prescription contacts every 24 consecutive months.	
BENEFIT - Adults	**Non-Represented**
Eye Exams (once every 12 months)	80%
Prescription frames, lenses and/or contacts (once every 24 months)	$300 maximum

DENTAL BENEFIT SUMMARY

Former Employees: Dental Coverage is optional for former employees continuing coverage, and is only available if you selected this benefit level and pay the additional required premium.

Dental coverage is administered by Delta Dental, a Moda Health affiliated company.

This is only a brief summary of your dental benefits. Please refer to the additional information provided in the Dental Coverage section of this handbook for details.

The City Hybrid Plan utilizes the Delta Dental Premier Dental Network. Delta Dental has contracted with participating dentists and has approved their fee schedules. As a result, your share of the dental costs may be reduced. Benefit levels for non-participating providers are based on the prevailing fee level charged by other dentists for the same services.

BENEFIT	**Dental coverage is administered by Delta Dental of Oregon**
Delta Dental Network Service Area	The Delta Dental Premier Dental Network includes all counties in Oregon. Members living outside the Delta Dental Premier Dental Network can receive in-network benefits from a Premier provider through Delta Dental' nationwide network, the Delta Dental Network.
Calendar Year Deductible	$50 per person; $150 family maximum
Maximum Dental Benefit*	IATSE-represented: $250 per person for expenses incurred first calendar year of eligibility; $1,250 per person each calendar year thereafter Non-Represented: $1,500 per person each calendar year *Essential dental benefits for members under the age of 16 will not be subject to the annual dental maximum. See the Dental Plan Coverage section of this handbook for details.
Preventative Services Exams, Bitewing X-rays, Fluoride, Cleaning	100% no deductible
Basic Services Fillings, Crowns, Denture Repairs	80% after deductible
Major Services Initial Dentures and Bridgework	50% after deductible
Dental Implants	Non-Represented: 50% after deductible. Implant placement and removal once per lifetime per tooth space IATSE: Not covered
Orthodontic Services	50% no deductible. $2,000 per person maximum lifetime benefit

USING THE MEDICAL PROVIDER NETWORK

This section explains how your plan's medical benefits differ depending on how you access care. This information is not meant to prevent you from seeking treatment from any provider if you are willing to take increased financial responsibility for the charges incurred.

Medical Provider Network

PacificSource contracts with participating providers throughout the Oregon, Idaho, and Montana service areas and in bordering communities in southwest Washington. They also have an agreement with certain nationwide networks whose providers outside the PacificSource service area are considered participating providers under your plan. Contact PacificSource or go to PacificSource.com for details.
See the Payment to Providers section below for information on participating and nonparticipating providers.

Primary Care Provider

A primary care provider (PCP) is a participating family practitioner, pediatrician, internist, nurse practitioner, or women's care specialist for your plan who you choose to be responsible for your medical care. Your PCP is extremely important because he or she will be the first physician or provider you call when you or your covered dependents need medical care. These physicians have agreed to be available, either directly or through other arrangements, 24-hours a day, seven days a week to manage your healthcare needs.

To have services paid at the maximum benefit level, you and your family members must each select a PCP from the PacificSource network. Your family members may each choose a different PCP or share the same one. If a person does not choose a PCP, claims will be paid at the Nonparticipating benefit level. A directory of participating providers in the PacificSource network is available on the PacificSource website at www.pacificsource.com, or by calling the PacificSource Customer Service Department.

Your PCP is responsible for providing and/or coordinating all your healthcare needs, including contacting PacificSource for pre-authorization for hospitalizations and specialist referrals. Should the PCP be unavailable, he or she will arrange for another participating physician to assume responsibility for your care. If the PCP refers you to a specialist who determines hospitalization is needed, the specialist will request the pre-authorization for you.

Once you have selected a primary care provider, PacificSource will notify the PCP of your enrollment. You should contact your PCP to introduce yourself as a new PacificSource Network member. When you call, you can arrange for medical records to be transferred and find out how to contact the PCP after office hours. This is the first step in establishing a relationship with your PCP.

Changing PCPs

If you would like to change your PCP, you will need to notify PacificSource before obtaining treatment from a new PCP. You may change your PCP through the PacificSource website or by contacting PacificSource's Customer Service Department. PCP changes will become effective the first of the month following the date of notification. All specialist referrals from your former PCP will still be valid for the referral period. Contact PacificSource if you have questions about referrals when changing PCPs.

Other Participating Physician or Professional Provider Care

A woman may see a participating Women's Healthcare Provider without referral from her PCP and still receive participating benefit levels for preventive women's health exams and for pregnancy care. See the Definitions section for more information on Women's Healthcare Providers.

Referrals

When you and your PCP decide that services of a specialist are necessary, your PCP will request a referral on your behalf from PacificSource. You may use any PacificSource network physician or provider when referred to them by your primary care provider. If you do not get a referral from your PCP, your benefits will be paid at the Nonparticipating benefit level, unless this handbook specifically states that the service does not require a referral.

Nonparticipating Physician or Provider Care

Services by a Nonparticipating physician or provider must be referred by your PCP, authorized by PacificSource, and not available in the PacificSource network in order for the highest benefit levels to apply. PacificSource will work with the PCP to refer you to a participating physician or provider whenever possible because participating physicians and providers have agreed to cooperate in quality assurance and utilization review programs. Payment for services rendered by Nonparticipating physicians and providers will be based on the allowable fee for those services. See the Definitions section for more information on allowable fee.

Services that Do Not Require a Referral

Referral authorization is not required for the following types of treatment:

- **Children's routine vision exams.** Covered children through age 18 may obtain a routine vision exam by any participating optometrist or ophthalmologist without a referral.
- **Women's routine gynecological exams.** You may visit your PCP or any participating Women's Healthcare Provider without a referral for annual preventive gynecological exams.
- **Obstetric care and delivery.** You do not need a referral to access maternity and delivery care from a participating Women's Healthcare Provider.
- **Mental health and chemical dependency outpatient services.** You do not need a referral for office visits to a participating mental health or chemical dependency provider.
- **Services of an alternative care provider**.
- **Services of a physical or occupational therapist**. A referral from your PCP is not required but services must be prescribed by a qualified medical provider. See "Physical, Occupational or Speech Therapy and Pulmonary Rehabilitation" for details.

Accessing Specialist Care without a Referral

If you are willing to pay more out of your own pocket, you may seek the care of a specialist without referral from your PCP. If a specialist performs services without an approved referral authorization, benefits will be paid at the nonreferred provider percentage shown on your Medical Benefit Summary. In this case, the nonreferred benefit applies even if the specialist is a participating provider for your plan. Keep in mind that services of nonreferred providers are still subject to all the other limitations and exclusions that apply to covered services under this plan.

Coverage Outside the Provider Network

Your plan also provides benefits when you live or travel outside the boundaries of the PacificSource provider network outlined in the Medical Benefit Summary.

When you need medical services outside the PacificSource network, you can save out-of-pocket expense by using the participating providers available through PacificSource's supplemental networks. These supplemental networks can minimize your out-of-pocket expense by providing you with access to providers nationwide and the associated savings that can be realized through contracted rates.

Living Outside the Network

If you live outside the PacificSource Network, you can contact PacificSource to arrange to have a PacificSource supplemental network become your primary network. You can then receive benefits at the in-network benefit level when using a PacificSource supplemental network provider.

Covered Children Living Outside the Network

If your covered child resides outside the service area, benefits will be extended for treatment of an illness or injury, preventive healthcare (including routine physicals and immunizations) and maternity services as if the care were rendered by participating physicians and providers. A referral from a primary care provider is not required for an out of area covered child to receive benefits for medically necessary care.

All non-emergency hospital confinements must be authorized. Fees charged by out-of-area physicians or providers will be reimbursed at the allowable fee for those services.

Traveling Outside the Network

Emergency Care: If you are traveling outside the network and need emergency care, you should seek immediate treatment, and then call your PCP as soon as possible. For emergencies, your plan pays benefits at the participating provider level regardless of your location, with covered expenses based on PacificSource's allowable fee. Please see the section in this handbook on Emergency Care and Urgent Care for more information.

Non-Emergency Care: When you need non-emergency medical services while traveling outside your network, you can save out-of-pocket expense by using participating providers available through PacificSource's national network. While claims are paid at the lower benefit level for all non-emergency care received outside your primary service area, you will be able to take advantage of provider discounts that apply when the provider is participating in PacificSource's supplemental networks. If you seek care from a Nonparticipating provider, you will receive the out of network benefit and may be required to pay any cost that exceeds your allowable fee.

Whenever possible, call your PCP first. Your PCP will direct you to the appropriate setting for care, such as an emergency room, urgent care clinic, or physician's office. You can then contact PacificSource to find a participating provider in your area. PacificSource's phone number is printed on your PacificSource ID card for your convenience, or you can use the provider search tool available on the PacificSource website at www.pacificsource.com.

Payment to Providers

Participating Providers

Participating providers contract with PacificSource to furnish medical services and supplies to members for a set fee, and agree not to charge more than the contracted reimbursement rate. When you receive covered services or supplies from a participating provider, you are only responsible for the amounts shown on your Benefit Summary.

In addition to participating providers, PacificSource has contracted with several Centers of Excellence for specialized treatment programs to handle services such as transplants, neonatal care, and open heart surgery. If you need services within your network for which PacificSource has provider contracts, you will be required to use the contracted providers for your treatment to be covered at the plan's highest benefit level.

Even when you are treated at a participating medical facility, it is not safe to assume that all services are performed by participating providers. Whenever possible, you should arrange for professional services such as surgery and anesthesiology to be provided by a participating provider. Doing so will help you maximize your benefits and limit your out-of-pocket expenses.

Nonparticipating Providers

Nonparticipating providers are physicians, other healthcare professionals, hospitals, medical facilities, or medical supply vendors who do not have an agreement with PacificSource to provide services for members. Services of nonparticipating providers are still subject to all the other limitations and exclusions that apply to covered services under this plan.

Nonreferred Providers

A nonreferred provider is any physician, healthcare professional, hospital, medical facility, or medical supply vendor other than your PCP from whom you receive non-emergency care without an authorized referral. Nonreferred providers can be participating or nonparticipating providers. Services of nonreferred providers are still subject to all the other limitations and exclusions that apply to covered services under this plan.

PCP or Referred Provider Benefits

For covered services, this plan pays benefits at the "PCP or Referred Benefit After Co-pay" level shown on your Benefit Summary:

- When you are treated by your PCP
- When you are treated by another provider with an authorized referral from your PCP
- When you are treated by a participating provider for services that do not require a referral
- In a true medical emergency

In those cases, you are only responsible for the amounts shown on your Benefit Summary. Those amounts may include a co-payment, a coinsurance payment, or both.

Nonreferred Provider Benefits

Except for true medical emergencies and services that do not require a referral, your benefits are reduced if you are treated by a provider other than your PCP without an authorized referral.

- For nonreferred services of participating providers, the provider is paid at the percentage shown in the "Nonparticipating/Nonreferred Provider" column of your Benefit Summary.
- For nonreferred services of nonparticipating providers, PacificSource determines the allowable fee and pays the provider at the percentage shown in the "Nonparticipating/Nonreferred Provider" column of your Benefit Summary. The allowable fee is a fixed amount, and depends on the specific service or supply and the geographic area where the service is provided.

Nonparticipating Provider Benefits

For nonparticipating providers, the allowable fee is often less than the provider's charge. In that case, the difference between the allowable fee and the provider's billed charge is also your responsibility. That amount does not count toward your out-of-pocket maximum. It also does not apply toward any co-payments. In any case, after any co-payments, the amount payable to a nonparticipating provider will not be less than 50% of the allowable fee for a like service or supply.

Example of Provider Payment

The following illustrates how payment could be made for a covered service billed at $120 under three different scenarios: with an authorized referral, from a participating provider without a referral, and from a nonparticipating provider without a referral.

This is only an example using a sample co-pay of $15; your co-pays and benefits may be different.	**With Referral**	**Participating Provider No Referral**	**Nonparticipating Provider No Referral**
Provider's usual charges	$120.00	$120.00	$120.00
Billed charge after negotiated provider discounts	$100.00	$100.00	$120.00
PacificSource' allowable fee	$100.00	$100.00	$100.00
Allowable fee less patient co-payment	$85.00	$85.00	$85.00
Percent of payment (after co-payment) from Benefits Summary	100%	50%	50%
PacificSource' payment	**$85.00**	**$42.50**	**$42.50**
Patient's responsibility			
Co-payment	$15.00	$15.00	$15.00
Patient's amount of allowable fee (after co-payment)	$0.00	$42.50	$42.50
Difference between allowable fee and billed charge after discounts	$0.00	$0.00	$20.00
Patient's total payment to provider	**$15.00**	**$57.50**	**$77.50**

MEDICAL COVERAGE GENERAL INFORMATION

Qualified Medical Professionals

A qualified professional provider includes, but is not necessarily limited to, the following, when providing medically necessary covered services within the lawful scope of their license:

- Physician - Doctor of Medicine (MD) or Doctor of Osteopathy (DO)
- Licensed physician assistant under the supervision of a physician
- Registered Nurse (RN) Licensed Practical Nurse (LPN) or a registered first nurse assistant, but only for services rendered upon the written referral of a Doctor of Medicine or Osteopathy, or only for those services nurses customarily provide to patients
- Certified nurse practitioner, including certified registered nurse anesthetist (CRNA) and certified nurse midwife (CNM)
- Certified surgical assistant, surgical technician, or registered nurse (RN) when providing medically necessary services as a surgical first assistant during a covered surgery
- Board-certified or board-eligible genetic counselor when referred by a physician or nurse practitioner for evaluation of genetic disease
- Podiatrist, for non-routine foot care when authorized by a Primary Care Practitioner
- Licensed massage therapist, when medically necessary
- Licensed Naturopath
- Registered Acupuncturist
- Chiropractor
- Registered Dietician
- Licensed Dentist (Doctor of Medical Dentistry or Doctor of Dental Surgery), but only for services covered under this plan
- Optometrist
- Licensed Pharmacist
- Licensed Psychologist
- Licensed Psychologist Associate
- Licensed Clinical Social Worker (MSW), but only for services rendered upon the written referral of a Doctor of Medicine or Osteopathy, or a Psychologist
- Registered Physical, Occupational, Speech or Audiological Therapist, an individual who is licensed to perform audiometric examinations and dispense hearing aids (Audiologist), or Certified Speech Pathologist
- Licensed Professional Counselor (LPC) and
- Licensed Marriage and Family Therapist (LMFT)
- State Licensed Audiologist

For IATSE-Represented employees, this plan will not discriminate against any health care provider who is acting within the scope of their license or certification under state law.

Please note that even when seeing an approved provider, certain services may not be covered under your plan. Contact PacificSource if you would like to verify coverage prior to receiving a service.

Medical Deductible

The medical deductible is the amount you and your eligible dependents must pay for covered medical expenses each calendar year (January 1 through December 31) before the plan will pay benefits for any additional covered expenses you incur that year. The medical deductible only applies to services that require a co-insurance amount. See the Summary of Medical Benefits for the deductible amounts for each employee group and the services to which they apply.

No more than three deductibles must be paid by any one family per calendar year.

Current employees and their dependents transferring to the City Hybrid Plan from any of the City's other plans during the annual open enrollment period will be given a 50% credit toward the first calendar year deductible (individual and family).

Carry-Over Deductible

The deductible must be satisfied each year. However, medical expenses incurred in October, November, or December which are used to meet the current year's deductible will be applied toward the individual's deductible for the next year.

For example, if your deductible is $200 and $50 in covered medical expenses is applied toward your deductible in December, you will need only $150 in eligible charges to meet the next year's deductible ($50 + $150 = $200 annual deductible).

Medical Benefits After Meeting the Deductible

After you meet the deductible, normally the plan will pay 80% of most eligible medical expenses each calendar year for services which require the deductible and co-insurance amounts. You pay the other 20% plus the deductible, up to your out of pocket maximum. After that, the plan pays 100% of eligible expenses in that calendar year for services which require the deductible and co-insurance amounts.

Medical Out-of-Pocket Maximum

This plan has an out-of-pocket limit provision to protect you from excessive medical expenses. The Medical Benefit Summary shows your plan's annual out-of-pocket limits. If you incur covered expenses over your out-of-pocket limit, this plan will pay 100% of eligible charges, subject to the allowable fee.

Your expenses for the following do not count toward the annual medical out-of-pocket limit:

- Excluded Services
- Prescription drugs (see below for information on a separate prescription out-of-pocket maximum)
- Charges over the allowable fee for services of nonparticipating providers
- Incurred charges that exceed amounts allowed under this plan
- Charges of an alternative care provider

Please note that if you change your enrollment from one City health plan to another during a calendar year, the expenses that have accrued toward your out-of-pocket maximum under the first plan will not carry over and be applied toward your out-of-pocket maximum under the new plan. As a result, only the expenses incurred by you after your enrollment in the new plan will be counted against your out-of-pocket maximum under that plan.

Prescription Out-of-Pocket Maximum

Your plan has a calendar year out-of-pocket maximum for all covered prescriptions obtained at a retail pharmacy. The Pharmacy Benefit Summary shows your plan's annual pharmacy out-of-pocket limit. Prescriptions obtained through mail order do not apply to the out-of-pocket maximum, except for IATSE-Represented employees. The prescription out-of-pocket maximum is calculated separately from any other out-of-pocket limit that may apply to your plan. Once the out-of-pocket limit is met, covered prescriptions purchased at a retail pharmacy will be reimbursed at 100% for the remainder of the calendar year.

Please note that if you change your enrollment from one City health plan to another during a calendar year, the expenses that have accrued toward your out-of-pocket maximum under the first plan will not carry over and be applied toward your out-of-pocket maximum under the new plan. As a result, only the expenses incurred by you after your enrollment in the new plan will count toward your out-of-pocket maximum under that plan.

COVERED MEDICAL SERVICES, SUPPLIES AND TREATMENTS

You and your eligible dependents have a complete package of health care services and protection for illness, injury, and certain preventive care. However, with the exception of preventative and well care services, all services and supplies must be medically necessary as determined by the City of Eugene's Claims Administrator to be covered under this plan. For a medical expense to be eligible for payment, you must be covered under this plan on the date the expense is incurred.

IATSE-represented employees have certain women's preventative care services covered with no co-pay as outlined by the Affordable Care Act as it applies to non-grandfathered health plans. Please contact PacificSource for details.

Please be aware that just because a treatment is prescribed by a healthcare professional does not mean it is medically necessary under the Claims Administrator's guidelines or that it will be covered under this plan. See the Definitions section of this handbook for more information on Medical Necessity. In addition, some medically necessary services and supplies may be excluded from coverage under this plan. Be sure you read and understand the Excluded Services and Benefit Limitations sections of this handbook, including the section on Pre-authorization.

Some of the services and supplies listed below may not be covered for all employee groups. For amounts paid by the plan, refer to the Benefits Summary in the front of this handbook. If you ever have a question about your plan benefits, contact the Claims Administrator's Customer Service Department.

The City will comply with provisions of the Affordable Care Act (ACA) for Grandfathered or Non-Grandfathered plans, as appropriate, and no benefits outlined below are intended to limit ACA requirements. See the Notice of Grandfathered Health Plan Status in this handbook for more information

Alternative Care

Your plan's alternative care benefit allows you to receive treatment from alternative care practitioners for certain healthcare services. Services must be medically necessary, and are subject to the office visit co-payment for your plan. Your alternative care practitioner may perform or order other medically necessary services covered by your health plan, such as laboratory tests, x-rays, radiology, or durable medical equipment. Benefits for those services are paid according to your health plan's Medical Benefit Summary.

The benefit maximum for all treatments, services, and supplies provided or ordered by alternative care practitioners is limited to **12 visits for IATSE-Represented / 15 visits for Non-Represented** per person in any calendar year **for all alternative services combined**.

Listed below are the types of alternative care covered under this plan.

Acupuncture

Services of a licensed acupuncturist or physician are covered when necessary for diagnosis and treatment of illness or injury.

Chiropractic

Covered expenses are the reasonable and medically necessary charges of a licensed chiropractor for the treatment of bone, muscle, and joint disorders through manipulation of the spine, and related supporting services including lab and x-ray.

Massage Therapy

Services of a licensed massage therapist are covered as medically necessary.

Naturopathy

Services of a licensed naturopath are covered for medically necessary diagnosis and treatment of illness or injury.

Nutritional Counseling

One consultation with a registered dietician is covered per calendar year. This limitation does not apply to Non-Represented Employees. This benefit is in addition to any covered benefits allowed under Dietary and Nutritional Counseling.

Excluded Services

Your alternative care benefit does not cover the following:

- Drugs, homeopathic medicines, or homeopathic supplies furnished by an alternate care practitioner
- Services of an alternate care practitioner for pregnancy or childbirth
- Any service or supply not otherwise covered by your plan

For IATSE-Represented employees this plan will not discriminate against any health care provider who is acting within the scope of their license or certification under state law.

Ambulance Service

Medically necessary state certified ground or air ambulance service and/or transportation is covered when private transportation is inappropriate due to the medical condition. Benefits are provided for emergency ambulance service and/or transport to the nearest facility capable of providing the necessary treatment.

Air ambulance service is covered when medically necessary and ground transportation is medically or physically inappropriate. PacificSource contracts with the Life Flight Network for air ambulance services.

Biofeedback

This plan covers biofeedback to treat migraine headaches or urinary incontinence when provided by an otherwise eligible practitioner. Benefits are limited to a lifetime maximum of 10 sessions.

Blood Transfusions

This plan covers blood transfusions, including the cost of blood or blood plasma.

Breast Prosthesis

This plan covers removal, repair, or replacement of an internal breast prosthesis due to a contracture or rupture, but only when the original prosthesis was for a medically necessary mastectomy. Pre-authorization is required, and eligibility for benefits is subject to PacificSource's criteria. Please contact PacificSource Customer Service for more information.

Breast Reconstruction

Breast reconstruction with or without prosthesis, including reconstruction of the opposite breast to achieve cosmetic symmetry, is covered after a medically necessary mastectomy.

Cardiac Rehabilitation

This plan covers cardiac rehabilitation as follows:

- Phase I (inpatient) services are covered under inpatient hospital benefits.
- Phase II (short-term outpatient) services are covered at the percentages on your Medical Benefit Summary for outpatient hospital benefits. Pre-authorization by PacificSource is required.
- Phase III (long-term outpatient) services are not covered.

Circumcision

Circumcision for a newborn is covered when performed within three (3) months of birth and may be performed without pre-authorization. A circumcision beyond age three months must be medically necessary and requires pre-authorization.

Clinical Trials

Routine costs for the care of a member who is enrolled in or participating in qualifying clinical trials are covered under your plan. Routine costs mean medically necessary conventional care, items or services covered by the plan if typically provided absent a clinical trial. Coverage is subject to the provisions of your plan that apply to other benefits within the same category, including but not limited to copayments and coinsurance. This plan is not liable for any adverse effects of the clinical trials. Qualifying clinical trials are limited to those:

- Funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veteran Affairs
- Supported by a center or cooperative group that is funded by the National Institutes of Health, the Centers for Disease Control and Prevention, the Agency for Healthcare Research and Quality, the Centers for Medicare and Medicaid Services, the United States Department of Defense or the United States Department of Veterans Affairs
- Conducted as an investigational new drug application, an investigational new drug application to the United States Food and Drug Administration
- Exempt by federal law from the requirement to submit an investigational new drug application to the United States Food and Drug Administration

This plan does not cover:

- The drug, device or service being tested in the clinical trial unless the drug, device or service would be covered by the plan if provided outside of a clinical trial
- Items or services required solely for the provision of the drug device or service being tested in the clinical trial
- Items or services required solely for the clinically appropriate monitoring of the drug, device or service being tested in the clinical trial
- Items or services required solely for the prevention, diagnosis or treatment of complications arising from the provision of the drug, device or service being tested in the clinical trial
- Items or services that are provided solely to satisfy data collection and analysis needs and that are not used in the direct clinical management of the member
- Items or services customarily provided by a clinical trial sponsor free or charge to any person participating in the clinical trial
- Items or services that are not covered by the plan if provided outside of the clinical trial

Cochlear Implants

Cochlear implants, including bilateral cochlear implants, are covered when determined medically necessary and authorized by PacificSource.

Colorectal Cancer Screening

Examinations and laboratory tests are covered for members per the schedule below beginning at age 50, or as recommended by a medical provider for those at high risk for colorectal cancer:

- One fecal occult blood test annually
- One flexible sigmoidoscopy every 5 years
- One colonoscopy every 10 years
- One double contrast barium enema every 5 years

Contraceptive Devices

This plan covers IUD, Norplant, diaphragm, and cervical cap contraceptive devices along with their insertion or removal. Contraceptive devices that can be obtained over the counter or without a prescription, such as condoms, contraceptive sponges, female condoms, and spermicides are not covered. See the Prescription Drug Program section for more information.

Corneal Transplants

This plan covers corneal transplants. Pre-authorization is not required. This benefit is not subject to the 12-month waiting period for transplants.

Cosmetic or Reconstructive Surgery

In the following situations, this plan covers one attempt at cosmetic or reconstructive surgery:

- When necessary to correct a functional disorder
- When necessary because of an accidental injury, or to correct a scar or defect that resulted from treatment of an accidental injury
- When necessary to correct a scar or defect on the head or neck that resulted from a covered surgery
- To correct congenital anomalies on children under age 18.

Cosmetic or reconstructive surgery must take place within 18 months after the injury, surgery, scar, or defect first occurred. Pre-authorization is required for all cosmetic and reconstructive surgeries covered by this plan. For information on breast reconstruction, see "breast prosthesis" and "breast reconstruction" in this section.

Dental Services

Dental services are not covered under this medical plan except:

- Services of a dentist or physician to treat injury of the jaw or natural teeth. Services must be provided within 180 days of the injury
- Services of a dentist or physician for orthognathic (jaw) surgery as follows:
  - When medically necessary to repair an accidental injury. Services must be provided within one year after the accident
  - For removal of a malignancy, including reconstruction of the jaw within one year after that surgery
- Facility charges of a hospital or ambulatory surgery center for pediatric dental care requiring general anesthesia for children under six years of age, Professional charges for the dentist and anesthesiologist are not covered under the medical plan. Pre-authorization by PacificSource is required.
- Hospitalization for dental procedures is covered when the patient has another serious medical condition that may complicate the dental procedure, such as serious blood disease, unstable diabetes, or severe cardiovascular disease, or when a major dental procedure is necessary, such as a multiple extraction or removal of impacted teeth or oral tumors. Coverage requires pre-authorization by PacificSource, and only charges for the facility, anesthesiologist, and assistant physician are covered. Hospitalization because of the patient's apprehension or convenience is not covered.

See the Dental Plan Coverage section of this handbook for benefits covered under the City's Dental Plan.

Developmental Disorder

Subject to plan benefits and limitations, the plan will provide coverage for a child enrolled in the plan who is under 18 years of age and who has been diagnosed with a pervasive developmental disorder. The coverage will apply to all medical services, including rehabilitation services, that are otherwise covered under the plan.

Diabetic Supplies and Services

- Diabetic supplies other than insulin and syringes (such as lancets, test strips, and glucostix) are covered at the amount shown on your Medical Benefit Summary for durable medical equipment. You may purchase those supplies from any retail outlet and send your receipts to PacificSource, along with a Quick Claim Form that includes your name, group number, and member ID number. PacificSource will process the claim and mail you a reimbursement check.
- Diabetic insulin and syringes are covered under your prescription drug benefit, if your plan includes prescription coverage.
- The plan covers one diabetes self-management education program at the time of diagnosis, and up to three hours of education per year if there is a significant change in your condition or its treatment. To be covered, the training must be provided by an accredited diabetes education program, or by a physician, registered nurse, nurse practitioner, certified diabetes educator, or licensed dietitian with expertise in diabetes. Benefits are paid as shown on your Medical Benefit Summary.
- Routine foot care is covered for patients with diabetes mellitus.

Dietary or Nutritional Counseling

Covered when provided by a registered dietitian under certain circumstances. It is covered under the diabetic education benefit, or for management of inborn errors of metabolism (excluding obesity), or for management of anorexia nervosa or bulimia nervosa (to a lifetime maximum of five visits).

Durable Medical Equipment

Equipment is covered up to a 90-day supply at a time when prescribed exclusively to treat medical conditions. Covered equipment includes crutches, manual wheelchairs, orthopedic braces, home glucose meters, equipment for administering oxygen, and non-power assisted prosthetic limbs and eyes. Durable medical equipment must be prescribed by a licensed MD, DO, NP, PA, DDS, DMD, or DPM to be covered.

The durable medical equipment benefit also covers lenses to correct a specific vision defect resulting from a severe medical or surgical problem, such as stroke, neurological disease, trauma, or eye surgery other than refraction

procedures. Coverage is subject to specific criteria, and this benefit is subject to limitations including a $200 maximum allowance for lenses and frames. Please contact PacificSource Customer Service for more information.

This benefit covers the cost of either purchase or rental of the equipment for the period needed, whichever is less. Repair or replacement of equipment is also covered when necessary. If the cost of the purchase, rental, repair, or replacement is over $500, pre-authorization by PacificSource is required. Manual wheelchair rental is covered for 90 days. Additional rental or purchase of a manual wheelchair requires authorization by PacificSource.

Purchase, rental, or lease of a power-assisted wheelchair (including batteries and other accessories) is covered. Benefits for a power-assisted wheelchair are available in place of, not in addition to, benefits for a manual wheelchair.

This plan does not cover equipment commonly used for non-medical purposes, for physical or occupational therapy, or prescribed primarily for comfort. Please see the Excluded Services - Equipment and Devices section for information on items not covered.

Elemental Enteral Formula

Nonprescription elemental enteral formula is covered if ordered by a physician for home use when needed to treat severe intestinal malabsorption. Coverage is provided at the amount shown on your Medical Benefit Summary for Durable Medical Equipment.

Emergency and Urgent Care

Your PCP is responsible for providing and arranging all your medical care, including urgent and emergency care whenever possible. This plan does not cover routine healthcare rendered in a hospital emergency room or urgent care facility. By understanding the difference between urgent care and emergency care and following the plan's guidelines for accessing treatment, you will maximize your benefits and keep your out-of-pocket costs to a minimum.

Urgent Care

Urgent care is unscheduled medical care for an unforeseen illness or injury that is not life threatening, but that requires treatment within 24 hours to prevent serious deterioration of a patient's health. Urgent conditions are normally less severe than medical emergencies. Examples of conditions that could need urgent care are sprains and strains, vomiting, cuts, and severe headaches.

In any medical situation when the patient's life or health is not in immediate danger, call your PCP first. If your PCP is unavailable, ask to speak to the physician on call. The physician will advise you where to go for medical treatment. Urgent care is covered when provided by a physician.

Emergency Care

You are covered for treatment of emergency medical conditions worldwide, including services and supplies necessary to determine the nature and extent of the emergency condition and for stabilization. Emergency care is care that cannot be delayed due to injury or sudden illness, such as when a delay for the time required to reach a PCP or participating hospital would mean risking permanent damage to the patient's health.

An *emergency medical condition* is an injury or sudden illness so severe that a prudent layperson with an average knowledge of health and medicine would expect that failure to receive immediate medical attention would risk seriously damaging the health of a person or fetus. Examples of emergency medical conditions include (but are not limited to):

- Unusual or heavy bleeding
- Sudden abdominal or chest pains
- Suspected heart attacks
- Major traumatic injuries
- Serious burns
- Poisoning
  - Unconsciousness
  - Convulsions or seizures
  - Difficulty breathing
  - Sudden fevers

The following services are **not** considered emergency care: routine physical or eye exams, diagnostic work-ups for chronic conditions, routine prenatal care, elective surgery, and scheduled follow-up visits for emergency conditions.

Your PCP is available 24 hours a day, seven days a week. If you are uncertain if you have an emergency medical condition, contact your PCP. Your PCP will advise you if you should seek emergency care at the nearest facility.

If you need immediate assistance for a medical emergency, call 911. If you have an emergency medical condition, you should go directly to the nearest emergency room or appropriate facility and then call your PCP within 24 hours or as soon as possible.

Claims for a true medical emergency will be covered at the participating provider rate shown on your Medical Benefit Summary, even if you are treated at a nonparticipating hospital or do not have a referral by your PCP or authorization by the plan.

The emergency room facility co-payment will be waived if covered hospitalization immediately follows emergency services. If you are admitted to a nonparticipating hospital after your emergency condition is stabilized, PacificSource may require you to transfer to a participating facility in order to continue receiving benefits at the participating provider level.

The emergency room co-payment shown on your Medical Benefit Summary covers medical screening and any diagnostic tests needed for emergency care, such as radiology, laboratory work, CT scans, and MRIs. The co-payment does not cover further treatment provided on referral from the emergency room.

Emergency room charges for services, supplies, or conditions excluded from coverage under this plan are not eligible for payment. That includes conditions subject to the plan's reduced benefit periods for transplants. Please see the Benefit Limitations and Excluded Medical Services sections of this handbook.

End Stage Renal Disease

Members with a diagnosis of End Stage Renal Disease (ESRD) who enroll in Medicare will have their Medicare Part B premium reimbursed in full by submitting documentation of payment to the health plan administrator. Members who are receiving services for ESRD and who are enrolled in Medicare Part B will have benefits paid at 125% of the current Medicare allowable amount for non-participating ESRD service providers.

By enrolling in Medicare Part B, members are exempt from balance-billing for ESRD services received from providers for amounts above 125% of Medicare allowable and may have reduced out of pocket costs due to coordination of benefits with Medicare.

For members who are not eligible for Medicare, or who choose to not enroll in Medicare, benefits will continue to be paid at the cost share level applied to other benefits in the same category, as outlined in the Benefits Handbooks for each of the Plans.

Eye Exam - Children

One in a 24-month period for children through age 18, when provided by a physician or optometrist covered under the Medical Plan. Vision benefits are also available under the Vision Plan. Eye exams for children through age 18 are paid under the Medical Plan first and are then coordinated with the Vision Plan. See the Vision Plan Coverage section of this handbook for information on benefits under the Vision Plan.

Foot Orthotics

This plan covers medically necessary foot orthotics, including related charges for evaluation and casting. Foot orthotics must be custom made or fitted and prescribed by an appropriate medical provider to be covered.

Gender Identity Disorder/Gender Dysphoria

This plan will cover the following services and supplies if medically necessary. The health plan administrator will determine medical necessity based on the Standards of Care of the World Professional Association for Transgender Health (WPATH).

- Services and procedures used to treat a Gender Identity disorder, or which relate to Gender Transition surgery, if the services or procedures are otherwise covered under the applicable Plan in regard to the treatment for conditions unrelated to such a disorder or surgical procedure;

- Covered health care services that are ordinarily or exclusively available to individuals of one sex, without regard to the perceived Gender Identity of the covered person; and
- Mental health treatment of Gender Identity disorders under diagnostic codes 302.6, 302.85 or 302.9, regardless of the age of the individual being treated.

AFSCME-Represented Employees:

In addition to the benefits outlined above, this plan will cover the following services and supplies for AFSCME-Represented employees if medically necessary. The health plan administrator will determine medical necessity based on the Standards of Care of the World Professional Association for Transgender Health (WPATH).

- Medical evaluations required prior to hormone therapy or surgery.
- Hormone therapy.
- Gender-specific services that may be medically necessary for transgender persons appropriate to their anatomy.
- Genital surgical gender reassignment, to include multiple staged procedures.
- Mastectomy for female to male persons.
- Breast augmentation mammoplasty for male to female persons.

Gynecological Exam

One each calendar year for women 18 and over, or at any time upon the referral of the woman's health care provider. Exams may include Pap smear, pelvic exam, breast exam, blood pressure check, and weight check. Covered lab services are limited to occult blood, urinalysis, and complete blood count.

Exams may also include an annual mammogram for women 35 and over, or as recommended by a physician for women with a high-risk condition.

Hearing Aid Benefit - Adults

See your Medical Benefit Summary to determine how hearing aids are covered under your plan. Charges for fitting, internal or external placement or replacement (including implanted hearing aids or implant procedures) are not covered.

Hearing Aid Benefit - Children

Covers one hearing aid per hearing impaired ear for enrolled eligible children every 48 months. An enrolled eligible child must be examined by a physician before obtaining a hearing aid that is prescribed, fitted and dispensed by a licensed audiologist. Covered benefits include the following:

- A hearing aid (monaural or binaural) prescribed as a result of the examination
- Ear molds
- Hearing aid instruments
- Initial batteries, cords and other necessary supplementary equipment
- A warranty
- Repairs, servicing, or alteration of the hearing aid equipment

Hearing Analysis - Children

One in any 24-month period for eligible children through age 18, when provided by the dependent's primary care provider.

Home Health Care

This plan covers home health services when pre-authorized by PacificSource. Private duty nursing is not covered. Covered services include:

- Skilled nursing by an RN or LPN
- Physical, occupational, and speech therapy
- Medical social work services provided by a licensed home health agency

Hospice Care

Hospice services are covered when pre-authorized by PacificSource. Hospice services are intended to meet the physical, emotional, and spiritual needs of the patient and family during the final stages of illness and dying, while maintaining the patient in the home setting. Services are intended to supplement the efforts of an unpaid caregiver.

Hospice does not provide services of a primary caregiver such as a relative or friend, and private duty nursing is not a covered benefit. PacificSource uses specific criteria to determine eligibility for hospice benefits. For more information, please contact the PacificSource Customer Service Department.

Hospital Inpatient Services

This plan covers medically necessary hospital inpatient services. Charges for a hospital room are covered up to the hospital's semi-private room rate (or private room rate, if the hospital does not offer semi-private rooms). Charges for a private room are covered if the attending physician orders hospitalization in an intensive care unit, coronary care unit, or private room for medically necessary isolation.

In addition to the hospital room, covered inpatient hospital services may include (but are not limited to):

- Cardiac care unit
- Operating room
- Anesthesia and post-anesthesia recovery
- Respiratory care
- Inpatient medications
- Lab and radiology services
- Dressings, equipment, and other necessary supplies

This plan does not cover charges for rental of telephones, radios, or televisions, or for guest meals or other personal items.

Inpatient stays require authorization by PacificSource. PacificSource's medical director or staff will review elective admissions or non-elective emergency hospitalization and work with your PCP to assure that you avoid unnecessary time in the hospital. Medically necessary hospital admissions not authorized by PacificSource are paid at the Nonparticipating benefit level even if the facility is a participating provider.

In a medical emergency, participating benefit levels will be paid to a Nonparticipating facility until the covered person can be safely transported to a PacificSource participating facility for continued hospitalization. If you decline transport to a participating facility, you will receive the lower Nonparticipating benefits for that hospitalization and all concurrent Nonparticipating physician or provider care.

Immunizations

Immunizations are covered under preventative care. Immunizations for children under two years old are covered under well-baby care. Immunizations for adults and children over two years old include, but are not limited to the following:

- Diphtheria, pertussis, and tetanus (DPT) vaccines
- Hemophilus influenza B vaccine
- Hepatitis A vaccine for the following members:
  - Children ages 2 through 18
  - Adults over age 18 only if there is a history of Hepatitis C
- Hepatitis B vaccine
- Human Papillomavirus vaccine (HPV)
- Influenza vaccine
- Measles, mumps, and rubella (MMR) vaccines
- Meningococcal immunizations
- Pneumococcal vaccine for all children through age 2, and at any age for those at high risk
- Polio vaccine
- Varicella vaccine (chicken pox)

The claims administrator may approve immunizations not included above, pursuant to its standard administrative policies. Immunizations for employment, licensing, passports, and travel are not covered.

As a Value Added Service, PacificSource offers flu vaccinations for a $0 copay if received at a pharmacy participating in their Flu Shot Pharmacy Network. Information on participating pharmacies is on the PacificSource website.

Inborn Errors of Metabolism

This plan covers treatment for inborn errors of metabolism involving amino acid, carbohydrate, and fat metabolism for which widely accepted standards of care exist for diagnosis, treatment, and monitoring. Nutritional supplies are covered at the amount shown on your Medical Benefit Summary for Durable Medical Equipment.

Infertility Services

Covered when medically necessary subject to a 50% co-payment. In vitro fertilization and procedures determined to be experimental or investigational in nature are not covered (see Excluded Services section).

Infusion Therapy

Infusion therapy services and supplies are covered when medically necessary and pre-authorized by PacificSource. Benefits are paid at the percentage shown on your Medical Benefit Summary for home health care. Home infusion therapy must be provided by an accredited home infusion therapy agency. In addition, the patient receiving the services must qualify as homebound.

This benefit covers parenteral nutrition, medications, and biologicals (other than immunizations) that cannot be self-administered. Infusion therapy benefits are limited to the following:

- Aerosolized pentamidine
- Intravenous drug therapy
- Total parenteral nutrition
- Hydration therapy
- Intravenous/subcutaneous pain management
- Terbutaline infusion therapy
- Synchromed pump management
- IV bolus/push drugs
- 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

Injectable Drugs and Biologicals

Covered if administered by a physician when medically necessary for diagnosis or treatment of illness or injury. This benefit does not include immunizations (see Immunizations section above) or drugs or biologicals that can be self-administered or are dispensed to a patient.

Inpatient Rehabilitative Care

This plan covers up to 30 days in a 12-month period. Pre-authorization is required. If rehabilitative services are required following head, spinal cord injury, or a cerebral vascular accident (stroke), 60 days in a 12-month period may be allowed.

Mammogram

Routine annual mammograms are covered for women age 35 and over, or as recommended by a physician for women with a high-risk condition.

Maternity / Pregnancy Services

Services covered if provided by a physician or a licensed certified nurse midwife. Services are subject to the same payment amounts, conditions, and limitations that apply to similar expenses for illness.

Please contact the PacificSource Customer Service Department as soon as you learn of your pregnancy. PacificSource staff will explain your plan's maternity benefits and help you enroll in their free Prenatal Care Program for expectant mothers. This additional Value Added Service is a voluntary program that takes a positive, proactive role in ensuring a healthy baby and mother.

Maxillofacial Prosthetic Services

Covered when prescribed by a physician as necessary for restoration and management of head and facial structures that cannot be replaced with living tissue and that are defective because of disease, trauma or birth and developmental deformities. Restoration and management are covered when performed for the purpose of:

- Controlling or eliminating pain or infection
- Restoring functions such as speech, swallowing or chewing

Coverage is limited to the least costly clinically appropriate treatment, as determined by the physician. Cosmetic procedures and procedures to improve on the normal range of functions are not covered. Dentures and artificial larynx are also not covered.

Mental Health and Chemical Dependency

This plan covers medically necessary crisis intervention, diagnosis, and treatment of mental health conditions and chemical dependency. Not all mental health services are covered, however. Please refer to the Benefit Limitations and the Excluded Services sections of this handbook for more information on services not covered by the plan.

Providers of mental health and chemical dependency services eligible for reimbursement include, but are not necessarily limited to:

- Licensed medical or osteopathic physicians (MD or DO), including psychiatrists
- Licensed psychologists (PhD)
- Licensed psychology associates
- Registered nurse practitioners (NP)
- Licensed clinical social workers (LCSW)
- Licensed professional counselors (LPC)
- Licensed marriage and family therapists (LMFT)
- Programs licensed by a state mental health division for alcoholism, chemical dependency, or mental disturbance
- Hospitals and other facilities licensed for inpatient or residential treatment of mental health conditions or chemical dependency

Please note that even when seeing an approved provider, certain services may not be covered under your plan. Contact PacificSource if you would like to verify coverage prior to receiving a service.

Medical Necessity and Appropriateness of Treatment

As with all medical treatment, mental health and chemical dependency treatment is subject to review for medical necessity and/or appropriateness. Review of treatment may involve pre-service review, concurrent review of the continuation of treatment, post-treatment review, or a combination of these. PacificSource will notify the patient and patient's provider when a treatment review is necessary to make a determination of medical necessity. A second opinion may be required for a medical necessity determination. PacificSource will notify the patient when this requirement is applicable.

Covered Mental Health and Dual Diagnosis Services

This plan covers the following mental health services:

- Assessment and evaluation to make a definitive diagnosis of a mental disorder.
- Treatment provided in hospital inpatient facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services. Treatment in inpatient and residential settings requires pre-authorization by PacificSource.
- Treatment of dual diagnosis. Dual diagnosis means a condition involving both mental health and chemical dependency that requires the simultaneous treatment of both conditions. For dual diagnosis conditions, the

facility or program must be accredited for treatment of dual diagnosis, and services must be pre-authorized by PacificSource.

Covered Chemical Dependency Services

Chemical dependency means the addictive relationship with alcohol or any drug. Chemical dependency is characterized by a physical or psychological relationship, or both, that interferes with the person's social, psychological, or physical adjustment to common problems on a recurring basis. Chemical dependency does not include addiction to or dependency on tobacco or food.

For chemical dependency, this plan covers treatment provided in hospital inpatient facilities, residential programs or facilities, day or partial hospitalization programs, or outpatient services. Treatment in inpatient and residential settings requires pre-authorization by PacificSource.

Newborn Nursery Care

Routine nursery care of a newborn is covered while the mother is hospitalized and eligible for pregnancy-related benefits under this plan.

Obesity Treatment

For Non-Represented employees only, services and supplies for the treatment of obesity will be covered when authorized as medically necessary by the Claims Administrator.

Outpatient Services

Many ambulatory (outpatient) services require pre-authorization. For a complete list, contact PacificSource Customer Service. Failure to obtain required pre-authorization can result in denial of benefits. To receive the highest level of benefit, a medically necessary service may need to be arranged through your PCP and authorized by PacificSource.

This plan covers the following medically necessary outpatient care services:

- Diagnostic CT scans and MRIs. When services are provided as part of a covered emergency room visit, your plan's emergency room benefit applies. In all other situations and settings, the benefit shown on your Medical Benefit Summary for Outpatient Services/Imaging Procedures applies.
- Diagnostic radiology and laboratory procedures provided or ordered by a physician, nurse practitioner, or physician assistant. These services may be performed or provided by laboratories, radiology facilities, hospitals, and physicians, including services in conjunction with office visits.
- Surgery and other outpatient services. Benefits are based on the setting where services are performed. See the Medical Benefit Summary for additional information.
  - Benefits for physician services are based on whether the service is performed in the physician's office or at a surgery facility.
  - An outpatient surgery facility charge may also apply for surgeries or outpatient services performed in an ambulatory surgery center or outpatient hospital setting.
- Therapeutic radiology services, chemotherapy, and renal dialysis provided or ordered by a physician

Physical Exam

Routine physical examinations are covered for plan members over two years old once each calendar year. Physical exams for dependents age 0 – 2 are covered under Well-Baby Care.

Physician services and medical expenses for routine lab work and other diagnostic testing procedures ordered by your practitioner in connection with the exam are also covered under the plan.

Physical, Occupational or Speech Therapy and Pulmonary Rehabilitation

Total covered expenses for all physical, occupational, and speech therapy and pulmonary rehabilitation services combined is limited to 30 visits in any 12-month period beginning with the first date of service.

Physical or Occupational Therapy
Services covered if provided by a licensed physical therapist, occupational therapist, or physician. Services must be prescribed in writing by a licensed physician, dentist, podiatrist, nurse practitioner, or physician assistant. The prescription must include site, modality, duration, and frequency of treatment.

If rehabilitative services are required following head, spinal cord injury, or a cerebral vascular accident (stroke), 60 sessions in a 12-month period may be allowed. Coverage of additional visits requires pre-authorization, and will only be considered for active, rehabilitative, goal-specific programs to restore or compensate for lost function for acute conditions. Functional capacity evaluations, work hardening, vocational rehabilitation, driving evaluations and training programs, community reintegration, and motion analysis are not covered services.

Speech Therapy
Coverage requires pre-authorization by PacificSource, and will only be allowed when needed to correct stuttering, hearing loss, peripheral speech mechanism problems, and deficits due to neurological disease or injury. Speech therapy for developmental language and phonological disorders is only considered medically necessary for patients at least 2½ years old who are unable to communicate basic needs. The plan does not cover speech therapy for learning disorders or oral/facial motor therapy for strengthening and coordination of speech-producing muscles and structures.

Outpatient Pulmonary Rehabilitation
Rehabilitation programs are covered for patients with severe chronic lung disease that interferes with normal daily activities despite optimal medication management. A physician's prescription and pre-authorization by PacificSource are required.

Prescription Drug Program

Your Pharmacy Plan includes coverage for prescription drugs and contraceptives, subject to limitations and exclusions. It also covers diabetic supplies and bee sting kits – see Covered Pharmacy Expenses below. The prescription drug program is managed by PacificSource. The co-payments are based on whether the prescription drug is Generic (Tier 1), Preferred (Tier 2) or Non-Preferred (Tier 3), as determined by PacificSource. PacificSource reviews and updates the preferred drug list regularly. IATSE-Represented employees have certain women's preventative care services covered with no co-pay as outlined by the Affordable Care Act as it applies to non-grandfathered health plans. Please contact PacificSource for details.

General Information about Prescription Drugs

The City of Eugene uses the PacificSource Preferred Drug List (PDL), which is available on the PacificSource website at www.pacificsource.com/pdl/. This list is not all-inclusive. All generic drugs for covered services are covered at the generic copay (Tier 1). Brand name drugs on the list are covered at either the Preferred (Tier 2) or Non-Preferred (Tier 3) copay. Covered brand name drugs that are not on the list are covered at the Non-Preferred copay. Some drugs may be excluded from coverage.

Generic Drugs (Tier 1): are drugs determined to be therapeutically equivalent to the brand name version and are equally safe and effective. By law, both brand name and generic drugs must meet the same standards for safety, purity, strength and quality. Generic drugs are usually much less expensive than the brand name drug.

Preferred Brand Name Drugs (Tier 2): are drugs determined by PacificSource to be equally safe and effective as Non-Preferred brand drugs at favorable costs.

Non-preferred Brand Name Drugs (Tier 3): are drugs determined by PacificSource to be equally safe and effective as preferred brand drugs, but are more costly. Drugs that are usually not recommended as first line therapy and have alternative treatment modalities are also considered non-preferred drugs.

Retail Pharmacy

Participating Pharmacy refers to a pharmacy that has contracted with PacificSource to provide prescription drug benefits to plan members. Nonparticipating Pharmacy refers to a pharmacy that has not contracted with PacificSource.

In order to access the PacificSource discounts you must show the pharmacy your PacificSource wallet ID card each time you have a prescription filled.

If your pharmacy is not participating in the PacificSource network but would like to join the network, have your pharmacy contact Caremark's Network Enrollment Department at 480-391-4623.

Participating Retail Pharmacy:
- Present your PacificSource ID card so they can properly process your prescriptions and calculate your prescription discounts
- Pay the prescription co-payment as required by the Plan
- Your claim will be submitted to PacificSource electronically; you do not need to submit a claim form

Nonparticipating Retail Pharmacy:
- Pay the pharmacy in full for the prescription drugs
- Obtain a City of Eugene Quick Claim Form available on the Risk Services Employee Benefits website
- Mail the completed form and a copy of your pharmacy receipt to PacificSource for reimbursement

Eligible prescription drugs purchased and paid for in full by you will be reimbursed at the PacificSource Pharmacy contracted rate, minus your co-payment, or the allowable fee minus your co-payment, whichever is less.

Mail Order Pharmacy

Mail-order prescription service is also available through your plan. If you take a medication on a regular basis, the mail-order service is a convenient way to order prescriptions and have them delivered directly to your home. If you're ordering more than a one-month supply you may save money on co-payments, and there's no shipping or handling charge.

PacificSource offers mail-order pharmacy through your choice of CVS Caremark or Wellpartner. For more information contact the mail-order carrier or PacificSource Customer Service. You can register for the program on the carrier's website. Order forms are also available on the PacificSource website.

Wellpartner
PO Box 5909
Portland, OR 97228-5909
Phone: 877-568-6460
Website: www.wellpartner.com

Caremark
PO Box 659541
San Antonio, TX 78265-9541
Phone: 866-329-3051
Website: www.caremark.com

Specialty Pharmacy

Certain prescription drugs may be purchased through PacificSource's specialty pharmacy provider, Caremark Specialty Pharmacy Services. The Specialty Pharmacy program is designed to help members with chronic or genetic health conditions maximize the value of their health plan benefits. Drugs available through Caremark Specialty Pharmacy Services include most self-injectables, infusion drugs and many specialty and biotech drugs used to treat chronic or genetic disorders. If you are using a covered medication, you will be contacted and invited to participate in the program. In addition, these drugs may require prior-authorization from PacificSource. A complete list of medications covered under this program is available on the PacificSource website at www.pacificsource.com.

The Caremark Specialty Pharmacy Program offers:
- Personal attention from a pharmacist-led Care Team that provides condition-specific education, medication administration instruction, and expert advice to help you manage your therapy
- Easy access to pharmacists and other health experts 24 hours a day, seven days a week
- Easy ordering with a dedicated toll-free number
- Confidential and convenient delivery of medications to the location of your choice
- Participating provider benefits for specialty drugs when you use Caremark Specialty Pharmacy Services

Prescription Discount Program

As a Value Added Service, PacificSource offers you a way to save money on qualifying prescription drugs that are not covered by your health plan. This program is not a part of your Prescription Drug Benefit and purchases do not count toward your out of pocket maximum or other plan coverage.

Accessing the discount is as simple as presenting your PacificSource Member ID Card every time you go to your pharmacy:
- If a drug is covered under your plan, you pay the amount specified by your prescription benefit
- If a drug is not covered under your plan, a discount is automatically applied and you pay the discounted price. The discount does not apply to drugs covered by your plan or to over-the-counter medications.

Contact PacificSource for more information on their specialty pharmacy program.

Covered Pharmacy Expenses

Supplies covered under the pharmacy plan are in place of, not in addition to, those same covered supplies under the medical plan. See the Pharmacy Benefit Summary for information on co-payments and the pharmacy out-of-pocket maximum.

A **Covered Prescription Expense** is a charge that meets all of the following tests:

- It is for a covered drug supply that is prescribed for a covered person
- The expense is incurred while the covered person is eligible for the Prescription Drug Expense Benefit
- The prescribed drug is not excluded under the Plan

A **Covered Drug Supply**:

- Is a supply of a drug or medicine that is medically necessary for the treatment of an illness or injury that cannot legally be dispensed without a prescription, and that by law must bear the legend "Caution -- Federal law prohibits dispensing without prescription"
- Includes insulin (up to a maximum of 100 insulin syringes per 30 days and a maximum of 200 disposable needles per 30 days), insulin pens for pre-measured insulin cartridges (up to 4 per year), insulin cartridges for pens, blood glucose test strips, glucose tablets, and ketone test strips for urinalysis (separate co-pays are applied to a supply of insulin and to diabetic supplies)
- Includes contraceptive drugs and devices used for medical reasons and for birth control but only if they cannot legally be dispensed without a prescription, and by law must bear the legend “Caution - Federal law prohibits dispensing without prescription”
- Fluoride and prescription vitamins

Diabetic Supplies

- Insulin and diabetic syringes are available for your plan’s generic co-payment
- Lancets and test strips are available for your plan’s Preferred brand co-payment
- Glucagon recovery kits are available for your plan’s Preferred brand name co-payment. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise pre-authorized by PacificSource)
- Glucostix and glucose monitoring devices are not covered under this pharmacy benefit, but are covered under your medical plan’s durable medical equipment benefit

Bee Sting Kits

Anaphylactic recovery kits (for people with severe allergic reactions to bee stings) are available for your plan’s Non-Preferred drug co-payment. You may purchase up to two kits at one time, but no more than four kits in any calendar year (unless otherwise pre-authorized by PacificSource).

Contraceptives

- Oral Contraceptives
- Depo Provera injection. You are responsible for three Preferred (Tier 2) co-pays per injection
- Preven. You are responsible for one Preferred (Tier 2) co-pay
- Lunelle injection. You are responsible for one Preferred (Tier 2) co-pay per injection
- Diaphragm or Cervical Cap for one Generic (Tier 1) co-pay
- The insertion, removal, and cost of IUD and Norplant devices are covered under your medical plan benefits as a professional office visit and office supply

Pharmacy Limitations and Exclusions

- This plan only covers drugs prescribed by a licensed physician (or other licensed practitioner eligible for reimbursement under your plan) prescribing within the scope of his or her professional license
- Certain drugs require pre-authorization by PacificSource in order to be covered. PacificSource maintains the list of drugs requiring pre-authorization
- Quantities of any drug per fill or refill are limited to the amount listed in your Pharmacy Benefit Summary
- PacificSource may limit the quantity per co-payment of certain specific drugs to less than the quantity shown on your Pharmacy Benefit Summary
- For drugs purchased at nonparticipating pharmacies, reimbursement is limited to an allowable fee. Your share of the cost for prescription drugs does not apply to your medical plan’s out-of-pocket maximums. Prescription drug co-payments are still your responsibility even if the medical plan’s out-of-pocket maximum is satisfied
- Prescription drug benefits are subject to your plan’s coordination of benefits provision. For more information, see the Coordination of Benefits section in this handbook
- Your prescription drug plan does not cover:
    - Over-the-counter drugs, unless specifically allowed under this plan

- Drugs for any condition excluded under the health plan. That includes drugs intended to promote fertility, treatments for obesity or weight loss, smoking cessation drugs (although they may be covered under the Medical Plan Tobacco Cessation benefit), experimental drugs, and drugs available without a prescription (even if a prescription was provided). Exclusions for medically necessary obesity treatment do not apply to Non-Represented Employees.
- Immunizations (although certain immunizations are covered under your Medical Plan benefit – please refer to the Immunizations section of this handbook)
- Viagra and other drugs and devices to treat impotency
- Drugs used as a preventive measure against hazards of travel

Pharmacy Claims

A charge is considered to be incurred at the time the drug or medicine is furnished to you. Certain prescription drugs and/or quantities of prescription drugs may require service authorization by PacificSource. Contact PacificSource Customer Service if you have questions about your pharmacy claims or coverage.

Prostate Cancer Screening

Examinations and laboratory tests, including one digital rectal examination and one Prostate Specific Antigen (PSA) test, every two years or as determined by the treating physician for:

- Men age 50 and over
- Men younger than 50 if in a high risk category or with a family medical history of prostate cancer

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices that are not otherwise covered under the plan will be covered if the devices are:

- Medically necessary to restore or maintain the ability to complete activities of daily living or essential job-related activities
- Not solely for comfort or convenience
- Included in the list of covered prosthetic and orthotic devices prescribed in the annual updated rules issued by the Director of the Department of Consumer and Business Services

Covered expenses for eligible prosthetic and orthotic devices will include all services and supplies medically necessary for the effective use of a prosthetic or orthotic device, including formulating its design, fabrication, material and component selection, measurements, fittings, static and dynamic alignments, and instructing the patient in the use of the device.

Orthotic device means a rigid or semirigid device supporting a weak or deformed leg, foot, arm, hand, back or neck, or restricting or eliminating motion in a diseased or injured leg, foot, arm, hand, back or neck. Prosthetic device means an artificial limb device or appliance designed to replace, in whole or in part, an arm or a leg.

A covered person will have access to medically necessary clinical care, and to prosthetic and orthotic devices and technology, from not less than two distinct Oregon prosthetic and orthotic providers in the Preferred Provider Network.

Radiation and Chemotherapy Treatment

This plan covers radiation and chemotherapy treatment, including any orally administered anticancer prescription drug.

Skilled Nursing Facility

This plan covers up to 60 days per calendar year when pre-authorized by PacificSource. Confinement for dementia, mental illness, or custodial care is not covered.

Sleep Disorders and Studies

Medically necessary treatment for sleep apnea and other sleeping disorders is covered when pre-authorized by PacificSource. Coverage of oral devices includes charges for consultation, fitting, adjustment, follow-up care, and the appliance. The appliance must be prescribed by a physician specializing in evaluation and treatment of obstructive sleep apnea, and the condition must meet criteria for obstructive sleep apnea. Tongue retraining devices are not covered.

Sleep studies are covered when ordered by a pulmonologist, neurologist, otolaryngologist, or certified sleep medicine specialist, and when performed at a certified sleep laboratory.

Telemedical Health Services

Covered services requiring telemedicine delivered through a 2-way video communication that allows a physician or professional provider to interact with a member who is at an originating site are covered under this plan. Standard copayments and co-insurance for the covered medical services apply.

Temporomandibular Joint Syndrome (TMJ)

Treatment of all TMJ-related services, including but not limited to diagnostic and surgical procedures (see pre-authorization), for medical reasons only. Services are covered only when medically necessary due to a history of advanced pathologic process (arthritic degeneration) or in the case of severe acute trauma. Benefits for the treatment of TMJ and all related services are limited to 50% of eligible charges.

Therapeutic Injections

Administrative services for therapeutic injections, such as allergy shots, are covered when given in a physician or professional provider's office. When comparable results can be obtained safely with home self-care, or through oral use of a prescription drug, administrative services for therapeutic injections are not covered.

Vitamin and mineral injections are not covered unless medically necessary for treatment of a specific medical condition.

Tobacco Cessation

Tobacco Cessation expenses are covered for members age 15 or older who participate in a tobacco use cessation program recommended by a physician. Covered expenses include counseling, medical supplies, and drugs provided or recommended by a tobacco use cessation program. Your physician can help design a program for you that follows the guidelines or can recommend an existing program.

As an additional Value Added Service, PacificSource offers the Quit for Life tobacco cessation program. With this program you can receive phone-based, one-on-one treatment sessions with a professional Quit Coach, a Quit Kit of materials to help you stay on track, and recommended nicotine replacement products, such as an eight-week supply of nicotine patches or gum sent to your home. You can enroll in this program by calling 866-QUIT-4-LIFE (866-784-8454) or enroll online at www.quitnow.net.

Transplant Services

This plan covers certain medically necessary organ and tissue transplants. It also covers the cost of acquiring organs or tissues needed for covered transplants and limited travel expenses for the patient, subject to certain limitations.

Please Note: All transplant procedures must be authorized and be medically necessary and appropriate according to criteria established by PacificSource. To receive maximum Plan benefits, the transplant procedure must be performed at a participating transplant facility.

Covered Transplants

This plan covers the following organ and tissue transplants when they are medically necessary and appropriate, and when they meet the PacificSource Medical Necessity Criteria for the following organs or tissues:

- Heart
- Heart/lung or lung
- Liver (under certain criteria)
- Kidney
- Kidney and pancreas when transplanted together in the same operative session
- Pancreas (this includes pancreas alone and pancreas after kidney transplantation)
- Small bowel
- Bone marrow or stem cell transplant

See the Other Covered Services section of this handbook for information on Corneal Transplants.

This plan only covers transplants of human body organs and tissues. Transplants of artificial or animal organs and tissues are not covered. Travel and living expenses are not covered for the recipient's family members or the donor, and travel and housing expenses for the recipient are limited to $5,000.

All pre-transplant evaluations, services, treatments, and supplies for transplant procedures require pre-authorization by PacificSource. For detailed transplant criteria, please contact the PacificSource Customer Service Department.

Reduced Benefit Period

Except for corneal transplants, you must have been covered under this plan for at least 12 consecutive months or since birth to be eligible for transplant benefits, including benefits for transplantation evaluation.

If you were covered under another health insurance plan before enrolling in this plan, you can receive credit for your prior coverage. If you qualify for credit, PacificSource will count every day of coverage under your prior plan toward this plan's reduced benefit period. Contact PacificSource for more information about whether you qualify for the credit.

Payment of Transplant Benefits

If a transplant is performed at a participating transplantation facility, covered charges of the facility are paid in full. If our contract with the facility includes the services of the medical professionals performing the transplant (such as physicians, nurses, and anesthesiologists), those charges are also paid in full. If the professional fees are not included in our contract with the facility, then those benefits are provided according to your Medical Benefit Summary.

If transplant services are available through a contracted transplantation facility but are not performed at a contracted facility, you are responsible for satisfying any co-payments shown on your Medical Benefit Summary. This plan then pays 50%. Services of nonparticipating medical professionals are paid at the nonparticipating provider percentages shown on the Medical Benefit Summary.

Tubal Ligation and Vasectomy

This plan covers tubal ligation and vasectomy procedures.

Urgent Care

See the Emergency Care and Urgent Care section of this handbook for details.

Well-Baby Care

Well-baby care, including any appropriate lab services, is covered as follows:

Non-Represented Employees

- One in-hospital exam at birth
- Six more exams during the first year of life
- Two exams during the second year of life

IATSE-Represented Employees

Services are covered according to the schedule for preventative care recommended by the Health Resources & Services Administration.

EXCLUDED MEDICAL SERVICES

Please Note: The Benefit Summary outlines covered services for each employee group's plan. If your plan provides benefits for an exclusion listed below, then the exclusion does not apply to the extent that coverage exists under your plan. This is only a summary of excluded services, supplies, and expenses. For details, please contact the PacificSource Customer Service Department.

General Items

This plan does not cover the following:

- Services or supplies that are not medically necessary in the Claims Administrator's judgment
- Charges for inpatient stays that began before you were covered by this plan
- Services or supplies received before this plan's coverage began
- Services or supplies received after enrollment in this plan ends. (The only exception is that if this plan is replaced by another group health plan while you are hospitalized, the Claims Administrator will continue paying covered hospital expenses until you are released or your benefits are exhausted, whichever occurs first.)
- Treatment of any illness or injury resulting from an illegal occupation or attempted felony, or treatment received while in the custody of any law enforcement authority
- Services or supplies available to you from another source, including those available through a government agency
- Services or supplies with no charge, or which your employer would have paid for if you had applied, or for which you are not legally required to pay. This includes services provided by yourself or an immediate family member.
- Services or supplies for which you are not willing to release the medical information the Claims Administrator needs to determine eligibility for payment
- Treatment of any condition caused by a war, armed invasion, or act of aggression, or while serving in the armed forces
- Treatment of any work-related illness or injury, unless your plan provides on-the-job health coverage by endorsement. This includes illness or injury caused by any for-profit activity, whether through employment or self-employment, regardless of the availability of workers' compensation.
- Charges for phone consultations, missed appointments, get acquainted visits, completion of claim forms, or reports the Claims Administrator needs to process claims
- Any amounts in excess of the allowable fee for a given service or supply
- Services of providers who are not eligible for reimbursement under this plan
- Any services or supplies not specifically listed as covered benefits under this plan
- Services provided by the spouse, domestic partner, child, brother, sister of the covered person, or by a parent of the covered person, spouse or domestic partner
- Charges that are the responsibility of a third party who may have caused the illness or injury or other insurers covering the incident (such as workers' compensation insurers, automobile insurers, and general liability insurers)
- Services and supplies for treatment of illness or injury for which a third party is responsible are excluded to the extent of any recovery received from or on behalf of the third party. This 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 covered person, whether or not such benefits are requested

Medical Services and Supplies

This medical plan does not cover the following services and supplies:

- Biofeedback other than for migraine headaches or urinary incontinence, which is limited to 10 sessions
- Chelation therapy, unless pre-authorized by the Claims Administrator for certain medical conditions or heavy metal toxicities
- Custodial care or day care, including help with daily activities such as walking, getting in or out bed, bathing, dressing, eating, and preparing meals
- Dental examinations and treatment, which means any services or supplies to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures - see the Dental Plan section of this handbook for information on dental benefits
- Eye exams (routine) for adults over age 18 - see the Vision Plan section of this handbook for information on vision benefits
- Family planning services and supplies, other than sterilization, not specifically provided for under Covered Expenses

- Fitness or exercise programs and health or fitness club memberships
- Food supplementation programs, behavior modification and self-help programs for weight loss
- Foot care (routine), unless you are being treated for diabetes mellitus. Routine foot care includes services and supplies for corns and calluses, toenail conditions other than infection, and hypertrophy or hyperplasia of the skin of the feet
- Genetic (DNA) testing, except for tests identified by the Claims Administrator as medically necessary for the diagnosis and standard treatment of specific diseases
- Hearing aid services and supplies:
  - Batteries or other supplementary equipment other than those obtained upon purchase of the hearing aid;
  - A hearing aid exceeding the specifications prescribed for correction of hearing loss; and
  - Expenses incurred after coverage ends, unless the hearing aid is ordered before coverage terminated and it is received within 90 days of the end date.
- Homeopathic supplies
- Services or supplies to diagnose, prevent, or treat sterility, impotency, frigidity, or sexual dysfunction
- Instructional or educational programs, except diabetes self-management programs
- Jaw services or supplies for developmental or degenerative abnormalities of the jaw, malocclusion, dental implants, or improving placement of dentures
- Massage, massage therapy, or neuromuscular re-education, even as part of a physical therapy program, except as provided for under the Alternative Care Benefit
- Maternity care for surrogate mothers
- Motion analysis, including physician review
- Myeloablative high dose chemotherapy, except when the related transplant is covered
- Obesity (including all categories) or weight control treatment or surgery, and other services and supplies for weight loss, even if there are other medical reasons for you to control your weight (exclusion does not apply to Non-Represented employees
- Osteopathic manipulation, except for treatment of disorders of the musculoskeletal system
- Physical or eye exams required for administrative purposes, such as participation in athletics, admission to school, or employment, unless required by the City of Eugene for employment-related medical or vision exams
- Physical or occupational therapy for developmental delays and disorders, sensory integration disorders, motor skills disorders, or learning disorders
- Private nursing service
- Programs that teach a person to use medical equipment, care for family members, or self-administer drugs or nutrition (except for the diabetic education benefit)
- Screening tests, imaging, and exams solely for screening, and not associated with a specific diagnosis, sign of disease, or abnormality on prior testing (except as allowed under the preventive care benefit). Also excluded are total body CT imaging, CT colonography, and bone density testing.
- Self-help or training programs
- Snoring services or supplies for the diagnosis or treatment of snoring or upper airway resistance disorders, including somnoplasty
- Speech therapy for developmental language disorders, phonological disorders, and learning disorders, and facial motor therapy for strengthening and coordination of speech-producing muscles and structures
- Telemedical Health Services and telemedicine for excluded services
- Vocational rehabilitation, functional capacity evaluations, work hardening programs, community reintegration services, and driving evaluations and training

Surgeries and Procedures

This plan does not cover the following:

- Abdominoplasty
- Artificial insemination, in vitro fertilization, or GIFT procedures
- Cosmetic or reconstructive services, except as specified in the Covered Expenses - Other Covered Services, Supplies, and Treatments section
- Eye refraction procedures, orthoptics, vision therapy, or other services to correct refractive error
- Jaw surgery – Treatment for abnormalities of the jaw, malocclusion, or improving the placement of dentures and dental implants
- Orthognathic surgery - Treatment to augment or reduce the upper or lower jaw, except for reconstruction due to an injury (see Covered Expenses - Professional Services)
- Panniculectomy
- Surgery to reverse voluntary sterilization
- Transplants, except as specified in the Covered Expenses - Transplants section

Mental Health Services

This plan does not cover the following services, whether provided by a mental health specialist or by any other provider:

- Diagnoses: Treatment of mental retardation, learning disorders, motor skills disorders, communication disorders, developmental delays and disorders, disruptive behavior disorders, factitious disorders, sexual and gender identity disorders, impulse control disorders, paraphilias (except for pedophilia, which is covered), caffeine-related disorders, sensory integration disorders, and conduct disorders
- Types of treatment: Neurodevelopmental therapy, sensory integration training, biofeedback (other than as specifically noted under the Covered Services section of this handbook), hypnotherapy, academic skills training, narcosynthesis, and social skills training. Recreation therapy is only covered as part of a mental health inpatient or residential program.
- Adolescent wilderness treatment programs
- Counseling or training for career issues, personal growth, assertiveness, sensitivity, image therapy, relaxation, stress management, parenting skills, or family education
- Court-mandated psychological evaluations for child custody cases, and mental evaluations to adjudicate legal rights
- Self-help or training programs, other than programs expressly identified as covered in this handbook
- Sensory movement group therapy or marathon group therapy
- Sexual dysfunction - Psychological evaluation for sexual dysfunction or inadequacy
- Voluntary mutual support groups such as Alcoholics Anonymous
- Any mental health service unrelated to the treatment or diagnosis of a mental disorder
- Services of any provider not listed as eligible for reimbursement under the Covered Expenses - Mental Health and Chemical Dependency Services section

Drugs and Medication

This plan does not cover the following:

- Drugs and biologicals that can be self-administered (including injectables), other than those provided in a hospital, emergency room, or other institutional setting, or as outpatient chemotherapy and dialysis, which are covered;
- Growth hormone injections or treatments, except to treat documented growth hormone deficiencies;
- Homeopathic drugs and medications;
- Immunizations or other medications or supplies for protection while traveling or at work;
- Over-the-counter medications or nonprescription drugs, unless listed as covered on your Medical or Pharmacy Benefit Summary.

Equipment and Devices

This plan does not cover the following:

- Equipment commonly used for non-medical purposes, or marketed to the general public, or prescribed primarily for comfort, or intended to alter the physical environment. This includes appliances like air conditioners, air purifiers, room humidifiers, heating and cooling pads, home blood pressure monitoring equipment, light boxes, conveyances other than conventional wheelchairs, whirlpool baths, spas, saunas, heat lamps, tanning lights, and pillows. It also includes orthopedic shoes and shoe modifications. Mattresses and mattress pads are only covered when medically necessary to heal pressure sores
- Equipment used for physical or occupational therapy, or used primarily in athletic or recreational activities. This includes exercise equipment for stretching, conditioning, strengthening, or relief of musculoskeletal problems
- Computer or electronic equipment for monitoring asthmatic, diabetic, or similar medical conditions or related data
- Eyeglasses or contact lenses, except as specifically allowed under Covered Services - Durable Medical Equipment
- Modifications to vehicles or structures to prevent, treat, or accommodate a medical condition
- Personal items such as telephones, televisions, and guest meals during a stay at a hospital or other inpatient facility

Experimental or Investigational Treatment

Your plan does not cover experimental or investigational treatment. Investigational treatment mean services, supplies, protocols, procedures, devices, chemotherapy, drugs or medicines or the use thereof that are, in the Claims Administrator's judgment, experimental or investigational for the diagnosis and treatment of the patient. It includes treatment that, when and for the purpose rendered:

- Has not yet received full U.S. government agency approval (e.g. FDA) for other than experimental, investigational, or clinical testing
- Is not of generally accepted medical practice in Oregon or as determined by the Claims Administrator in consultation with medical advisors, medical associations, and/or technology resources
- Is not approved for reimbursement by the Centers for Medicare and Medicaid Services
- Is furnished in connection with research or clinical trials, unless it would be covered if provided outside of a clinical trial
- Is considered by any governmental agency or subdivision to be experimental or investigational, not reasonable and necessary, or any similar finding

When making decisions about whether treatments are investigational or experimental, the Claims Administrator relies on the above resources as well as:

- Expert opinions of specialists and other medical authorities
- Published articles in peer-reviewed medical literature
- External agencies whose role is the evaluation of new technologies and drugs
- External review by an independent review organization

Services and supplies are excluded that, in the Claims Administrator's judgment:

- Are not rendered by an accredited institution, physician or provider within the United States or by one that has not demonstrated medical proficiency in the rendering of the service or supplies
- Are not recognized by the medical community in the service area in which they are received
- Involve a treatment for which the approval of one or more government agencies is required, but has not been obtained at the time the services and supplies are rendered or are to be rendered
- Involve a treatment for which scientific or medical assessment has not been completed, or the effectiveness of the treatment has not been generally established
- Are available in the United States only as part of a clinical trial or research program for the illness or condition being treated, except for routine costs of qualifying clinical trials

Additionally, the plan does not provide coverage for any expenses incidental to or incurred as a direct consequence of experimental or investigational procedures.

If you or your provider have any concerns about whether a course of treatment will be covered, we encourage you to contact the PacificSource Customer Service. They will arrange for medical review of your case against their criteria, and notify you of whether the proposed treatment will be covered.

BENEFIT LIMITATIONS

Medically Necessary

All services and supplies must be medically necessary in order to be covered under the plan. The fact that a physician may prescribe, order, recommend, or approve a service or supply does not, of itself, make the service or supply medically necessary. See the Definitions section for more information.

Allowable Fee

The Maximum Plan Allowance (MPA) is the maximum amount that the Plan will reimburse physicians and providers. For a participating physician/provider, the maximum amount is the amount the provider has agreed to accept for a particular service.

For a service by a Nonparticipating physician/provider, the Claims Administrator will process charges for those services as follows: maximum amount is the lesser of the amount payable under any supplemental provider fee arrangements we may have in place and the seventy-fifth (75^{th}) 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, the Claims Administrator will consider seventy-five (75) percent of the billed charge as the MPA. The remaining twenty-five (25) percent over the MPA is the patient's responsibility.
In certain instances, when a dollar value is not available in the database, the claim is reviewed by the Claims Administrator'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.

In each of the above situations relating to a Nonparticipating physician/provider, any amount above the MPA is patient responsibility. Depending upon the Plan provisions co-insurance may apply.

The allowable fee for prescription benefits is the maximum amount that the Plan will reimburse physicians and providers for medications. For a participating physician or provider, the allowable fee is the contracted fee. For Nonparticipating physicians and providers, the allowable fee is no more than the prevailing pharmacy network fee based on Average Wholesale Price (AWP) determined by First Data Bank minus a percentage discount. AWP is a figure that is reported by commercial publishers of drug pricing data, based on wholesale pricing information provided to them by drug manufacturers.

Least Costly Setting for Services

Covered services must be performed in the least costly setting where they can be provided safely. If a procedure can be done safely in an outpatient setting but is performed in a hospital inpatient setting, your plan will only pay what it would have paid for the procedure on an outpatient basis. If services are performed in an inappropriate setting, your benefits can be reduced by up to 30% or $2,500, whichever is less.

Cost Effectiveness Services

Under unique and unusual circumstances, the Claims Administrator may approve benefits for cost effectiveness services not otherwise covered by this plan, when doing so is cost-effective and approved by the PCP and PacificSource' medical director.

Payment of benefits for cost effectiveness services shall be at the sole discretion of the Claims Administrator based on their evaluation of the individual case. The fact that benefits have been paid for cost effectiveness services for a covered person does not obligate the plan to pay continued or additional cost effectiveness benefits for that person, or to pay such benefits for any other person. All amounts paid for services under this provision will be included in calculating any benefits, limitations, co-pays, or co-insurance.

Pre-authorization

General Information

Coverage of certain medical services and surgical procedures requires written authorization by the Claims Administrator before the services are performed. This process is called "pre-authorization." Your medical provider can request pre-authorization from the Claims Administrator by phone, fax, mail, or e-mail. If your provider will not request pre-authorization for you, you may contact the Claims Administrator yourself. In some cases, the Claims Administrator may ask for more information or require a second opinion before authorizing coverage.

Pre-authorization is necessary to determine if certain services and supplies are covered under this plan, and if you meet the plan's eligibility requirements. If your treatment is not pre-authorized, you can still seek treatment, but you will be held responsible for the expense if it is not medically necessary or is not covered by this plan. Remember, any time you are unsure if an expense will be covered, contact the Claims Administrator's Customer Service Department.

If your (or your provider's) pre-authorization request is approved, it is valid for 90 days, except in the case of fraud or misrepresentation. Prior authorization for enrollee eligibility is binding if obtained no more than 5 business days prior to the date the service is provided. However, if your coverage under this plan ends before the service is performed, the pre-authorization becomes invalid.

If your (or your provider's) pre-authorization request is denied and you believe the denial is inappropriate, you may appeal the decision. Please see Complaints, Grievances, and Appeals - Appealing a Pre-authorization Denial for more information.

Hospital Pre-admission Authorization

Emergency hospital admissions:

- IATSE-Represented employees: no pre-authorization is required for emergency hospital admissions.
- Non-Represented employees: authorization is required for emergency hospital admissions. Your provider can obtain authorization for you by calling the Claims Administrator within 48 hours of the emergency hospital admission (or as soon as reasonably possible)

All non-emergency hospital admissions that are scheduled in advance must be pre-authorized in order for you to receive your maximum plan benefits. If you do not have the admission pre-authorized by the Claims Administrator, the benefits will be paid at the Nonparticipating level even if the facility is a participating provider. If the Claims Administrator determines that the hospital stay is not medically necessary, your claim will be denied.

As part of the authorization process, the Claims Administrator determines how long each patient is expected to remain hospitalized. The Claims Administrator will authorize medically necessary lengths of stay, based on the medical condition. If a patient's hospital stay extends beyond the assigned length of stay, the Claims Administrator will obtain current information about the patient's medical progress to determine if extended hospitalization meets the criteria for continued coverage. Additional hospital days are covered only upon medical evidence of need.

Occasionally, patients choose to extend their hospital stay beyond the length the attending physician considers medically necessary. Charges for hospital days and services beyond those determined to be medically necessary are the member's responsibility.

Ambulatory (Outpatient) Surgery

Certain diagnostic and therapeutic procedures can be performed without an inpatient admission or overnight stay in a hospital. You will need to obtain pre-authorization 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 authorization. Any covered benefit will be based on the cost of the most appropriate setting for the procedure.

Authorization Process

Pre-authorization involves the following steps:

- When your provider suggests that you be admitted to the hospital or have a non-emergency surgery, ask that your provider contact the Claims Administrator for pre-authorization.
- Your provider will either call the Claims Administrator or submit a service authorization form.
- The Claims Administrator will either approve the admission, ask for additional information and/or request that you get a second opinion. the Claims Administrator may also specify that you receive care on an outpatient basis only.
- If admission is approved, the Claims Administrator will assign the expected length of stay and an appropriate time of admission (such as the morning of or the night before a scheduled surgery.)
- The hospital, physician and patient are notified of the outcome of the pre-authorization process by letter.

If a service must be authorized for you to receive maximum plan benefits, the Claims Administrator will respond to the authorization request within two business days. The response time will be expedited if the patient has an urgent medical condition.

If you have any questions about the pre-authorization process, contact the PacificSource Customer Service Department.

CARE COORDINATION, WELLNESS & CONDITION SUPPORT

Care Coordination

The PacificSource Case Management program provides individualized managed care for you or your family member diagnosed with complex, catastrophic or high risk medical or mental health conditions, or with unusual and serious complications from a medical condition under treatment.

Nurse Case Managers are registered nurses (RNs) who work directly with you, your family, and your physician(s) to coordinate your healthcare needs and create an individualized treatment program. 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

PacificSource will coordinate access to a wide range of services spanning all levels of care depending on the patient's needs. Having a Nurse Case Manager available to coordinate these services ensures improved delivery of healthcare services. For more information about the program, please call PacificSource Health Services at 541-684-5584 or 888-691-8209.

Wellness and Condition Support Programs

The Wellness and Condition Support programs provide education and support to help you maintain your health or manage a chronic condition. The program goals are to optimize health status for you and your family members through various programs.

Wellness programs may address a variety of daily health issues such as nutrition, weight management, stress, exercise, and tobacco cessation via online programs or wellness programs at your worksite.

The Condition Support program offers condition-specific educational materials, individualized care plans that are developed to focus on your health goals, telephone consultations with a registered nurse, and a 24/7 nurse line for help with your questions.

Participating in online or worksite wellness programs, or engaging in a program to help you manage symptoms while living with a chronic condition can help you improve your health and quality of life.

To access wellness and health condition information online, visit the PacificSource website at www.pacificsource.com/extras/.

DENTAL AND VISION BENEFITS GENERAL INFORMATION

Former Employees: Dental and Vision Coverage is optional for former employees continuing coverage, and is only available if you selected this benefit level and pay the additional required premium.

Your dental and vision benefits are self-funded by the City of Eugene. The vision benefits are administered by PacificSource Health Plans and the dental benefits are administered by Delta Dental, a Moda Health affiliated company. Contact information for PacificSource and Delta Dental is in the front of this handbook if you have questions about your dental or vision coverage.

Benefit Description	
Eligibility	Active employees: The same as for Medical coverage. All active employees with City health insurance coverage also have dental and vision coverage. Retiree and COBRA Continuees electing coverage under the City's health plans may also choose to elect dental and vision coverage.
When Coverage Begins	Active employees: The same as for Medical coverage. Retiree and COBRA Continuees: First of the month following the last day of employment with the City of Eugene, provided timely election of coverage and premium payment. Dental/Vision coverage may also be added or dropped during the City's Open Enrollment period.
Required Premiums	Employees may be required to contribute to the cost of coverage under this plan. Premiums are included as part of your Health Insurance Payroll Deduction. Retiree and COBRA Continuees pay the full cost of the premium. Information on rates is available on the City of Eugene Benefits website at www.eugene-or.gov/employeebenefits.

VISION PLAN COVERAGE

Former Employees: Vision Coverage is optional for former employees continuing coverage, and is only available if you selected this benefit level and pay the additional required premium.

Your vision plan benefits are administered by PacificSource Health Plans.

The vision plan covers vision care if the examination is provided by an ophthalmologist or an optometrist.

Covered Vision Expenses

You do not have to pay a deductible for vision coverage. See the Summary of Vision Benefits for benefit amounts.

The plan covers exams, lenses and frames, contact lenses and medically necessary subnormal vision aids, including:

- Complete eye exams every 12 consecutive months; and
- Prescription lenses and frames every 24 consecutive months if the prescription changes; or
- Prescription contact lenses every 24 consecutive months if the prescription changes.

Vision Expenses for Children Under Age 19

Vision exams, eyeglasses and contact lenses are covered when prescribed by a licensed ophthalmologist or licensed optometrist.

If charges for a service or supply are less than the amount allowed, the benefit will be equal to the actual charge. If charges for a service or supply are greater than the allowed amount, the expense above the allowed amount is the member's responsibility and will not apply toward the member's medical plan deductible or Out of Pocket Maximum (OOP) limit.

Vision Expenses Not Covered

Services and supplies not listed in the Vision Benefits Summary are not covered, such as:

- Sunglasses, safety glasses or goggles;
- Replacement of lenses, including lenticular lenses or frames, unless an eye exam shows a vision change that requires a new prescription lens;
- Replacement of lost, stolen or broken lenses or frames, unless otherwise allowed as outlined in the Vision Benefits Summary;
- Benefits payable under Workers' Compensation Act or similar law;
- Surgery or medical treatment of the eyes;
- Services and supplies not listed in the Vision Benefits Summary;
- More than one complete eye exam per 12-consecutive month period;
- More than one pair of frames and/or lenses per 24-consecutive month period, unless otherwise allowed as outlined in the Vision Benefits Summary; and
- Any expenses related to a radial keratotomy, excimer laser refractive surgery or similar procedures.

DENTAL PLAN COVERAGE

Former Employees: Dental Coverage is optional for former employees continuing coverage, and is only available if you selected this benefit level and pay the additional required premium.

Your dental benefits are administered by Delta Dental, a Moda Health affiliated company. The City of Eugene's dental plan utilizes the Delta Dental provider organization. Delta Dental has contracted with participating dentists and has approved their fee schedules. As a result, your share of the dental costs may be reduced. Benefit levels for non-participating providers are based on the prevailing fee level charged by participating dentists for the same services.

Dental Benefits

The dental care program is designed to help you and your covered dependents pay for dental expenses, both for routine care and for unforeseen treatment. The plan will cover eligible dental expenses incurred by you or a covered dependent when performed by a licensed dentist, licensed physician or a certified denturist providing services within the scope of his or her practice, and when determined to be necessary dental care by Delta Dental.

In order to be covered under the plan, the dental service or treatment must be appropriate and required as determined by Delta Dental. Delta Dental will determine whether or not a treatment or service is necessary dental care and may use a consulting service or peer review process to assist in making such a determination. Delta Dental may determine that there are optional dental treatments and may consider alternative services or treatment plans when determining benefits payable under the covered dental expenses of this plan.

Prevailing Fees

The dental benefits are provided through the City's dental plan. Delta Dental has contracted with dentists throughout the
state and has approved their fee schedules for covered services. As a result, your share of the dental cost may be reduced.

Prevailing fees are those fees which satisfy and are charged by the majority of dentists in Oregon, as determined by Delta Dental. "Prevailing fee" in Oregon, means the fee for a single procedure which satisfied the majority (equivalent to the fifty-first (51st) percentile) of dentists in Oregon, as determined by Delta Dental based upon a confidential fee listing accepted by Delta Dental from participating dentists. The Prevailing fee in states other than Oregon shall be that State's Delta Affiliates non-participating dentist allowance.

The plan will pay non-participating dentists up to the prevailing fee level charged by participating dentists for the same services. For more information about the participating dentists, contact Delta Dental at 800-575-9295. You can find up-to-date dental provider listings on the Moda website (www.modahealth.com) and follow the instructions for searching the Delta Dental Premier Directory.

Maximum Plan Allowance

This plan will pay providers the Maximum Plan Allowance for the treatment or service according to the schedule of benefits in effect on the date such treatment or service is provided to the covered person. Maximum Plan Allowance means:

- The accepted filed fee for a participating dentist; or
- The prevailing fee for a non-participating dentist.

Non-participating dentists have the right to balance bill the difference between the maximum plan allowance and the actual charge.

Deductible

You must satisfy your deductible each calendar year before the plan starts paying benefits. There is a maximum of three deductibles per family, with no more than one deductible from any one person, that must be satisfied before the plan starts paying benefits each calendar year.

Carry-Over Deductible

The deductible must be satisfied each year. However, dental expenses incurred in October, November or December that are used to meet the current year's deductible will be applied toward the deductible for the next year.

Maximum Dental Benefit

The plan pays a maximum benefit for dental expenses you incur in each calendar year in which you are eligible for plan coverage. See the Summary of Dental Benefits for maximum dental benefit amounts.

AFSCME-, EPEA-, IAFF-, and IATSE-Represented employees have a lower dental maximum for the first calendar year in which coverage is established. The dental maximum will increase after the first calendar year of coverage. A new first year dental maximum will also apply if you or your dependent did not have dental coverage during a calendar year but later become re-eligible for coverage during that year. This may occur if you or your dependent temporarily lost eligibility under the plan, or if you are a Retiree or COBRA Continuee who did not elect dental coverage for part of the year.

Essential dental benefits for members under the age of 16 are not subject to the annual dental maximum. However, all contractual and/or administrative frequency limitations still apply. The following services are considered essential dental benefits for members under the age of 16:

- Exams
- Cleanings
- Fluoride
- Sealants
- Bitewings
- Full Mouth or Panorax X-rays
- Amalgam Fillings
- Composite Fillings
- Pins & Posts
- Extractions, except for third molar
- Therapeutic Pulpotomy
- Root Canal
- Prefabricated Resin Crown
- Stainless Steel Crown

Covered Dental Expenses

Preventive Treatment

The plan pays 100% of covered preventive treatment. Most preventative services are payable once every six months. There is no deductible required for preventative treatment. This plan pays for the following preventative services:

- Routine dental exams
- Routine bitewing x-rays
- Fluoride treatment
- A non-excisional soft tissue screening to detect oral cellular abnormalities (Vizilite)
- Routine cleaning once every six months; except for the following plan members enrolled in the Delta Dental *Oral Health, Total Health* Program:
  - plan members with diabetes are eligible for a total of 4 routine cleanings each eligibility year;
  - pregnant women are eligible for a routine cleaning in the third trimester of pregnancy regardless of normal plan frequency limits

Basic Treatment

After you meet the applicable deductible, the plan pays 80% of the following covered basic treatments:

- Full mouth x-rays (one set of full mouth x-rays in a period of 36 consecutive months)
- Space maintainers for missing primary teeth
- Temporary treatment needed to ease dental pain
- Sealants for permanent molars (covers children ages 6 to 14, once every 3 years)
- Diagnostic x-rays and lab procedures
- Amalgam, silicate, acrylic and composite fillings. If another restorative material is selected, such as gold foil, the plan will cover up to the cost of a silver amalgam filling. Composite, plastic, silicate, or similar restorations in posterior teeth, other than facial class V restorations on bicuspids, are considered optional services. Benefits shall be based on a corresponding amalgam restoration
- Removal of teeth, including surgery for impacted wisdom teeth (except when due to pre-orthodontic treatment)
- Prescription drugs for dental conditions

- Anesthesia for oral surgery
- Root canal therapy (endodontics)
- Periodontal therapy to stop any severe and recurring symptoms, including periodontal prophylaxis and occlusal adjustments
- Consulting with your dentist or doctor when required, except when due to pre-orthodontic treatment
- Surgery to prepare dental ridges for prosthetic appliances
- Oral surgery performed by your dentist or doctor within six months of an accidental injury to your jaw or natural teeth (prosthetic appliances are included)
- Emergency care and treatment of the jaw or natural teeth received within 72 hours after the first visit
- Relining or rebasing after six months from the date of placement of a denture (one relining or rebasing in a period of 36 consecutive months)
- Inlays, onlays, and crowns when the tooth cannot be restored with a filling or when needed as a support for a bridge
- Repair of dentures or bridgework
- Brush biopsy is covered once in any 6 month period, limited to the sample collection and does not include coverage for lab services

Major Treatment

After you meet the applicable deductible, the plan pays 50% of the following covered major treatments:

- First placement of bridgework
- First placement of partial or full dentures
- Bridge or denture replacement if over five years from the last placement and not serviceable, or the existing denture cannot be used because of the first placement of an opposing full denture
- Implant placement and removal once per lifetime per tooth space (for Non-Represented group members only)

Any benefits paid for temporary crowns, bridges, or dentures are subtracted from benefits paid for permanent crowns, bridges, or dentures. The total benefit paid for temporary dentures will not be more than the maximum benefit paid for permanent dentures.

Orthodontic Treatment

50% of covered orthodontic treatment is paid by the plan. There is no deductible for the following treatment:

- Initial diagnostic procedures
- Correction of malocclusion by wire appliances, braces and other mechanical aids
- Removal of teeth

If needed, the plan includes any separate charges for the first appliances. The plan pays according to the type of dental treatment incurred on the day treatment begins.

Prior to any orthodontic work, your dentist must send in a pre-treatment estimate form to Delta Dental, who will review the service or treatment before it begins. The pre-treatment estimate is designed to inform you of the amount of the benefits paid under the plan before you incur major expenses.

Dental Implant Coverage for Non-Represented Employees

Surgical placement and removal of implants are covered for Non-Represented Employees. Implant placement and implant removal are limited to once per lifetime per tooth space.

The plan will also cover one of the following:

- The final crown and implant abutment over a single implant, limited to once per tooth or tooth space in any 5-year period; or
- A full or partial denture for the final implant-supported full or partial denture prosthetic device when the implant is placed to support a prosthetic device, limited to once in any 5-year period; or
- The final implant-supported bridge abutment and implant abutment, or pontic, limited to once per tooth or tooth space in any 5-year period.

Implant-supported bridges are not covered if one or more of the abutments is supported by a natural tooth. These benefits or alternate benefits are not provided if the tooth, implant, or tooth space received a cast restoration or prosthodontic benefit, including a pontic, within the previous 5 years.

Dental Expenses Not Covered

The following services and supplies are not covered under the plan:

- Charges from providers that exceed “prevailing fees,” as determined by Delta Dental
- Services, procedures, supplies and drugs constituting experimental or investigational treatment as determined by Delta Dental
- Services which are paid for by the government (except services provided by a Veteran's Hospital for non-service related illnesses or injuries)
- Services for which you or your covered dependent are not charged, or for which the charges are waived
- Treatment of an illness or injury for which you are covered under Workers' Compensation or similar State or Federal programs, except services provided by a Veterans Hospital for non-service related illnesses or injuries (this exclusion does not apply to medical assistance provided under Medicaid)
- Dental checkups or dental screening by your employer, a school or a government
- Dietary planning, plaque control or oral hygiene instructions
- Missed appointments or completion of claim forms
- Any restorations or treatment used mainly to keep periodontally involved teeth from moving or to restore occlusion
- Replacement of a lost or stolen prosthetic device or any other device or appliance
- Any dentures, crowns, inlays, onlays, bridgework or other appliances or services mainly for increasing vertical dimension
- Illness or accidental injury resulting from an act of war or during military service for any country while you are covered
- Tooth or denture implants, except for Non-represented group members
- Precision attachments
- Dental treatment for cosmetic reasons except for cosmetic dental surgery that is required: Due to an injury
  - For crown facings on molar teeth if needed as a result of accidental injury
  - For a birth defect or sickness of a covered eligible child born to a covered person
- Replacement of dentures or bridgework if less than five years from the last denture or bridgework placement, except for denture or bridgework placement if the existing dentures or bridgework cannot be used because of first placement of an opposing denture
- The first placement of dentures or bridgework to replace teeth removed before you or your covered dependent were eligible for coverage under the plan, unless:
  - The expenses were eligible under the City’s prior group dental plan; and
  - The teeth were removed while you or your covered dependent were covered under the City’s prior group dental plan.

ELIGIBILITY AND ENROLLMENT

It is your responsibility to make changes to your plan enrollment within 60 days of a qualifying event, including adding newly eligible dependents or dropping ineligible dependents. You can submit changes to your plan enrollment at www.eugene-or.gov/healthenroll.

Employees

All regular full-time and part-time or Limited Duration employees scheduled to work at least one half the available hours in the pay period (or who otherwise qualify as regular part-time employees under an applicable labor agreement or administrative policy) are eligible for the medical, dental, and vision plan. Eligibility for AFSCME-represented Recreation Activity Employees (RAE) is specified in the most recent labor agreement between AFSCME and the City of Eugene.

Regular employees may opt-out of City-provided health insurance (medical, dental, and vision) coverage with *proof of other coverage*. The proof, such as a copy of your ID card from another insurance carrier or similar documentation, must be attached to the "Opt-out" form and submitted to the Risk Services Benefit Program.

Compensated elected officials (the Mayor and City Councilors) are eligible for coverage on a self-pay basis. In order to qualify for coverage, the elected official must elect to participate in the plan and pay the required premiums. Compensated elected officials are eligible for the same coverage under the plan as Non-represented employees.

Temporary employees who qualify under provisions of the Affordable Care Act are eligible for coverage under the Non-Represented plan on a self-pay basis. In order to qualify for coverage, the Temporary employee must elect to participate in the plan when notified of their eligibility and must pay the required premiums.

COBRA/Retirees

Qualified participants may become eligible for COBRA or Retiree health insurance coverage effective the first of the month after they lose coverage under an Active Employee plan. Please see the Continuation of Coverage section for more information.

Dependents and Eligible Children

While you are covered under this plan, eligible dependents are also eligible for coverage.

Regular Employees and Elected Officials - eligible dependents include:

- Your legal spouse or domestic partner. For information regarding coverage of domestic partners, please see the "Domestic Partner Coverage" section of this handbook.
- Your eligible children under age 26.
- Your unmarried children who are mentally or physically disabled regardless of age*. To qualify as dependents, they must have been continuously unable to support themselves since age 19 because of a mental or physical disability. PacificSource requires documentation of the disability from the child's physician. PacificSource will review the case before authorizing coverage and periodically thereafter*
- Children of enrolled domestic partners are eligible on the same terms and conditions as eligible children of enrolled employees

The following are considered eligible children:

- Your natural, step, and adopted children for whom you are legally obligated to support or contribute support.
- Your nieces, nephews, grandchildren or siblings under age 26 living in your household for at least a year, if you are the court appointed legal custodian or guardian. You will need to provide a court order showing legal guardianship.
- Children for whom you have obtained and provided to the City a Decree of Parental Rights (for Non-represented employees and retirees only)
- Children of enrolled domestic partners who meet the definition of eligible child as outlined above

Temporary Employees - Eligible dependents are your biological or adopted children under age 26.

No family or household members other than those listed above are eligible to enroll under your coverage.

Payroll Deductions

Certain groups of employees may be required to contribute toward the cost of health insurance coverage through a payroll deduction for a portion of the health insurance premium. Premiums may change annually, and generally increase each year. Payroll deduction rate information is available on the Employee Benefits website or by contacting the Risk Services Benefits Program.

The portion of the premium that you pay through payroll deductions will be deducted on a before-tax basis through automatic enrollment in the Flexible Spending Account Premium Conversion Program. This means you will avoid paying taxes on these payroll deductions. As a result, your actual take-home pay may increase because your tax payments have been reduced. Employees who have enrolled their domestic partners in a group health plan maintained by the City are not eligible to participate in the Premium Conversion Program.

Although the Premium Conversion Program will benefit most employees, you can opt out of this program by signing an election form indicating that you do not want your premiums to be taken on a before-tax basis within 30 days after you initially become eligible for health plan coverage. Election forms are available in the Risk Services Benefits Program.

When Coverage Begins

For New or Newly Eligible Employees: Health insurance coverage for you and any eligible dependents you choose to cover on your plan begins on the first of the month following your date of hire or date of eligibility. If your date of hire or date of eligibility is the first day of the month, your coverage will begin in the month following the month you are hired.

Regular Employees and Elected Officials: To enroll or add dependents to your plan, you must complete and sign a Health Plan Enrollment form **within 60 days of your date of hire or date of eligibility**.

Temporary Employees: To enroll or add dependents to your plan, you must complete and sign a Health Plan Enrollment form **within 30 days of the date you are notified of your eligibility for coverage.**

If you fail to enroll within 60 days, the City will automatically enroll you in a default health plan. Elected Officials and Temporary Employees are not subject to auto-enrollment. Please see additional information in the Timing of Enrollment section of this handbook.

For Current Members: If you previously declined coverage for yourself or your dependents under the City's plans, you may still be able to enroll or add dependents to your plan under certain circumstances. Please see below for additional information.

How to Enroll

You can enroll or change your enrollment online 24 hours a day from home or work at www.eugene-or.gov/healthenroll. The enrollment form must include complete information on yourself and the eligible family members you are enrolling in your plan. If submitting a paper enrollment form, return the completed application to the Risk Services Benefits Program. Contact information is in the front of this handbook.

Timing of Enrollment

Everyone who becomes eligible for coverage has an initial enrollment period, which is the 60-day period beginning on the date a person is first eligible for enrollment in this plan (30-days from the date notified of eligibility for Temporary Employees). If you do not submit a form during your or your dependent's initial enrollment period, you may be required to wait until Open Enrollment to enroll dependents or to make changes to your plan.

To enroll yourself or add dependents to your plan, you must complete and sign a Health Plan Enrollment form within your initial enrollment period.

You can add a dependent outside the initial enrollment period only if adding your dependent would not increase your health insurance payroll deduction or if you are not required to contribute to either employee or dependent coverage.

Benefits cannot be paid until a new enrollment form is submitted to the Risk Services Benefits Program. If the form is completed within your initial enrollment period, your enrollment and required payroll deductions will be processed in accordance with the applicable effective date of coverage. If you add a dependent outside the initial enrollment

period, coverage will become effective the first of the month after the Risk Services Benefits Program receives your health plan enrollment form.

For Regular Employees: If you are a new or newly eligible employee and do not enroll in a health plan or Opt-out of City-provided coverage within 60 days of your date of hire, the City will automatically enroll you in *employee-only* coverage under a Default Health Plan. You will then have two calendar weeks *immediately following your 60-day initial enrollment period* to enroll eligible dependents in the Default Health Plan. Coverage and payroll deductions will be retroactive to the date they would normally have been effective if you had enrolled during your initial enrollment period. You will not be able to change from the Default Health Plan until the next Open Enrollment or mid-year Special Enrollment period, as outlined in this handbook.

You will not have to wait for the next Open Enrollment in any of the following situations:

- You are adding a dependent, and the addition will not increase your health insurance payroll deduction contribution
- The individual qualifies for special enrollment under any of the special enrollment provisions described below
- A court has ordered that coverage be provided for the spouse or eligible child of an employee under the plan and a request for enrollment is made within 60 days after issuance of the court order
- The individual's coverage under Medicaid, Medicare, CHAMPUS, Indian Health Service or a publicly sponsored or subsidized health plan, including but not limited to the Oregon Health Plan, has been involuntarily terminated within 63 days of applying for coverage under the plan

Elected Officials and Temporary Employees are not subject to auto-enrollment.

Open Enrollment

The City of Eugene has annual open enrollment each May or June. This is generally the only time during the year that you may change from this health plan to another health plan offered by the City. In addition, you may at that time add eligible dependents who were not previously enrolled under the plan. All changes become effective July 1.

Special Enrollment – Change in Employment Status

Employees who change union/employee units during the year, who change from part-time to full-time status (or vice versa), or who have another similar status change within an employee unit may elect to change health plans or add or drop eligible dependents.

To change enrollment due to an employment status change, a new Health Plan Enrollment Form must be completed within 60 days of official notification by the employee's department. The enrollment change and required payroll deductions will be processed effective the first of the month after the date of the qualifying event.

Special Enrollment – Loss of Other Coverage

If you declined coverage under a City health insurance because you were covered under another group health plan or insurance policy, or if you declined coverage for a dependent who was then covered under another group health plan or insurance policy and if that coverage is later terminated involuntarily, you or your dependent may be eligible for coverage under any health insurance plan offered by the City of Eugene for which you are eligible.

"Involuntarily" includes coverage that ended because COBRA continuation coverage was exhausted, employment terminated, work hours were reduced below the employer's minimum requirement, the other insurance plan was discontinued, or the employer's premium contributions toward the other insurance plan ended It also includes a loss of eligibility for coverage as a result of the death of a spouse, divorce, legal separation or the loss of a child's dependency status.

You are also eligible to enroll in the plan if you declined coverage for yourself because you were covered under Medicaid or a State Children's Health Insurance Program (SCHIP) or if you declined coverage for a dependent who was covered under Medicaid or SCHIP, and that coverage is later terminated.

If you are adding a dependent to your plan due to the dependent's loss of coverage under another plan, you have the option to switch to any health insurance plan offered by the City of Eugene for which you are eligible.

To enroll or change enrollment due to the loss of eligibility for other coverage, a new Health Plan Enrollment Form must be completed within 60 days after the other health insurance coverage ends. The enrollment change and required payroll deductions will be processed effective the first of the month after the form is submitted to

the Risk Services Benefits Program. In addition, you must also provide PacificSource a certificate of creditable coverage or other acceptable documentation of the prior coverage.

Special Enrollment – Eligibility for Premium Assistance Subsidy

If you or your dependent are covered under Medicaid or a State Children's Health Insurance Program (SCHIP) and either you or your dependent become eligible for a premium assistance subsidy with respect to that coverage, you and your dependent are eligible for coverage under the City's plans prior to the next open enrollment date.

This special enrollment right applies to:

- A current employee who becomes eligible for a premium assistance subsidy
- An enrolled employee's dependent who becomes eligible for a premium assistance subsidy
- Both the current employee and the dependent if neither is enrolled under the City's plan, and either becomes eligible for a premium assistance subsidy

To enroll or add a dependent to your plan due to eligibility for a premium assistance subsidy, a new Health Plan Enrollment Form must be completed within 60 days of the date the individual becomes eligible for the premium assistance subsidy. Coverage will be effective the first of the month after the form is received by the Risk Services Benefits Program.

Special Enrollment - Newly Acquired Dependents and Eligible Children

If you acquire new dependents because of marriage, birth, or placement for adoption, you may be able to enroll yourself and/or your newly acquired dependents at that time. In the event of a newborn or adopted child, your spouse or domestic partner is also eligible for coverage effective the date of birth, adoption, or placement for adoption, even if you do not enroll the new eligible child in your plan. If adding a newly acquired dependent to your plan, you have the option to switch to any health insurance plan offered by the City of Eugene for which you are otherwise eligible.

If the enrollment of a new dependent will result in an increase in your required payroll deduction for health insurance coverage, you must submit a new Health Plan Enrollment form enrolling the dependent within 60 days after the marriage, birth, or placement for adoption. If you do not enroll your dependents within 60 days of eligibility, you might have to wait until the next open enrollment period to cover them under the health plan. See the specific section below for more information.

Newborn Children

Your newborn child will be automatically covered for 31 days after birth, but your newborn's initial eligibility for coverage will continue for 60 days from the date of birth. **To continue coverage after 31 days, you must submit a new Health Plan Enrollment form to the Risk Services Benefits Program.** If the form is not received within 31 days, coverage will be terminated after the 31st day from the date of birth. However, if you complete a new Health Plan Enrollment Form within 60 days of the date of birth, your newborn's coverage and the appropriate payroll deductions will be reinstated retroactive to the date of birth.

Your newborn's continuing eligibility for enrollment depends on whether adding your child results in an increase in your premium contribution payroll deduction.

- **If adding your newborn increases your payroll deduction, the baby's eligibility for enrollment ends 60 days after birth.** To add your newborn to your plan, you must complete a new Health Plan Enrollment form within those 60 days. The enrollment change and required payroll deductions will be processed effective with the date of birth. If a new form is not received within 60 days, your newborn's coverage will end after 31 days from the date of birth and you may not be able to add the baby to your plan until open enrollment.

- If adding your newborn does not increase your payroll deduction, the baby's eligibility for coverage continues as long as you are covered. However, your newborn cannot be enrolled in the plan and benefits cannot be paid until a new Health Plan Enrollment form is received. If the form is completed outside the 60-day initial eligibility period, the enrollment change will be effective the first of the month following the date the form is received by the Risk Services Benefits Program.

Adopted Children

When a child is placed in your home for adoption, the child is eligible for coverage beginning on the date of placement, but to add the child to your plan you must submit a new Health Plan Enrollment form to the Risk Services

Benefits Program. “Placement” means you have assumed financial responsibility for the support and care of the child in anticipation of adoption.

The child’s eligibility for enrollment depends on whether adding your child results in an increase in your premium contribution payroll deduction.

- **If adding the child increases your payroll deduction, the child’s eligibility for enrollment ends 60 days after placement.** To add your child to your plan, you must complete a new Health Plan Enrollment form within those 60 days, after which the enrollment change and required payroll deductions will be processed retroactive to the date of placement. If a new form is not received within 60 days, you may not be able to add the child to your plan until open enrollment.

- If adding the child does not increase your payroll deduction, the child’s eligibility continues as long as you are covered. However, the child cannot be enrolled in the plan and benefits cannot be paid until a new Health Plan Enrollment form is received. If the form is completed outside the 60 day initial eligibility period, the enrollment change will be effective the first of the month following the date the form is received by the Risk Services Benefits Program.

Family Members Acquired by Marriage

If you marry, you may add your new spouse and any newly eligible children to your plan by submitting a new Health Plan Enrollment form to the Risk Services Benefits Program.

Your new dependent’s eligibility for enrollment depends on whether adding your new family member results in an increase in your premium contribution payroll deduction.

- **If adding a new family member increases your payroll deduction, eligibility for enrollment ends 60 days after the date of marriage.** To add your new dependents to your plan, you must complete a new Health Plan Enrollment form within those 60 days, after which the enrollment change and required payroll deductions will be processed effective the first of the month after the date of marriage. If a new form is not received within 60 days, you may not be able to add your dependents to your plan until open enrollment.
- If adding your new dependent does not increase your payroll deduction, the dependent’s eligibility continues as long as you are covered. However, the dependent cannot be enrolled in the plan and benefits cannot be paid until a new Health Plan Enrollment form is received. If the form is completed outside the 60 day initial eligibility period, the enrollment change will be effective the first of the month following the date the form is received by the Risk Services Benefits Program.

Family Members Placed in Your Guardianship

If a court appoints you custodian or guardian of an eligible sibling, niece, nephew, or grandchild, you may add that family member to your coverage. To be eligible for coverage, the family member must be under age 26 and expected to live in your household for at least a year. You may add a qualifying family member by submitting a new Health Plan Enrollment form to the Risk Services Benefits Program.

Your family member’s eligibility for enrollment depends on whether adding your family member results in an increase in your premium contribution payroll deduction.

- **If adding a new family member increases your payroll deduction, eligibility for enrollment ends 60 days after the date of the court appointment.** To add your family member to your plan, you must complete a new Health Plan Enrollment form within those 60 days, after which the enrollment change and required payroll deductions will be processed effective the first of the month after the date of the court order. If a new form is not received within 60 days, you may not be able to add your family member to your plan until open enrollment.
- If adding your family member does not increase your payroll deduction, the family member’s eligibility continues as long as you are covered. However, the family member cannot be enrolled in the plan and benefits cannot be paid until a new Health Plan Enrollment form is received. If the form is completed outside the 60 day initial eligibility period, the enrollment change will be effective the first of the month following the date the form is received by the Risk Services Benefits Program.

Qualified Medical Child Support Orders

This health plan complies with qualified medical child support orders (QMCSO) issued by a state court or state child support agency. A QMCSO is a judgment, decree, or order, including approval of a settlement agreement that provides for health benefit coverage for the child of a plan member.

If a court or state agency orders coverage for your spouse or child, they may enroll in this plan within a 60-day initial enrollment period beginning on the date of the order. Coverage will become effective on the first day of the month after the Risk Services Benefits Program receives the enrollment application.

Your family member's eligibility for enrollment depends on whether adding your family member results in an increase in your premium contribution payroll deduction.

- **If adding your family member increases your payroll deduction, eligibility for enrollment ends 60 days after the date of the court appointment.** To add your family member to your plan, you must complete a new Health Plan Enrollment form within those 60 days, after which the enrollment change and required payroll deductions will be processed effective the first of the month after the Risk Services Benefits Program receives the enrollment application. If a new form is not received within 60 days, you may not be able to add your family member to your plan until open enrollment.
- If adding your family member does not increase your payroll deduction, the family member's eligibility continues as long as you are covered. However, the family member cannot be enrolled in the plan and benefits cannot be paid until a new Health Plan Enrollment form is received. If the form is completed outside the 60 day initial eligibility period, the enrollment change will be effective the first of the month following the date the form is received by the Risk Services Benefits Program.

Domestic Partner Coverage

You may enroll your domestic partner in your plan if both you and your domestic partner have met all the criteria outlined in the Eligibility section below.

Eligibility

For purposes of eligibility for coverage under City health insurance, a domestic partner means either a "statutory domestic partner" or a "non-statutory domestic partner."

A "statutory domestic partner" is a person of the same sex as the employee who, with the employee, has been issued a Certificate of Registered Domestic Partnership pursuant to ORS Chapter 99 or who has otherwise entered into a legally recognized civil contract in regard to such domestic partnership. A statutory domestic partner is eligible for coverage under the plan under the same terms and conditions as a legal spouse. If you have been issued a Certificate of Registered Domestic Partnership, you do not need to submit a Declaration of Domestic Partnership or meet the eligibility criteria as outlined below for non-statutory domestic partners.

A "non-statutory domestic partner" is a person of either the same sex or opposite sex as the employee, who, with the employee, has **not** entered into a legally recognized civil contract or been issued a Certificate of Registered Domestic Partnership. Your non-statutory domestic partner is eligible for coverage only if you and your domestic partner submit a "Declaration of Domestic Partnership" to the Risk Services Benefits Program and have met all the criteria below for at least 6 months:

- Are each 18 years of age or older
- Are not legally married to anyone
- Are each other's sole domestic partner living together in a spousal equivalent relationship
- Have shared the same regular permanent residence for at least six (6) months immediately preceding the date of the Declaration of Domestic Partnership and represent in such Declaration an intent to continue to do so indefinitely
- Are financially interdependent and jointly responsible for "basic living expenses"
- Are not related by blood so close as to bar marriage in the State of Oregon and are mentally competent to consent to a contract

"Basic living expenses" means the cost of basic food, shelter and other expenses. The employee and domestic partner need not contribute equally or jointly to the costs of these expenses as long as they agree that both are responsible for the cost.

Upon request, you must provide the Risk Services Benefits Program with documents establishing that a person enrolled under the plan as a non-registered domestic partner meets the eligibility criteria set forth above. The domestic partner may be terminated from the plan if you do not produce documentation within thirty calendar days of the request.

For statutory domestic partners, you will not be required to submit a Certificate of Registered Domestic Partnership, or any other documentation evidencing an individual's status as a statutory domestic partner, except in the same circumstances a marriage certificate may be required.

Enrolling Eligible Domestic Partners

You can enroll your eligible domestic partner and the legal dependents of your domestic partner in your plan by submitting a Declaration of Domestic Partnership form (required for non-statutory domestic partners only), a Health Plan Enrollment form, and, if appropriate, a Declaration of Tax Dependent Status form. You may incur an additional tax liability when enrolling a statutory or non-statutory domestic partner in your plan. Forms and information on the possible tax consequences of domestic partner coverage are available on the Domestic Partnership page of the Employee Benefits website at www.eugene-or.gov/employeebenefits or from Benefits Program staff. Coverage is effective on the first day of the month after the Declaration of Domestic Partnership is approved by the Benefits Program.

A qualified statutory or non-statutory domestic partner may be enrolled within the same time periods that apply to the enrollment of spouses under the plan, including, but not limited to, during the first 60 days of eligibility following the domestic partner's initial eligibility for coverage or during an annual open enrollment period.

Except as provided in the Additional Conditions section below, domestic partners and their dependents are eligible under the health plan for the same benefits under the same conditions as provided to spouses and dependents of married employees.

Additional Conditions

The coverage of domestic partners and their dependents is subject to the following additional terms and conditions:

- Domestic partners and their dependents are eligible for continued coverage under either the COBRA or the retired employee continuation coverage provisions of the health plan.
- By enrolling your domestic partner and, if applicable, the dependents of your domestic partner, you will be responsible for the same premium contribution towards the cost of dependent coverage as married employees having dependent coverage.
- You will not be eligible to pay for the cost of domestic partner coverage under the plan (including for the coverage of the employee and any dependents of the employee) on a before-tax basis under the City of Eugene Flexible Spending Account (FSA) program unless you advise the Risk Services Benefits Program that the domestic partner qualifies as a dependent of the employee under applicable IRS rules by submitting an "Declaration of Dependent Status". Otherwise, all premium contributions for domestic partner coverage must be made on an after-tax basis.
- Under IRS rules, the plan's coverage of a domestic partner who is not a qualified dependent is a taxable benefit to you. In such circumstances, you must pay income taxes on the fair market value of the health plan coverage provided to your domestic partner. The value of the domestic partner coverage is considered wages, is included in your gross income, and is subject to state and federal income tax and FICA withholding.
- The value of the coverage of a domestic partner who qualifies as your dependent under the IRS rules will not be subject to taxation, and thus will not be included in your wages.

Upon request, you must provide the Risk Services Benefits Program a new Declaration of Dependent Status and other documents establishing the domestic partner's status as your dependent. If you do not provide such documents within 31 calendar days of the request, the value of the coverage of the domestic partner under the plan will become taxable to you as outlined above.

Termination of Domestic Partnership

Coverage under the plan for a statutory domestic partner will end on the last day of the month after the date of a final judgment of dissolution or annulment of the domestic partnership, or after the date of a legal separation. Coverage under the plan for a non-statutory domestic partner will end on the last day of the month after the termination of the domestic partnership, or the date that the non-statutory domestic partner no longer satisfies the eligibility criteria to qualify as a non-statutory domestic partner.

Upon termination of the non-statutory domestic partner relationship, or if the non-statutory domestic partner no longer meets the criteria for plan coverage, you must submit a "Termination of Non-Registered Domestic Partnership" form to the Benefits Program within 60 calendar days of the event. After such termination of coverage, you may not enroll a non-statutory domestic partner under the plan within six (6) months of the date the Termination of Non-Registered Domestic Partnership was submitted.

Returning to Work After an Absence

Layoff

If you are laid off and are recalled to your previously held classification, your health coverage will resume retroactively to the first day of the month in which you return to a regular schedule meeting the minimum hours required for health insurance coverage under City policy or the applicable union contract. If your family members were covered before your layoff, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment form within 60 days after your return to work.

Leave of Absence

Your coverage and that of your covered dependents will be continued while you are on *paid* leave of absence. Coverage will ordinarily terminate on the last day of the month in which the paid leave ends, unless you are on approved leave under the Family and Medical Leave Act.

If you are granted a leave of absence *without pay*, or take an unpaid leave of absence under the Oregon Family Leave Act (OFLA), you can continue your health insurance coverage on a self-pay basis. See the section COBRA Continuation Coverage for more information.

If you return to work after an approved leave of absence without pay, your health coverage will resume retroactively to the first day of the month in which you return to a regular schedule meeting the minimum hours required for health insurance coverage under City policy or the applicable union contract. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment form within 60 days after your return to work.

FMLA Unpaid Leave of Absence

If you are on an unpaid leave of absence under the Family and Medical Leave Act of 1993 (FMLA), you and your enrolled dependents will remain eligible for coverage under the same conditions as if you had been continuously employed during the entire leave period.

If you return to work after Family and Medical Leave and did not continue your health coverage while on FMLA, your coverage will resume retroactively to the first day of the month in which you return to a regular schedule meeting the minimum hours required for health insurance coverage under City policy or the applicable union contract. If your family members were covered before your leave of absence, they can resume coverage at that time as well. You must re-enroll your family members by submitting an enrollment form within 60 days after your return to work.

When Coverage Ends

You are required to notify the Risk Services Benefits Program when you have a qualifying event that would cause a loss of eligibility for you or your dependent under the plan.

Note: You must drop ineligible dependents within 60 days of the date of the qualifying event by submitting a new Health Plan Enrollment form to the Employee Benefits Program.

Employees who pay a portion of their health insurance premium through a payroll deduction should promptly notify the Risk Services Benefits Program when any covered dependent no longer qualifies for health insurance coverage to ensure that the correct payroll deduction is taken.

Medical, dental, and vision coverage for your eligible dependents also ends when your coverage stops or, if earlier, as of the date your dependents no longer qualify for coverage. Coverage for an eligible child who is covered by virtue of a Decree of Parental Rights (for a non-represented employee) will end when the child ceases to be covered by the Decree.

Some circumstances can cause coverage for you and/or your covered dependents to end. In those cases, you or your dependents might be eligible to continue coverage for a limited time. Please see the COBRA Continuation Coverage section of this handbook for more information.

Termination of Employment

If your employment with the City of Eugene ends for any reason, coverage for you and/or your enrolled family members will end after the last day of the month in which your employment ends.

Work Hour Reduction

If your work hours are reduced below the minimum hours per week required for coverage, coverage for you and/or your enrolled family members will end after the last day of the month in which your eligibility ends.

Divorce or Legal Separation

If you divorce or become legally separated, you must drop your legally separated spouse or former spouse from your plan within 60 days of the date of the qualifying event (either legal separation or divorce) by submitting a new Health Plan Enrollment form to the Risk Services Employee Benefits Program. Coverage for your spouse will end after the last day of the month in which the divorce decree or legal separation is final, even if you are legally required to provide coverage for your spouse. Continuation coverage may be available. Please see the COBRA Continuation Coverage section for more information.

Termination of Domestic Partnership

If you terminate your domestic partnership, you must drop your former domestic partner from your plan within 60 days by submitting a new Health Plan Enrollment form (and, for non-statutory domestic partners, a Termination of Domestic Partnership form) to the Risk Services Employee Benefits Program. Coverage under the plan for a statutory domestic partner will end on the last day of the month after the date a final judgment of dissolution or annulment of the domestic partnership. Coverage under the plan for a non-statutory domestic partner will end on the last day of the month after the termination of the domestic partnership, or the date the non-statutory domestic partner no longer satisfies the eligibility criteria to qualify as a non-statutory domestic partner.

Voluntary Termination of Coverage

While you can voluntarily discontinue coverage for your enrolled family members at any time, your payroll deduction for health insurance, taken out pre-tax through the Premium Conversion Program, can only be reduced if the disenrollment occurs during the health insurance open enrollment period or if it is prompted by and consistent with a Qualified Change in Status Event under the City of Eugene Flexible Spending Plan.

This means that your payroll deduction might stay the same even if you discontinue enrollment for a dependent under your plan unless the disenrollment occurs as stated above. Please see the Flexible Spending Account section of this handbook for a list of Qualified Change in Status Events. (Note: This provision does not apply to enrolled domestic partners who are not tax-qualified dependents since their coverage is not governed by Flexible Spending Plan federal regulations.)

To disenroll a family member, you must submit a new Health Insurance Enrollment form to the Risk Services Benefits Program. Keep in mind that once coverage is discontinued, you may need to wait until the next open enrollment period if you wish to re-enroll them in your plan.

Children Age 26 and Over

If your child is age 26 or over, they are not eligible for coverage under the plan, unless they meet eligibility for coverage due to a mental or physical disability. **You must drop your ineligible child from your plan within 60 days of the date they lose eligibility by submitting a new Health Plan Enrollment form to the Employee Benefits Program.** Coverage for your over-age child will end on the last day of the month in which they turn age 26. Continuation coverage may be available. Please see the Continuation of Coverage section for more information.

Certificates of Creditable Coverage

Certificates of Creditable coverage will be issued by the Claims Administrators when active coverage ends, when COBRA or Retiree coverage ends, and when an individual requests a certificate while covered by the plan or within two years of losing coverage.

CONTINUATION OF COVERAGE

COBRA/Retiree Contact Information

If you have questions about your COBRA or Retiree continuation coverage, you can contact the COBRA/Retiree Administrator, BenefitHelp Solutions, or the Plan Administrator, the City of Eugene Risk Services Benefits Program.

Contact information is in the front of this handbook.

COBRA Continuation

You and/or your eligible dependents (including domestic partners and their dependents) may continue your health care coverage on a self-pay basis under certain qualifying events. This continuation coverage is made available pursuant to the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended. The following sections describe your rights to continuation under state and federal laws, and the requirements you must meet to enroll in continuation coverage.

You, your spouse or domestic partner, and your dependents, as applicable, may only continue the health coverage that was in effect when the qualifying event took place. You would not be eligible to switch health plans due to COBRA, but you may change your coverage during the open enrollment period. If you had the combined health coverage (medical/dental/vision), you may continue that combined coverage. You may also elect to continue the medical coverage only and not dental/vision coverage. The coverage will be the same as that provided under the City of Eugene's benefit plans for active employees.

A child who is born to or adopted by you while you are receiving continuation coverage is also entitled to continuation coverage. Written notice of a child born to or adopted by you while you are receiving continuation coverage must also be provided to the COBRA Administrator within 60 days of that event.

Individuals entitled to COBRA continuation coverage have the same rights afforded similarly situated plan participants who are not enrolled in COBRA. COBRA participants may add newborns, new spouses, and adopted children (or children placed for adoption) as covered dependents in accordance with the plan's eligibility and enrollment rules, including the plan's special enrollment rules.

Address Changes

In order to protect your family's rights, you should keep the Risk Services Benefits Program informed of any changes in the addresses of family members. You should keep a copy, for your records, of any notices you send to the Benefits Program or to the COBRA Administrator.

Qualifying Events

A "qualifying event" is the event that causes your regular coverage to end and makes you eligible for continuation coverage. If you are a City employee, you will become a qualified beneficiary if you lose coverage under the plan because either one of the following qualifying events happens:

- Your hours of employment are reduced; or
- Your employment ends for any reason other than your gross misconduct.

Your spouse or domestic partner will become a qualified beneficiary if they lose coverage under the plan because any of the following qualifying events happens:

- You die
- Your hours of employment are reduced
- Your employment ends for any reason other than for gross misconduct
- You become divorced or legally separated, or terminate your domestic partnership

Your covered eligible children will become qualified beneficiaries if they lose coverage under the plan because any of the following qualifying events happens:

- You die
- Your hours of employment are reduced
- Your employment ends for any reason other than for gross misconduct
- You become divorced or legally separated from your spouse, or terminate your domestic partnership
- Your child is no longer eligible for coverage under the plan

Notification of Qualifying Event--Your Responsibility

The plan will offer COBRA continuation coverage to qualified beneficiaries only after the City of Eugene Benefits Program has been notified that a qualifying event has occurred. When the qualifying event is the end of employment, reduction of hours of employment or death of the employee, the City of Eugene will notify the COBRA Administrator of the qualifying event within 30 days following the date coverage ends.

For the qualifying events of divorce or legal separation of the employee and spouse, termination of domestic partnership, or an eligible child's losing eligibility for coverage as an eligible child, you must notify the City of Eugene Benefits Program within 60 days after the qualifying event occurs. Your notice must include the nature and date of the qualifying event, the name of the person losing coverage, and a mailing address for that person.

Once the City of Eugene Benefits Program receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered employees may elect COBRA continuation coverage on behalf of their spouses or domestic partners, and parents may elect COBRA continuation coverage on behalf of their children. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date that the plan coverage would otherwise have been lost.

Length of COBRA Continuation Coverage

COBRA continuation coverage is a temporary continuation of coverage. When the following qualifying events happen, you may continue coverage for the lengths of time shown:

Qualifying Event	Continuation Period
Employee's termination of employment or reduction in hours	Employee, spouse or domestic partner, and children may continue for up to 18 months[1]
Employee's divorce or legal separation, or termination of domestic partnership	Spouse or domestic partner and children may continue for up to 36 months[2]
Employee's eligibility for Medicare benefits if it causes a loss of coverage	Spouse or domestic partner and children may continue for up to 36 months
Employee's death	Spouse or domestic partner and children may continue for up to 36 months[2]
Child no longer qualifies as a dependent	Child may continue for up to 36 months[2]

[1] If the employee or covered dependent is determined disabled by the Social Security Administration within the first 60 days of COBRA coverage, all qualified beneficiaries may continue coverage for up to 29 months.

[2] The total maximum continuation period is 36 months, even if there is a second qualifying event. A second qualifying event might be a divorce, separation, domestic partnership termination, death, or child no longer qualifying as a dependent after the employee's termination or reduction in hours.

When the qualifying event is the death of the employee, divorce or legal separation, termination of domestic partnership, or an eligible child loses eligibility as an eligible child, COBRA continuation coverage lasts for up to a total of 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement. For example, if a covered employee becomes entitled to Medicare 8 months before the date

on which his employment terminates, COBRA continuation coverage for his spouse or domestic partner and children can last up to 36 months after the date of Medicare entitlement, which is equal to 28 months after the date of the qualifying event (36 months minus 8 months).

Otherwise, when the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage generally lasts for only up to a total of 18 months. There are two ways in which this 18-month period of COBRA continuation can be extended, which are detailed below.

Disability Extension of 18-month Period of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration (SSA) to be disabled and you notify the COBRA Administrator in a timely fashion, you and your entire family may be entitled to receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of continuation coverage.

In order to be eligible for this extended continuation coverage period, the disabled individual (or someone on the individual's behalf) must notify the COBRA administrator of the SSA disability determination within 60 days of the issuance of the determination by the SSA (or, if later, within 60 days of the end of the month in which the employee terminates employment or transfers to part-time status) and before the end of the otherwise applicable 18-month continuation period, whichever period ends first. The notice must include a copy of the SSA determination. If the notice of the SSA determination is not provided to the COBRA Administrator within this time period, then the 11-month extension of coverage will not be available.

If the SSA later makes a final determination that the individual is no longer disabled, the individual must notify the COBRA Administrator within 30 days of the final determination by the SSA.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving 18 months of COBRA continuation coverage, the spouse or domestic partner and eligible children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if notice of the second qualifying event is properly given to the plan. This extension may be available to the spouse (or domestic partner) and any eligible children receiving continuation coverage if the employee or former employee dies, gets divorced or legally separated, or has a domestic partnership termination, or if the eligible child stops being eligible under the plan as an eligible child, but only if the event would have caused the spouse, domestic partner or eligible child to lose coverage under the plan had the first qualifying event not occurred.

In all cases, you must make sure that the COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. Your notice must include the nature and date of the second qualifying event, the name of the person losing coverage, and a mailing address for that person.

Once Notification Is Given

When the COBRA Administrator is notified that one of the above events has occurred, they will notify you or your covered dependents of the right to elect continuation coverage. Under this provision, the COBRA-eligible person must elect continuation coverage within 60 days from the date coverage would otherwise be lost because of one of the events described above or 60 days from the date of notification from the COBRA Administrator, whichever is later. Failure to elect continuation coverage within that period will cause coverage under the plan to end as it normally would under the terms of the plan.

Cost of COBRA Continuation Coverage

You or your covered dependent is responsible for the full cost of continuation coverage and any administrative fee assessed. Payment for continuation coverage for any month is due on the first day of the month, and, in all events, must be made within 30 days of the due date. The only exception is the premium payment for continuation coverage during the period preceding the election, which must be made within 45 days of the date of election. Premium rates may change annually.

When COBRA Continuation Coverage Ends

COBRA continuation coverage will end for a person (i.e., you, your spouse, domestic partner, or dependent, as applicable) if one of the following events occurs:

- Failure to timely pay the full required continuation premium

- The City of Eugene no longer offers group health coverage
- The person later becomes covered under any other medical, dental, or vision plan. However, coverage under another plan will not cause continuation to end if the other plan excludes or limits coverage for a pre-existing condition of the person
- The person later becomes entitled to Medicare benefits under Part A, Part B, or both
- In the case of a person who qualified for an extra 11 months continuation coverage based on the disability and persons receiving continuation coverage by reference to such disabled person, the date of a final determination by the Social Security Administration that the person is no longer disabled
- The applicable period of continuation ends
- Coverage is terminated for cause (e.g., a covered person submits a fraudulent claim)

Continuation coverage may also be terminated for any reason the plan would terminate coverage of an employee or dependent not receiving continuation coverage. Once COBRA Continuation coverage ends, it cannot be reinstated.

Termination for Gross Misconduct

Pursuant to federal law, employees who are terminated from employment for gross misconduct are not entitled to COBRA continuation coverage under the plan. The spouse (or domestic partner) and dependents of an employee terminated for gross misconduct are also not entitled to COBRA continuation coverage.

The City will review the specific circumstances surrounding each disciplinary termination in order to determine whether an employee's termination was for gross misconduct.

Extension of Hospital Coverage

A covered person who is hospitalized at the time of the termination of coverage under the plan will continue to receive benefits for services received while hospitalized until discharged from the hospital or until the limits of coverage under the plan have been reached, whichever is earlier. Continuation of coverage under this provision will be concurrent with any eligibility period under COBRA continuation.

Continuation during Strike or Lockout

If you are a union member, you have certain continuation rights in the event of a labor strike. Your union is responsible for collecting your premium and can answer questions about coverage during the strike.

In the event of cessation of work by employees due to a strike or lockout, your coverage under the plan will continue in effect if you:

- Were covered by the plan on the date of the cessation of work;
- Continue to pay your individual contribution; and
- Assume and timely pay the contribution due from the City.

Continuation of coverage under this provision will be concurrent with any eligibility period under COBRA continuation.

Continuation for Spouses or Domestic Partners over Age 55

If you die, become divorced, legally separated or discontinue your domestic partnership, and your covered spouse or domestic partner is then age 55 or over, your spouse or domestic partner and any covered dependents may continue medical coverage under the City's Plan on a self-pay basis until the earliest to occur of the following:

- Failure to pay premiums when due
- Termination of the plan, unless another group health plan is made available by the City of Eugene to its employees
- Your legally separated, divorced or surviving spouse or domestic partner becomes covered under another group health plan or becomes eligible for Medicare
- Covered dependents no longer meet the eligibility requirements of the plan

In order to be eligible for continued coverage, your spouse, domestic partner or dependent must give written notice of the legal separation, termination of marriage or domestic partnership, or death of the employee to the Risk Services Benefits Program within:

- Thirty days of the date of the employee's death
- Sixty days of the date of legal separation (or dissolution of domestic partnership)
- Sixty days of the date of entry of the divorce decree

USERRA Continuation Coverage

Coverage During Military Service

An employee who leaves the employment of the City of Eugene to perform services in the Armed Forces or another uniformed service, and who would then otherwise cease to be eligible for coverage under the plan, will then have the choice between two forms of continuation coverage. First, the employee can elect COBRA continuation coverage as discussed above. Alternatively, the employee can elect continuation coverage that is made available pursuant to the Uniformed Services Employment and Reemployment Rights Act (USERRA). The terms and conditions of the USERRA continuation coverage are discussed below.

Right to USERRA Coverage

An employee who leaves employment with the City to enter into military service may elect USERRA continuation coverage. If the employee elects USERRA continuation coverage, the employee can also elect USERRA continuation coverage for any eligible dependents. However, in contrast to the COBRA rules, the employee's dependents do not have independent USERRA coverage rights. Therefore, dependents cannot elect separate continuation coverage under USERRA if the employee chooses not to do so. In addition, a dependent of an employee (including a spouse or domestic partner) who ceases to be eligible for coverage under the plan upon entering into military service does not have USERRA continuation coverage election rights under the plan.

Scope of USERRA Coverage

The USERRA continuation coverage rules do not provide coverage for any illness or injury caused or aggravated by an employee's military service, as determined by the Veterans Administration.

During the period that the employee remains in such military service, the employee and covered dependents are eligible for coverage under this plan even if they are then also covered under another group health program, such as the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS).

Length of USERRA Coverage

If an employee elects USERRA continuation coverage, the period for that coverage will extend until the earlier of (i) the end of the 24 month period beginning on the date the employee leaves employment for the purpose of performing military service, and (ii) the date the employee fails to timely return to employment or reapply for a position with the City upon the completion of such military service. USERRA coverage will end automatically for the employee and dependents if either of the following events occurs:

- The City no longer provides health coverage to any employees
- The premium for the USERRA continuation coverage is not paid on time

Electing USERRA Continuation Coverage

An employee who intends to leave employment to perform service in the military is generally required by USERRA to provide the City with notice of such. When feasible, the notice is to be provided at least 30 days prior to the departure. If the employee does not provide the advance notice when able to do so, then the employee will not have the right to elect USERRA coverage. The employee, however, may still be eligible to elect COBRA coverage.

When the City receives the notice of intended departure, the employee will be provided with an USERRA coverage election form. To elect USERRA continuation coverage, the employee must complete the election form, and mail or deliver it to the COBRA Administrator. The completed election form must be postmarked or delivered within 60 days following the last day of the month in which the employee left employment to perform military service (or, if later, within 60 days after the USERRA election form was provided to the employee). If the employee does not submit a completed USERRA election form by the due date, the employee will lose the right to elect USERRA coverage.

If an employee was unable to give advance notice of a departure for military service because it was impossible or unreasonable to do so under the circumstances, or because the employee was precluded from doing so by military necessity, the 60-day election deadline will be waived. In this situation, the employee should submit the USERRA election form when first able to do so.

In all cases, the right to USERRA coverage is conditioned upon the employee first remitting payment for the period extending through the date the election is made, as discussed more fully below.

Paying For USERRA Continuation Coverage

Generally, an employee electing USERRA continuation coverage is required to pay the entire cost of the continuation coverage. If the period of the employee's absence is less than 30 days, the contribution rate will be the same as for active employees. If the absence is longer than 30 days, the required contribution will not exceed 102% of the cost of coverage.

The USERRA continuation coverage payment rules are substantially the same as applicable under the COBRA rules discussed earlier in this section of the handbook. Thus, an employee who elects continuation coverage is not required to send payment for continuation coverage with the USERRA election form. However, the employee must make the first payment for USERRA coverage in full within 45 days after the date of the initial election. If the employee does not make the first payment for continuation coverage within that 45-day period, the employee (and the employee's covered dependents) will lose all USERRA coverage rights under the plan.

After the employee has made the initial payment, future payments for USERRA coverage will be due as of the first day of each month. However, the employee has a grace period of 30 days to make each monthly payment. If the employee fails to make a monthly payment before the end of a grace period, the USERRA continuation coverage will be terminated effective as of the last day of the period for which the USERRA continuation coverage premium was received.

Reinstatement upon Returning to Work

Regardless of whether an employee elects continuation coverage under USERRA, coverage under the plan will be reinstated on the first day the employee returns to active employment with the City or the date outlined by the City's normal Leave of Absence policy, whichever is earlier, provided that the employee is released under honorable conditions and returns to employment, or applies for reemployment, within the time period prescribed under USERRA. When coverage is reinstated, all provisions and limitations of the plan will apply to the extent that they would have applied had the employee not taken military leave and coverage had been continuous under the plan.

Retiree Continuation

If you retire under the Oregon Public Employees Retirement System (PERS) or Oregon Public Service Retirement Program (OPSRP) immediately upon your termination of employment from the City of Eugene, you can continue your health insurance coverage through the City's plan on a self-pay basis, as provided under state law. Retirees have the choice of either COBRA or the Retiree Continuation Coverage, but not both. See the COBRA Continuation section for more information about COBRA coverage.

Eligibility

Oregon law requires public employers to allow retired employees the option of continuing to purchase health insurance coverage from the employer after retirement. If you are a regular employee and retire under the Oregon Public Employees Retirement System (PERS) or Oregon Public Service Retirement Program (OPSRP) (or any other retirement system or plan to which contributions were paid by the City on the your behalf) immediately upon your termination of employment from City of Eugene service (or if you are no longer actively employed due to a disability), you may elect to continue to be covered under the plan on a self-pay basis.

Coverage Options

On your retirement, you may elect either:

- Medical-only coverage; or
- Medical, dental and vision coverage

If you initially elect medical-only coverage, you can later elect to add dental and vision coverage, but not until a subsequent open enrollment period. You and your eligible dependents have the same open enrollment and special enrollment options as do active employees.

Duration of Coverage

- You and your spouse or domestic partner may continue coverage under the retiree plan on a self-pay basis until eligible for Medicare benefits.
- If you retire under PERS/OPSRP immediately upon leaving employment with the City of Eugene but are ineligible to continue coverage under the Retiree plan due to Medicare eligibility, your spouse or domestic partner who is covered under your active employee plan can continue coverage on the retiree plan until they become eligible for Medicare.
- If, while covered under the retiree plan, you divorce or a discontinue your domestic partner relationship after your spouse or domestic partner attains age 55, your spouse or domestic partner has the right to continued coverage under the plan.
- If you divorce or discontinue your domestic partnership before your spouse or domestic partner attains age 55, your spouse or domestic partner will then cease to be eligible for retired employee coverage, but may then be eligible for COBRA continuation coverage.
- You may continue coverage for your child as long as they are considered an eligible child under the plan. Once your child loses eligibility under your plan they may then be eligible for COBRA continuation coverage.

Election Deadline

In order to be covered under the Retiree health insurance program, you must timely elect the coverage and timely pay the required self-pay premiums. You must retire under PERS or OPSRP immediately upon termination from the City of Eugene and must elect to secure retired employee coverage no later than 60 days after your retirement date.

Monthly Payments

As a retired employee, you are responsible for the full cost of retired employee continuation coverage and any applicable administrative fee assessed. Payment for coverage for any month is due on the first day of the month, and, in all events, must be made within 30 days of the due date. The only exception is the premium payment for retired employee coverage during the period preceding the election of such coverage, which must be made within 45 days of the date of election. In all regards, retired employee coverage will terminate as of the last day of the prior month for which the monthly self-pay premium was not timely made.

No Reinstatement of Coverage

If you fail to timely elect retired employee coverage, or after electing coverage have your coverage terminated as a result of failing to timely pay the required premium or for any other reason, you will cease to be eligible for retired employee coverage. Once the retired employee coverage is terminated, it will not be reinstated.

CLAIMS ADMINISTRATION AND PAYMENT

General Submission and Payment Information

When a participating provider treats you, your claims are automatically sent to the appropriate Claims Administrator, either PacificSource or Delta Dental, and processed. All you need to do is show your PacificSource or Delta Dental ID card to the provider. If you receive care from a nonparticipating provider, the provider may submit the claim to the Claims Administrator for you. If not, you are responsible for sending the claim to the Claims Administrator for processing.

All claims for benefits must be submitted to the Claims Administrator within 90 days of the date of service. If it is not possible to submit a claim within 90 days, submit the claim with an explanation as soon as possible. In some cases the Claims Administrator may accept the late claim. No claim will be paid if submitted later than one year from the date of service. A claim that was paid, but for which additional information is received, will not be reprocessed after the claim submission period described above.

Manual Claim Submission

If you paid for a product or service out-of-pocket, you can submit the claim to the Claims Administrator for reimbursement through the following process:

- Complete a Quick Claim Form, available on the Risk Services Employee Benefits website or from the Benefits Program staff.
- Obtain a copy of the bill or prescription receipt, which should include:
  - Your name
  - The name of the patient
  - The date of treatment
  - Total charge
  - A description of the diagnosis or symptoms treated
  - The prescription number (if applicable)
  - A description of the services
- If the treatment is for an accidental injury, include a statement explaining the date, time, place, and circumstances of the accident.

Submit manual claims to the appropriate Claims Administrator at the address listed in the Contact Information page in the front of this handbook.

The same procedure should be followed with bills for hospital, physician or professional provider care you receive outside the United States.

Hospital Claims

If you or a covered dependent are hospitalized, you will need to present your PacificSource identification card to the admitting office. In most cases, the hospital will bill PacificSource directly for the cost of the hospital services. PacificSource will pay the hospital and send you copies of the payment record. The hospital will then bill you for any charges that were not covered under your plan. If you are billed by the hospital directly, you will need to submit the bill to PacificSource in order to claim your benefits for the charges.

Sometimes, a hospital will require you, at the time of discharge, to pay charges that might not be covered by your plan. If this happens, you must pay these amounts yourself. PacificSource will reimburse you if any of the charges you pay are later determined to be covered by your plan.

Ambulance Claims

Bills for ambulance service must show where the patient was picked up and where the patient was taken. The bill should also show the date of service, the patient's name, and your group and identification numbers.

Explanation of Benefits (EOB)

Soon after you make a claim, the Claims Administrator will report to you on the action taken by sending you a document called an Explanation of Benefits. The Explanation of Benefits (EOB) will indicate if a claim has been paid,

denied, or accumulated toward satisfying the deductible. If the Claims Administrator denies all or part of a claim, the reason for the action will be stated in the Explanation of Benefits. To be eligible for reimbursement, claims must be received within the claim submission period noted under General Submission and Payment Information.

You can also review claims payment information by logging on to InTouch on the PacificSource website at www.pacificsource.com. For Delta Dental information, log into myModa on the Moda website at www.modahealth.com. See the Member Access Websites section of this handbook for more information.

Claim Inquiries

If you have any questions about how to file a claim, the status of a pending claim, or any action taken on a claim, please contact the Claims Administrator's Customer Service Department. They will respond to your inquiry within 30 days of receipt.

Time Frames for Processing Claims

If your claim is denied, the Claims Administrator will send an EOB to you with an explanation of the denial within 30 days after receiving your claim. If they need additional time to process your claim for reasons beyond their control, they will send you a notice of delay explaining those reasons within 30 days after receiving your claim. The Claims Administrator will then complete the claim processing and send an EOB to you within 45 days after receiving your claim.

If the Claims Administrator needs additional information to complete the processing of your claim, they will send you a notice of delay and describe the information needed. The party responsible for providing the additional information will have at least 45 days to submit the additional information. Once the additional information is received, they will process the claim within 15 days. Submission of information necessary to process a claim is subject to the plan's claim submission period explained under General Submission and Payment Information.

Benefits Paid in Error

If the Claims Administrator makes a payment to you that you are not entitled to, or pays a person who is not eligible for payment, they may recover the payment. They may also deduct the amount paid in error from future benefits.

The fact that a claim was paid in error does not constitute a waiver of applicable eligibility requirements or any plan limitations or exclusions, and does not mean that benefits will continue to be provided for an otherwise excluded condition, service or supply.

Bill Audit Incentive Program – Share the Savings!

As a smart health care consumer, you should check for errors in your medical bills. Many mistakes are ones only you are aware of. Check these items:

- Duplicate Charges – Does your bill indicate too many charges for the same service?
- Room and Board – Are the charges for the actual number of nights you spent in the hospital?
- Medications – Were you charged for drugs or medications that you didn't receive?
- Diagnostic/Laboratory Charges – Were the tests you were billed for actually completed?

The Bill Audit Incentive Program awards you for finding errors in your (or your dependents') bills from a hospital, physician or other professional provider, or if you find that the Claims Administrator has paid a provider more than allowed under the plan. Finding these errors reduces the total expenses paid by the health plan.

Take the following steps if you believe a provider overcharged you or that the Claims Administrator paid more than allowed under the plan:

- Call the hospital or the provider as applicable, and report the overcharge. Request a revised bill.
- For a claims overpayment by the Claims Administrator, call the Claims Administrator to report the error and request that the claim be reprocessed.
- Send the original bill or explanation of benefits (EOB) from the Claims Administrator, along with either a revised bill or a revised EOB to the Risk Services Benefits Program.

The error must be acknowledged by both the Claims Administrator and the City of Eugene. The Benefits Program will then have 50% of the plan savings, up to a maximum of $500, issued to you on your paycheck.

COORDINATION OF BENEFITS

It is common for family members to be covered by more than one health care plan, for example when both parents work and chose to have family coverage through both their employers' health plans. When an individual is covered by more than one health plan, state law permits the health plans to follow a procedure called "Coordination of Benefits" to determine how much each plan should pay. The goal is to make sure that the combined payments of all plans do not exceed 100% of the individual's covered health care expenses. If a person is covered under more than one health benefit plan, the individual should submit all of his or her claims to each plan.

The Coordination of Benefits "order of benefits determination" rules govern the order in which each "COB Plan" (defined below) will pay a claim for benefits and determine whether the City of Eugene's health plan is the Primary Plan or a Secondary Plan when a person has health care coverage under more than one plan.

How Coordination of Benefit Rules Works

The City's health plans provides benefits for health care expenses to which the Coordination of Benefits (COB) rules apply. As a result, benefits otherwise payable under the City's plans may be reduced because of the benefits covered under other COB Plans. The medical benefits of the City's plans will be coordinated with other medical plans, while the dental and vision benefits will be coordinated with plans providing similar benefits.

If an employee, former employee or any dependents, are covered both by this City plan and by another COB Plan (including, for example, another City health plan), the benefits under this City plan and the other COB Plan will be coordinated. This means one plan (the "Primary Plan") pays its full benefits first, and then the other plan (the "Secondary Plan") pays benefits not to exceed 100% of the total allowable expense. If this City plan is the Primary Plan, it will determine payment for benefits first, without considering any other plan's benefits.

A COB plan may consider benefits paid or provided by another plan in calculating payment of benefits only when it is secondary to that other plan.

Any plan that does not include a COB provision consistent with the state of Oregon's COB rules will be the Primary Plan.

Definitions

The definitions below will apply for purposes of implementing the Coordination of Benefits rules for the City's health plans.

COB Plan means this City of Eugene health plan, and any of the following that provides benefits or services for medical or dental care or treatment:

- Group insurance contracts and group-type contracts;
- HMO (Health Maintenance Organization) coverage;
- Coverage under a labor-management trusteed plan, a union welfare plan, an employer organization plan or an employee benefits plan;
- Medical care components of group long-term care contracts, such as skilled nursing care;
- Medicare or other government programs (other than Medicaid), and any other coverage required or provided by law; or
- Other arrangements of insured or self-insured group or group-type coverage.

A **COB Plan** does not include any of the following:

- Hospital indemnity coverage or other fixed indemnity coverage;
- Accident-only coverage;
- Specified disease or specified accident coverage;
- School accident-type coverage;
- Benefits provided under group long-term care insurance policies for non-medical services;
- Medicare supplement policies;
- Medicaid policies; or
- Coverage under other federal governmental plans, unless permitted by law.

Claimant means the person for whom the claim is made (i.e., either the employee, former employee or a covered dependent, as applicable).

Claims Administrator means the organization selected by the City to maintain employee participation records and provide claims processing services under the plan.

An **Allowable Expense** means a health care expense, including the deductible, coinsurance, and any co-payment, which is covered at least in part by any COB Plan covering the Claimant. When a COB Plan provides benefits in the form of a service rather than cash payments (such as services provided by an on-site health clinic), 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 COB Plan covering the Claimant (for example, cosmetic surgery) is not an Allowable Expense. In addition, any expense that a health care provider is prohibited from charging a Claimant, whether by law or in accordance with a contractual agreement, is not an Allowable Expense.

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

- The difference between the cost of a semi-private hospital room and a private hospital room, unless one of the COB Plans provides coverage for private hospital room expenses.
- Any amount in excess of the highest reimbursement amount for a specific benefit, if the Claimant is covered by two or more COB 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 with a preferred provider, if the Claimant is covered by two or more COB Plans that provide benefits or services on the basis of negotiated fees.
- If the Claimant is covered by one COB Plan that calculates its benefits or services on the basis of such a non-negotiated fee reimbursement methodology, such as on the basis of usual and customary fees, and by another COB Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangement will be the Allowable Expense for all COB Plans. However, if the health care 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 health care provider's contract permits, the negotiated fee or payment will be the Allowable Expense used by the Secondary Plan to determine its benefits.
- The amount of any benefit reduction by the Primary Plan because a Claimant has failed to comply with the provisions of a COB Plan, for example, provisions requiring second surgical opinions, prior authorization of admissions or services, or use of a preferred provider.

A **Closed Panel Plan** is a plan, such as an HMO, that provides health care benefits to covered persons primarily in the form of services through a panel of health care 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 a preferred 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.

General Rule for Determining Which COB Plan is Primary

Under the order of benefit determination rules, if a COB Plan covers someone as an employee, or former employee and not as a dependent, then that COB Plan will be the Primary Plan, and will determine and pay benefits before the COB Plan that covers the person as a dependent (the Secondary Plan).

However, if the person is covered under Medicare, then, as a result of federal law, Medicare is generally (i) secondary to the health plan covering the person as a dependent, and (ii) primary to the health plan covering the person as other than a dependent. However, special rules apply if a person is covered under Medicare, as well as under two (or more) COB Plans. In that event, the order of benefits between the two COB Plans is reversed. As such, the COB Plan covering the person as an employee, or former employee is the Secondary Plan, and the other COB Plan covering the person as a dependent is the Primary Plan.

If the Primary Plan is a Closed Panel Plan and the Secondary Plan is not a Closed Panel Plan, the Secondary Plan will provide benefits as if it were the Primary Plan and the covered person used a non-preferred provider, except for emergency services or authorized referrals that are paid or provided by the Primary Plan.

Determination of Primary Plan for Eligible Child Covered under More Than One Plan

The rules for determining when a COB Plan is either primary or secondary when an eligible child is covered under more than one plan and the general rule does not apply are set forth below.

Eligible Child/Parents Married, Registered under the Oregon Family Fairness Act, or Living Together. If the Claimant is an eligible child whose parents are married, registered under the Oregon Family Fairness Act, or are living together whether or not they have ever been married or registered under the Oregon Family Fairness Act, the

COB 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 COB Plan that has covered the parent the longest is the Primary Plan. (This is called the "Birthday Rule.")

Eligible Child/Parents Separated or Divorced or Not Living Together. If the Claimant is an eligible child of divorced or separated parents, or of 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 COB Plan of that parent has actual knowledge of those terms, that plan is primary. If the parent with responsibility has no health care coverage for the eligible child's health care expenses, but that parent's spouse does, that parent's spouse's plan is the primary plan. This rule applies to plan years commencing after the COB 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 eligible child's health care expenses, the order of benefits is as follows:
    - The COB Plan covering the custodial parent;
    - The COB Plan covering the spouse or Partner of the custodial parent;
    - The COB Plan covering the non-custodial parent; and then
    - The COB Plan covering the spouse of the non-custodial parent.

Eligible Child Covered by Individual Other than Parent. For an eligible child of individuals who are not the parents of the child, the first applicable provision (#1 or #2) above shall determine the order of benefits as if those individuals were the parents of the child.

Active/Retired or Laid Off Employee. The COB Plan that covers a Claimant as an active employee (that is, an employee who is neither laid off nor retired) or as an active employee's dependent, is primary and determines and pays benefits before those of a COB Plan that covers a Claimant as a laid off or retired employee, or as that employee's dependent. If the other COB Plan does not have this rule, and if, as a result, the COB Plans do not agree on the order of the benefits, this rule is ignored.

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 COB Plan, the COB Plan covering that Claimant as an employee, or former employee, or covering the Claimant as a dependent of an employee, or former employee, is the Primary Plan, and the COBRA or other continuation coverage is the Secondary Plan. If the other COB 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.

Longer/Shorter Length of Coverage. The COB Plan that covered an employee or former employee (non-dependent) longer is the Primary Plan, and the COB Plan that covered the Claimant for the shorter period of time is the Secondary Plan.

None of the Above. If the preceding rules do not determine the order of benefits, the Allowable Expenses will be shared equally between the COB Plans. In that event, however, the City's plan will not pay more than it would have paid had it been the Primary Plan.

Coordination with a Non-Complying Plan

A "Non-Complying Plan" is a group health plan that does not comply with the standardized COB rules. All of the City's health plans are "Complying Plans." If the other plan is a Non-Complying Plan, the rules below will apply.

- If the City's plan is the Secondary Plan and the Non-Complying Plan does not provide its primary payment information to the Claims Administrator within a reasonable time after it is requested to do so, the Claims Administrator will assume that the benefits of the Non-Complying Plan are identical to the City plan's benefits, and shall pay benefits accordingly. The City's plan will provide its benefits first, but the amount of the benefits payable will be determined as if it were the Secondary Plan. If within two years of payment the Claims Administrator receives information as to the actual benefits of the Non-Complying plan, the benefits payments will be adjusted accordingly. In consideration of such an advance, the City's plan will be subrogated to all rights of the covered person, against the Non-Complying Plan.
- If the Non-Complying Plan reduces its benefits so that a covered person receives less in benefits than what would have been received had the City plan provided its benefits as the Secondary Plan and the Non-Complying Plan provided its benefits as the Primary Plan, then the City's plan will advance additional benefits to that person equal to the difference between the amount that was actually paid and the amount that would have been paid if

the Non-Complying Plan had not improperly reduced its benefits. Additional payment will be limited so that the City's plan will not pay any more than it would have paid if it had been the Primary Plan.

Effect on the Benefits of This Plan

When the City's plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all COB Plans during a plan year are not more than the total Allowable Expenses. When the City's plan is primary, 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 City's plan. The Secondary Plan may then reduce its payment by the amount so that, when combined with the amount paid by the City's 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 will credit to its plan deductible any amounts it would have credited to its deductible in the absence of other health care coverage.

Example of Coordination of Benefit Involving Co-Insurance

Note: Both of the following examples assume that both the Primary Plan and the Secondary Plan negotiate fees with preferred providers.

Primary Plan Benefit Calculation

$10,000	Billed Amount
$7,000	Primary Plan's Negotiated Amount with Preferred Provider
$7,000	Allowable Expense
($1,000)	Less: Primary Plan's Deductible
$6,000	Balance
$4,800	Benefit @ 80/20 Coinsurance ($6,000 x .80)
$4,800	Amount Paid by Primary Plan
$1,200	Balance of Unpaid Allowable Expense

Secondary Plan Benefit Calculation – Secondary plan calculates benefits as if no other insurance coverage exists and pays up to the Allowable Expense defined by the Primary Plan.

$10,000	Billed Amount
$8,000	Secondary Plan's Negotiated Amount with Preferred Provider
$8,000	Secondary Plan's Allowable Expenses upon which benefit calculation is based
($2,000)	Less: Secondary Plan's Deductible
$6,000	Balance
$4,800	Benefit @ 80/20 Coinsurance ($6,000 x .80)
$1,200	Amount Paid by Secondary Plan, which is balance of unpaid Allowable Expenses as defined by the Primary Plan
$0	Balance of Unpaid Allowable Expense

Example of Coordination of Benefit Involving a Co-Payment

Primary Plan Benefit Calculation

$1,200	Billed Amount
$900	Primary Plan's Negotiated Amount with Preferred Provider
$25	Office Visit Co-Pay
$900	Allowable Expense
N/A	Coinsurance
$875	Amount Paid by Primary Plan
$25	Balance of Unpaid Allowable Expense

Secondary Plan Benefit Calculation – Secondary plan calculates benefits as if no other insurance coverage exists and pays up to the Allowable Expense defined by the Primary Plan.

$1,200	Billed Amount
$1,000	Secondary Plan's Negotiated Amount with Preferred Provider
$35	Office Visit Co-Pay – Secondary Plan
$1,000	Secondary Plan's Allowable Expenses upon which benefit calculation is based
$965	Secondary Plan's Benefit if paid as the Primary Plan
$25	Amount Paid by Secondary Plan, which is balance of unpaid Allowable Expenses as defined by the Primary Plan
$0	Balance of Unpaid Allowable Expense

Right to Collect and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under the City's plan and other plans. The Claims Administrator may get the facts it needs from, or give them to, other organizations or persons for the purpose of applying these rules and determining benefits payable under the City's plan and other plans covering the Claimant. The Claims Administrator need not tell, or get the consent of, any person to do this. Each person claiming benefits under the City's plan must provide the Claims Administrator any facts it needs to apply those rules and determine benefits payable.

Facility of Payment

If another plan makes payments the City's plan should have made under the COB rules, the Claims Administrator will reimburse the other plan directly. Any such reimbursement payments will count as benefits paid under the City's plan, and the City's plan will not have to pay that amount again. 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.

Medicare Coordination of Benefits

In certain situations, the City's plan provides primary coverage when both Medicare and the plan cover you or a dependent. This means that the plan pays benefits first and Medicare pays benefits second. Those situations are:

- When you or your enrolled spouse is age 65 or over and by law Medicare is secondary to the plan;
- When you or your enrolled dependents incur covered services for kidney transplant or dialysis and by law Medicare is secondary to the plan for the first 30 months of coverage; and
- When you or your enrolled dependents are entitled to benefits under Section 226(b) of the Social Security Act (Medicare Disability) and by law Medicare is secondary to the plan.

To the extent permitted by law, this plan will not pay benefits for any part of covered expenses to the extent the covered expense is actually paid or would have been paid under Medicare Part A or B, had the covered person

properly enrolled in Medicare and applied for benefits. This means that for coordination of benefits purposes, this plan will estimate what Medicare would have paid and reduce benefits based on the estimate. This plan will not pay benefits toward any part of a covered expense to the extent the covered expense is covered by Medicare.

In addition, if this plan is secondary to Medicare, the plan will not pay for any part of expenses incurred from providers who have opted out of Medicare participation.

Third Party Liability

Third party liability means claims that are the responsibility of someone other than the City of Eugene. The liable party may be a person, firm, or corporation. Auto accidents and "slip-and-fall" property accidents are examples of common third party liability cases. If you use this plan's benefits for an illness or injury you think may involve another party, contact the City's Claims Administrators, PacificSource and Delta Dental, right away. When the Claims Administrators receive a claim that might involve a third party, they will send you a questionnaire to help them determine responsibility.

In all third party liability situations, this plan's coverage is secondary. By enrolling in this plan, you automatically agree to the following terms regarding third party liability situations:

- If the Claims Administrator pays any claim determined to be the responsibility of another party, you will hold the right of recovery against the other party in trust for the Claims Administrator.
- The Claims Administrator is entitled to reimbursement for any paid claims if there is a settlement or judgment from the other party. This is so regardless of whether the other party or insurer admits liability or fault.
- You may subtract a proportionate share of the reasonable attorney's fees you incurred from the money you pay back to the Claims Administrator.
- The Claims Administrator may ask you to take action to recover medical expenses they have paid from the responsible party. They may also assign a representative to do so on your behalf. If there is a recovery, the Claims Administrator will be reimbursed for any expenses or attorney's fees out of that recovery.
- If you receive a third party settlement, that money must be used to pay your related medical expenses incurred both before and after the settlement. If you have ongoing medical expenses after the settlement, the Claims Administrator may deny your related claims until the full settlement (less reasonable attorney's fees) has been used to pay those expenses.
- In a third party liability situation, The Claims Administrator will ask you to agree to the third party liability terms of the group health plan by signing an agreement. The Claims Administrator is not required to pay benefits until that agreement is signed and returned.

Motor Vehicle and Other Accidents

If you are involved in a motor vehicle accident or other accident, your related medical expenses are not covered by this plan if they are covered by any other type of insurance policy. The City's Claims Administrator may pay your claims from the accident if an insurance claim has been filed with the other insurance company and that insurance has not yet paid. But before they do, you must sign a written agreement to reimburse the Claims Administrator out of any money you recover. By enrolling in this plan, you agree to the terms in the previous section regarding third party liability.

On-the-Job Illness or Injury and Workers' Compensation

This plan does not cover any work-related illness or injury, including those arising from self-employment. This is true regardless of whether workers' compensation benefits are available to you. The City's Claims Administrators may pay your claims if a workers' compensation claim has been denied on the basis that the illness or injury is not work related, and the denial is under appeal. But before they do, you must sign a written agreement to reimburse the Claims Administrator out of any money you recover from the workers' compensation coverage.

Coordination of Benefit Questions

The contractual rules for third party liability, motor vehicle and other accidents, and on-the-job illness or injury are complicated and specific. Please contact the Claims Administrator if you have a question or concern about a third-party claim. The City of Eugene has the discretionary authority to waive its right to recovery from other sources described in this section if the waiver would serve the public interest.

COMPLAINTS, GRIEVANCES AND APPEALS

Questions, Concerns, or Complaints

At times you may have questions or concerns about your benefits, eligibility, the quality of care you receive, or how the City's Claims Administrators, PacificSource and Delta Dental, reached a decision or handled a claim. If you have a question, concern, or complaint about your coverage, please contact the Claims Administrator's Customer Service Department. In many cases the Customer Service staff can answer your question or resolve an issue to your satisfaction right away.

Claims Appeal

The City of Eugene Claims Administrators, PacificSource and Delta Dental, have established a formal process by which you may appeal the denial of a claim made under this plan. Before taking action under the formal appeals process, you should call or write the appropriate Claims Administrator's Customer Service Department. They will try to resolve the problem informally to prevent the need for a formal appeal process.

- **Initial Appeal of Claim**. If you disagree with decisions made regarding coverage or services provided under the plan (including, for example, a denial of a request for services, a denial of benefits or a disagreement regarding the amount of benefits), you may appeal the decision and ask for a resolution. The appeal must be made within 180 days of the date of the Claims Administrator's action on the claim. You may also call the Claims Administrator's Customer Service Department to discuss the issue. It may be possible to resolve the question at that time without having to file a formal appeal.

- **First Level Appeal.** If you wish to formally appeal a claim decision, you may request a First Level Appeal. Under this step, you should submit the appeal to the Claims Administrator in writing, along with any additional information having a bearing on the matter, within 60 days of the Initial Appeal response. The Claims Administrator will acknowledge in writing receipt of the appeal within 7 days after receipt and will begin a review of the matter. The appeal will receive a full review by persons who were not involved in the initial determination.

  A decision regarding the appeal will be made by the Claims Administrator. Written notice of the appeal decision will be provided to you within 30 days after the receipt of the appeal. The written notice of the disposition of the appeal will include the basis for the decision, along with information regarding your right to a Second Level Appeal.

- **Second Level Appeal.** If after the First Level Appeal you are still dissatisfied with a claim denial decision, a request may be made for a Second Level Appeal within 60 days of the First Level Appeal response. The Claims Administrator will acknowledge in writing receipt of the appeal within 7 days after receipt, and will begin a review of the matter. The Second Level Appeal will be reviewed by a committee comprised of persons who were not previously involved in the claim denial or the First Level Appeal.

  A written decision regarding the appeal will be made by the Claims Administrator within 30 days after its receipt of the appeal request.

- **Right to Appear.** You have the right to appear before the review committee in connection with either a First Level Appeal or a Second Level Appeal (or both). If you cannot appear, you may request that arrangements be made so that you may communicate with the review committee by conference call or other appropriate technology. The Claims Administrator will allow requests for practitioners or a representative to act on your behalf in connection with the appeal process.

- **External Review.** If a covered person is not satisfied with the outcome of the Second Level Appeal, and the claim involves a matter prescribed below, the covered person may request that the claim be reviewed by an independent review organization appointed by the Oregon Insurance Division. The dispute must relate to an adverse decision in regard to one or more of the following:
  - Whether a course or plan of treatment is medically necessary;
  - Whether a course or plan of treatment is experimental or investigational; or
  - Whether a course or plan of treatment that a covered person is undergoing is an active course of treatment for purposes of continuity of care rates under this plan.

The claims administrator agrees to be bound by the decision of the independent review organization, but only with respect to a matter described above. The availability of the external review process is further subject to the following conditions:

- The covered person must have exhausted the First and Second Levels of Appeal described in this section, unless the claims administrator waives the requirement;
- The covered person must apply in writing for external review not later than the 180th day after receipt of the final written decision following the Second Level Appeal (unless such Second Level Appeal has been waived by the claims administrator);
- The covered person must sign a waiver granting the independent review organization access to the individual's medical records; and
- The covered person must provide complete and accurate information to the independent review organization in a timely manner.

Appealing a Pre-authorization Denial

If you believe the City's Claims Administrators inappropriately denied a pre-authorization request, you have the right to appeal the decision. Either you or your healthcare provider can appeal the decision. An appropriate medical consultant, peer review committee, or both will review your appeal. The Claims Administrator will acknowledge your appeal within one week and make a decision on the appeal within 30 days (or sooner if there is an urgent medical situation).

Grievance Process

The City's Claims Administrators have established procedures for you to voice any dissatisfaction with the service provided under the plan, or any other problem not directly covered by the plan's claim appeals process described above. However, before submitting a grievance you may want to contact the Claims Administrator's Customer Service Department with your concerns. Issues can often be resolved at this level. If your issue is not resolved, the procedures below cover grievances, complaints and inquiries.

Grievance means a written complaint submitted by or on your behalf regarding either of the following:

- The availability, delivery or qualify health care services, including a complaint regarding an adverse determination made pursuant to a utilization review; or
- Claim payment, handling or reimbursement for health care services.

Complaint means an expression of dissatisfaction about a specific problem encountered by you or about a decision by an agent acting on behalf of the Claims Administrator. A complaint includes a request for action to resolve the problem or change the decision. An inquiry does not include a complaint.

Inquiry means a written request for information or clarification regarding:

- A specific problem encountered by you;
- A decision by the Claims Administrator or an agent acting on behalf of the Claims Administrator; or
- Any subject matter related to the plan.

If you have a complaint regarding the quality of medical care, the timeliness of care, the access to care or the appropriateness of care, you may register the complaint with the Claims Administrator and ask for a review of the clinical judgments involved. The complaint will be documented and a review of the matter will be conducted. If you are unable to complete a written complaint, you should contact the Claims Administrator's Customer Service Department and ask for assistance.

A written acknowledgment of the receipt of the complaint will be provided within seven days of its receipt. The decision regarding the complaint will generally be made within 30 days of its receipt. However, Claims Administrator may have an additional 15 days to resolve the issue if, before the end of the 30-day period, it gives notice of the delay, explaining the specific reason for the delay, to you (or to your representative).

Waiver of Deadlines

The timelines pertaining to the disposition of appeals and grievances addressed in this Section do not apply:

- When the time period is too long to accommodate the clinical urgency of the situation;
- You do not reasonably cooperate in the appeal or grievance process; or
- Circumstances beyond either the control of you or Claims Administrator prevents that party from meeting the deadlines, but only if the party which is unable to comply with the deadline gives a notice explaining the circumstances to the other party.

Where to Submit a Grievance, Appeal or Complaint

Before submitting a grievance or appeal, you may want to contact the Claims Administrator's Customer Service Department with your concerns as they may be able to resolve your issue immediately. Otherwise, you can file a written appeal, complaint or grievance to the appropriate Claims Administrator below:

PacificSource Health Plans (for medical, vision or pharmacy issues)

Call Customer Service at 541-225-1950 or 888-532-5332 to informally resolve the issue, or
Email: lc@pacificsource.com, with "Grievance" as the subject
Fax: 541-225-3628
Write: PacificSource, Attn: Grievance Review
PO Box 7068
Eugene OR 97401

Delta Dental (for dental issues)

Call Customer Service at 888-217-2365 to informally resolve the issue, or
Fax: 503-243-5105, Attn: Appeal Unit
Write: Delta Dental, Attn: Appeal Unit
601 S.W. Second Avenue
Portland, OR 97204

Additional Rights

You have the right to file a complaint or seek other assistance from the Oregon Insurance Division. Assistance is available:

Through the Internet at: www.cbs.state.or.us/external/ins/
By calling: 503-947-7984
By writing: Oregon Insurance Division
Consumer Protection Unit
350 Winter Street, NE, Room 440-2
Salem, Oregon 97310

This Plan Is Not Responsible for the Quality of Medical Care

In all cases, covered persons have the exclusive right to choose their hospital or provider of care. This plan is not responsible for the quality of medical, dental or vision care a person receives, since all those who provide care do so as independent contractors. This plan cannot be held liable for any claim or damages connected with injuries suffered by a covered person while receiving medical, dental or vision services or supplies.

SOURCES FOR INFORMATION AND ASSISTANCE

Assistance in Other Languages

City of Eugene members who do not speak English as their primary language may contact the Claims Administrator's Customer Service Department for assistance. A PacificSource or Delta Dental representatives will coordinate the services of an interpreter over the phone.

Para asistencia en Español, por favor ll á me al número:

PacificSource: 541-686-1242 ext. 1009 o gratuito 800-624-6052 ext 1009
Delta Dental: gratuito 888-786-7461

Information and Assistance from the Oregon Insurance Division

If you believe the City's Claims Administrator has not responded to your grievance appropriately, you have the right to file a complaint or seek other assistance from the Oregon Insurance Division.

In addition, the following consumer information is available from the Oregon Insurance Division:

- The results of all publicly available accreditation surveys.
- A summary of health promotion and disease prevention activities.
- An annual summary of grievances and 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.

To obtain any of this information or to file a complaint with the Oregon Insurance Division, write to:

Oregon Insurance Division
Consumer Protection Unit
350 Winter Street NE, Room 440-2
Salem, Oregon 97310

You can also call 503-947-7984, visit their web site at www.cbs.state.or.us/external/ins or send an e-mail to: dcbs.insmail@state.or.us.

Information Available from PacificSource and Delta Dental

PacificSource and Delta Dental make the following written information available to you free of charge. You may contact their Customer Service Department by phone, mail, or e-mail to request any of the following:

- A directory of participating healthcare providers under your plan
- Information about your drug formulary, if your plan benefits include coverage for prescription drugs
- A copy of the Claims Administrator's annual report on complaints and appeals.
- A description of the Claims Administrator's efforts to monitor and improve the quality of health services.
- Information about procedures for credentialing network physicians and providers and how to obtain the names, qualifications, and titles of the physicians or providers responsible for an enrollee's care.
- Information about the Claims Administrator's prior authorization and utilization review procedures.

Feedback and Suggestions

Your feedback is very important to us. If you have suggestions for improvements about your plan or provided services, we would like to hear from you! Please feel free to contact the City of Eugene, PacificSource or Delta Dental directly with your comments. Contact information is in the front of this handbook.

IMPORTANT NOTICES

Notice of Grandfathered Health Plan Status

For Non-Represented employees, the City of Eugene believes this plan is considered a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Risk Services Benefits Program at 541-682-8868. You may also contact the U.S. Department of Health and Human Services atwww.healthcare.gov.

Notice of Primary Care Provider Designation Rights

Whether you are required to designate a primary care provider depends on the health plan you are covered under. The City Health Plan does not require designation of a primary care provider. The City Managed Care Plan and the City Hybrid Plan generally require designation of a primary care provider. You have the right to designate any primary care provider who participates in the network and who is available to accept you or your family members. For children, you may designate a pediatrician as the primary care provider. You do not need prior authorization from this plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For information on how to select a primary care provider, and for a list of the participating primary care providers and/or a list of participating health care professionals who specialize in obstetrics or gynecology, contact PacificSource Health Plans at 888-532-5332 or PO Box 70088, Eugene, OR 97401-0105.

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. This plan is in compliance with NMHPA.

Federal Women's Health and Cancer Rights Act of 1998

This plan, 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). Contact PacificSource for more information.

Women's Health Act Frequently Asked Questions

1. **I have 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.

State Children's Health Insurance Program

Medicaid and the Children's Health Insurance Program (CHIP) Offer Free Or Low-Cost Health Coverage To Children And Families - If you are eligible for health coverage from your employer, but are unable to afford the premiums, some States have premium assistance programs that can help pay for coverage. These States use funds from their Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Medicaid or CHIP and you live in a State listed below, you can 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, you can 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, you can ask the State if it has a program that might help you pay the premiums for an employer-sponsored plan. Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and **you must request coverage within 60 days of being determined eligible for premium assistance**.

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 July 30, 2015. You should contact your State for further information on eligibility –

ALABAMA
Medicaid: 855-692-5447
ALASKA
(Outside Anchorage):
Medicaid: 888-318-8890
(Anchorage):
Medicaid: 907-269-6529
COLORADO
(In State)
Medicaid: 800-866-3513
(Out of State)
Medicaid: 800-221-3943
FLORIDA
Medicaid: 877-357-3268
GEORGIA
Medicaid: 404-656-4507
INDIANA
Medicaid: 800-889-9949
IOWA
Medicaid: 888-346-9562
KANSAS
Medicaid: 800-792-4884
KENTUCKY
Medicaid: 800-635-2570
LOUISIANA
Medicaid: 888-695-2447
MAINE
Medicaid: 800-977-6741
MASSACHUSETTS
Medicaid/CHIP: 800-462-1120
MINNESOTA
Medicaid: 800-657-3629
MISSOURI
Medicaid: 573-751-2005
MONTANA
Medicaid: 800-694-3084
NEBRASKA
Medicaid: 855-632-7633
NEVADA
Medicaid: 800-992-0900
NEW HAMPSHIRE
Medicaid: 603-271-5218
NEW JERSEY
Medicaid: 609-631-2392
CHIP: 800-701-0710
NEW YORK
Medicaid: 800-541-2831
NORTH CAROLINA
Medicaid: 919-855-4100
NORTH DAKOTA
Medicaid: 800-755-2604
OKLAHOMA
Medicaid: 888-365-3742
OREGON
Medicaid: 800-699-9075
PENNSYLVANIA
Medicaid: 800-692-7462
RHODE ISLAND
Medicaid:401-462-5300
SOUTH CAROLINA
Medicaid: 888-549-0820
SOUTH DAKOTA
Medicaid: 888-828-0059
TEXAS
Medicaid: 800-440-0493
UTAH
Medicaid: 866-435-7414
VERMONT
Medicaid: 800-250-8427
VIRGINIA
Medicaid: 800-432-5924
CHIP: 855-242-8282
WASHINGTON
Medicaid: 800-562-3022 Ext. 15473
WEST VIRGINIA
Medicaid: 877-598-5820
WISCONSIN
Medicaid: 800-362-3002
WYOMING
Medicaid: 307-777-7531

To see if any more States have added a premium assistance program since July 30, 2015, or for more information on special enrollment rights, you can contact either:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa 866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov 877-267-2323, Ext. 61565

Patient Protection Act

The Patient Protection Act, also known as Senate Bill 21, was passed by the 1997 Oregon State Legislature to assure that patients, physicians and providers are informed about the benefits and policies of their health insurance plans. This question and answer section is provided to outline many of the terms and conditions of the plan, as administered by our Claims Administers, PacificSource and Delta Dental.

1. What are a member's rights and responsibilities?

Members have the right to:

- Be treated with respect and dignity at all times.
- Have access to urgent and emergency services, 24 hours a day, 7 days a week.
- Know what their rights and responsibilities are. Members will be given information about their health plan and how to use it. Members will be given information about the physicians and providers who will care for them. This information will be provided in a way that members can understand.
- Be informed about their health.
- Refuse care. Members have the right to be advised of the medical result of their refusal.
- Receive services as described in the Summary Plan Document.
- Have their medical and personal information remain private. Information will not be given out unless allowed by the member or required by law.
- Make a complaint or appeal about any aspect of their care or service. Members have a right to a quick response to their complaint or appeal. Members are welcome to make suggestions to the plan.
- Have a statement of wishes for treatment on file. A statement of wishes for treatment is known as an Advanced Directive.
- Have a power of attorney filed. A power of attorney 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 Summary Plan Document to make sure they understand the plan. Members are advised to call the Claims Administrators with any questions.
- Treat all physicians and providers and their staff with courtesy and respect.
- Give all the facts needed for their physician or provider and the plan to provide good health care.
- Help make decisions about their medical care and form a treatment plan.
- Follow instructions for care they have agreed to with their physician or provider.
- Take their medical identification card with them when medical care is needed. Let physicians and providers know they are covered by the Claims Administrator.
- Tell physicians and providers if there is any other insurance.
- Reimburse the Claims Administrator from any third party payments. An example of this may be an auto accident claim.
- Keep appointments and be on time. If this is not possible, members must call ahead of time to let the physician or provider know they will be late or cannot keep their appointment.
- Seek preventive services. This should be done on a regular basis.

If you have any questions about these rights and responsibilities, please call the appropriate Claims Administrator. Contact information is in the front of this handbook.

2. What do I do if I have a medical emergency?

If you believe that 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 voice a grievance or file an appeal?

You can voice a grievance or file an appeal by contacting the Claims Administrator or the Oregon Insurance Division. See the section titled Complaints, Grievance and Appeals for complete information.

5. What are your prior authorization and utilization review criteria?

Prior authorization, also known as pre-authorization, is the process we use to determine the medical necessity of a service before it is rendered. Contact the Claims Administrator's Customer Service Department for a list of services that should be pre-authorized. Many types of treatment may be available for certain conditions; the pre-authorization process helps your physician work together with you, other providers, and the Claims Administrators to determine the treatment that best meets your medical needs and to avoid duplication of services.

An approved pre-authorization is your assurance that your medical services won't be denied because they don't meet the contract definition of "medical necessity."

Utilization review is a process in which the Claims Administrator examines services a member receives to ensure that they are medically necessary/appropriate with regard to widely accepted standards of good medical practice. For further explanation, look at the definition of "medically necessary" in your benefits handbook.

Except in the case of fraud or misrepresentation, prior authorization for benefit coverage and medical necessity shall be binding if obtained no more than 90 days prior to the date the service is provided, and prior authorization for enrollee eligibility shall be binding if obtained no more than 5 business days prior to the date the services is provided.

If you would like a written summary of information that the Claims Administrator may consider in their utilization review of a particular condition or disease simply contact the Claims Administrator.

6. How are important documents, such as my medical records, kept confidential?

The Claims Administrator has a written policy to protect the confidentiality of health information. Only employees who need to know in order to do their jobs may access enrollee personal information. Disclosure outside the company is permitted only when necessary to perform functions related to providing your coverage and/or when otherwise allowed by law. Note that with certain limited exceptions, Oregon law requires insurers to obtain a written authorization from the enrollee or his or her representative before disclosing personal information. One exception to the need for a written authorization is disclosure to a designee acting on behalf of the insurer for the purpose of utilization management, quality assurance, or peer review.

7. How can I participate in the development of the Claims Administrator's corporate policies and practices?

Your feedback is very important. If you have suggestions for improvements about your plan or services, we would like to hear from you. Please feel free to contact PacificSource, Delta Dental or the Risk Services Benefits Program. Contact information is in the front of this handbook.

8. My co-worker has a question about the plan he has through the City of Eugene, but doesn't speak English very well. Can you help?

Yes. Simply have your co-worker call the Claims Administrator. A PacificSource or Delta Dental representative will coordinate the services of an interpreter over the phone.

9. I'd like to get additional information from PacificSource and Delta Dental

Information from our Claims Administrators is available by calling their customer service representative. Please see the section Sources for Information and Assistance in this handbook for more details.

10. What information can I get about the Claims Administrator from the Oregon Insurance Division?

Information about our Claims Administrators is available by contacting the Oregon Insurance Division. Please see the section Sources For Information and Assistance in this handbook for more details.

HIPAA Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The City of Eugene sponsors the following self-insured plans and programs that provide group health benefits:

- City Health Plan;
- City Managed Care (Point of Service) Plan;
- City Hybrid Plan;
- Dental and Vision Insurance Plans;
- Health Care Component of the Flexible Spending Account Program;
- Employee Assistance Program; and
- The Health Risk Assessment ("HRA") Component of the Health & Wellness Program.

The Health Insurance Portability and Accountability Act of 1996, as amended ("HIPAA") requires group health plans to implement practices designed to protect the confidentiality of health information of covered individuals. It is the policy of the City to comply fully with the health information privacy standards of HIPAA.

This Notice describes the health information privacy practices of the above plans and programs (the "Plans"). The Plans will create, receive and maintain records that contain health information about you as necessary to administer the Plans and provide you with health care benefits. This Notice describes the Plans' health information privacy policy and practices. The Notice informs you of the ways the Plan may use and disclose health information about you, and describes your rights and the obligations of the Plans regarding the use and disclosure of your health information. However, the Notice does not address the health information policies or practices of your health care providers.

PRIVACY OFFICIAL

If you have any questions regarding the matters covered by this Notice, please contact the Plans' designated Privacy Official:

Myrnie Daut, Privacy Official
Risk Services Division
940 Willamette St, Suite 200
Eugene, Oregon 97401
541-682-5790

Our Pledge Regarding Protected Health Information

We are committed to protecting the health information that you share with us. The privacy practices of the Plans are designed to safeguard confidential health information (including genetic information) that identifies you, and which relates to a physical or mental health condition or the payment of your health care expenses. We use procedural, technical and physical safeguards to ensure your Protected Health Information is treated in accordance with our privacy policy. We also restrict access to this information within our organization to those employees who need the information in order to administer the Plans. This identifiable health information will not be used or disclosed without a written authorization from you, except as described in this Notice or as otherwise permitted by applicable health information privacy laws.

This Notice will tell you about the ways in which the Plans may use and disclose Protected Health Information about you. It also describes our obligations and your rights regarding the use and disclosure of this information.

Privacy Obligations of the Plan

The Plans are required by law to:

- Make sure that health information that identifies you is kept private;
- Give you this Notice of the Plans' legal duties and privacy practices with respect to health information about you; and
- Follow the terms of the Notice that is currently in effect.

How the Plans May Use and Disclose Health Information

The different ways that the Plans may use and disclose your health information are described below.

To Make or Obtain Payment. The Plans may use or disclose your health information to make payment to or to obtain payment from third parties, such as other health plans or providers, for the care you receive. For example, we may provide health information to another health plan to coordinate the payment of benefits.

To Conduct Health Plan Operations. The Plans may use and disclose Protected Health Information about you to facilitate the administration and operation of the Plans, and to provide coverage and services to all individuals covered under the Plans. For example, the Plans may use Protected Health Information in connection with eligibility and enrollment activities, medical review, case management, actuarial, underwriting and legal services, audit services, fraud and abuse detection programs, planning and development programs such as cost management, or to engage in general administrative activities, such as customer service or the responding to questions or concerns.

For Treatment and Treatment Alternatives. The Plans may disclose your health information to a health care provider who renders treatment on your behalf. The Plans may use and disclose your health information to inform you of possible treatment options or alternatives that may be of interest to you.

For Health-Related Benefits and Services. The Plans may use or disclose your health information to provide you with information regarding health-related benefits and services that may be of interest to you.

Disclosure to Plan Sponsor. Health Information may be disclosed to designated City personnel solely for purposes of carrying out Plan-related administrative functions. These individuals will protect the privacy of your health information and ensure that it is used only as described in this Notice or as permitted by law.

To an Individual Involved in Your Care or Payment of Your Care. The Plans may disclose health information to a close friend or family member involved in, or who helps pay for, your health care.

To a Business Associate. The Plans may disclose health information to other persons or organizations, known as business associates, who provide services on the Plan's behalf. For example, a Plan may hire an administrative firm to process claims made under the Plan. To protect your health information, the Plan requires its business associates to appropriately safeguard the health information disclosed to them.

As Required by Law. The Plans will disclose Protected Health Information about you when required to do so by federal, state, or local law.

Special Use and Disclosure Situations

The Plans may also use or disclosure your health information in the situations described below.

Military and Veterans. If you are a member of the armed forces, we may release Protected Health Information about you as required by military command authorities. We may also release Protected Health Information about foreign military personnel to the appropriate foreign military authority.

Workers' Compensation. The Plans may release Protected Health Information about you as necessary to comply with applicable workers' compensation or similar laws.

To Avert Serious Threat to Health or Safety. The Plans may use and disclose Protected Health Information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Public Health Activities. The Plans may disclose Protected Health Information about you for public health activities, such as providing information to an authorized public health authority for the purpose of preventing or controlling a disease, injury or disability.

Health Oversight Activities. The Plans may disclose your health information to a health oversight agency for audits, investigations, inspections and licensure necessary for the government to monitor the health care system and government programs, or to ascertain compliance with applicable civil rights laws.

Judicial and Administrative Proceedings. The Plans may disclose your health information in response to a court or administrative order, a subpoena, warrant, discovery request or other lawful process.

Law Enforcement. The Plans may release Protected Health Information if asked to do so by a law enforcement official.

Coroners and Medical Examiners. The Plans may release Protected Health Information about you to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of a person's death.

Organ and Tissue Donation. If you are an organ donor, the Plans may release Protected Health Information to organizations that handle organ procurement or organ, eye, or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

Specialized Government Functions. In certain circumstances, federal regulations require the Plans to use or disclose your health information to facilitate government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

Other Uses and Disclosures of Health Information

Other uses and disclosures of health information not covered by this Notice or by the laws that apply to the Plans will be made only with your written authorization. Although not applicable under the Plans, the law expressly restricts the use and disclosure of (i) psychotherapy notes, (ii) the use or disclosure of health information for marketing purposes, or (iii) disclosures that constitute a sale of health information, unless authorized by you. If you authorize a Plan to use or disclose your health information, you may revoke the authorization, in writing, at any time. If you revoke your authorization, the Plan will no longer disclose or use your health information for the reasons covered by your written authorization. However, the Plan will not retract any uses or disclosures previously made as a result of your prior authorization.

Your Rights Regarding Protected Health Information About You

Your rights regarding your health information are described below.

Protection of Genetic Information. Genetic information about you or your family members may not be used or disclosed by the Plans for activities relating to the creation, renewal, or replacement of a contract of health insurance or health benefits, or for any other underwriting purpose.

Notification of Breach of Unsecured Health Information. You will be promptly notified if the Plans or a business associate discovers a breach of unsecured health information that affects you.

Right to Inspect and Copy. You have the right to inspect and copy your health information maintained by the Plans. To inspect and copy health information maintained by the Plans, you must submit your request in writing to the Privacy Officer. A Plan may charge a fee for the costs of copying and mailing your request. In limited circumstances, a Plan may deny your request to inspect and copy your health information. Generally, if you are denied access to health information, you may request a review of the denial.

Right to Amend. If you feel that your health information maintained by a Plan is incorrect or incomplete, you may ask the Plan to amend it. You have the right to request an amendment for as long as the information is maintained by the Plan.

To request an amendment, you must send a detailed request in writing to the Privacy Official. You must provide the reasons supporting your request.

The Plan may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

1. Is not part of the Protected Health Information kept by or for the Plan;
2. Was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
3. Is not information that you are permitted by law to inspect and/or copy; or
4. Is accurate and complete.

Right to an Accounting of Disclosures. You have the right to request an accounting of disclosures of your Protected Health Information other than disclosures made:

1. For health care treatment, payment or operation purposes;
2. To you, or to a person involved in your care;
3. To a law enforcement custodial official, or for national security purposes; or
4. In a manner that removed information that identified you.

To request this accounting of disclosures, you must submit your request in writing to the Privacy Official.

Your request must specify the time period for which you are requesting the information (for example, disclosures made during the six months preceding the date of the request). The Plans are not required to provide an accounting for disclosures made more than six years prior to the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on Protected Health Information the Plans use or disclose about you for treatment, payment or health care operations, or that the Plans disclose to someone who may be involved in your care or payment for your care, for example, a family member or friend. While a Plan will consider your request, it is not required to agree to it. A Plan will not agree to a restriction on the use or disclosure of Protected Health Information that is legally required, or that is necessary to administer the Plan. A Plan may also disclose health information about you if you need emergency treatment, even if the Plan has agreed to a restriction. To request a restriction, you must make your request in writing. A Plan may terminate the restriction upon your written request or with your agreement. A Plan may also terminate the restriction without your consent, but only as it affects Protected Health Information created or received after we advise you of the termination.

Right to Receive Confidential Communications. You have the right to request that a Plan communicate with you about Protected Health Information in a certain way or at a certain location if you believe that the disclosure of your health information can endanger you. For example, you can ask that a Plan only contact you at a certain telephone number or by email.

To request confidential communications, you must make your request in writing to the Privacy Official. Your request must specify how or where you wish to be contacted. The request must also include a statement that the disclosure of all or part of the information to which the request pertains could endanger you. The Plan will attempt to honor all reasonable requests for confidential communications.

Right to a Paper Copy of This Notice. You have the right to a paper copy of this Notice at any time. To obtain a paper copy of this Notice, contact the Privacy Official. You may also obtain a copy of this Notice on the City of Eugene website, www.eugene-or.gov. Follow the link to Employee Benefits and click on Health Insurance.

Changes to This Notice

The Plans reserve the right to change the terms of this Notice and to make the new Notice provisions effective for all health information that the Plans maintain. If the Notice is revised, a copy of the revised Notice will be distributed to you. The provisions of the new Notice will apply to all health information thereafter maintained by the Plans. Until such time as a Notice is revised, the Plans are required by law to comply with the current version of the Notice.

Complaints

Concerns or complaints about the Plan's safeguarding of your health information should be directed to the Privacy Official. The Plan will not retaliate against you in any way for filing a complaint. All complaints must be submitted in writing. If you believe your privacy rights have been violated, you may also file a complaint with the Office of Civil Rights, U.S. Department of Health and Human Services.

Effective Date of Notice: September 23, 2013

DEFINITIONS

ACA refers to the Affordable Care Act.

Allowable Fee (also known as Maximum Plan Allowance) is the maximum amount that the Plan will reimburse physicians and providers. For a participating physician/provider, the maximum amount is the amount the provider has agreed to accept for a particular service.

Ambulatory Care means medical care provided on an outpatient basis.

Ancillary Services are support services provided to a patient in the course of care. They include such services as laboratory and radiology.

Authorization or **Authorized** refers to obtaining approval by the Claims Administrator prior to the date of service for services that have been referred by the PCP or specialist physician.

Authorized Services means services or supplies that have been referred by your PCP and approved by the Claims Administrator.

Chemical Dependency (including alcoholism) means a substance-related disorder, as defined by the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR), except for those related to foods, tobacco or tobacco products.

Chemical Dependency Outpatient Treatment Program means a state-licensed program that provides an organized outpatient course of treatment, with services by appointment, for substance-related disorders.

Claims Administrator means the organization selected by the City of Eugene to provide claims processing and adjudication under the City's plans..

Condition means a medical condition.

Co-payment or Co-insurance means the fixed dollar amounts or percentages of covered expenses to be paid by the eligible person.

Cost Effectiveness services means services or supplies which are not otherwise benefits of the Plan, but which we believe to be medically necessary and cost effective.

Covered Dependent means an eligible dependent of a covered employee.

Covered Employee means an employee of the City of Eugene who is covered by this plan.

Covered Service is a service or supply that is specifically described as a benefit of this plan.

Creditable Coverage means prior healthcare coverage as defined in 45 CFR § 146.113 of the Public Health Service Act regulations, and includes coverage remaining in force at the time the enrollee obtains new coverage. The term creditable coverage means, with respect to an individual, coverage of the individual under any of the following:

- A group health plan;
- Individual Insurance coverage including student health plans;
- Medicare Part A and B;
- Medicaid, other than benefits consisting solely of benefits under Section 1928 (pediatric vaccines);
- CHAMPUS;
- A medical care program of the Indian Health Service or of a tribal organization;
- A State high risk pool;
- Federal Employees Health Benefit Plan (FEHBP);
- A public health plan (as defined in regulations); or
- A State Children's Health Insurance Program (S-CHIP); or
- A health benefits plan under section 5(e) of the Peace Corps Act (22 U.S.C. 2504(e)).

Some plans that provide medical care coverage do not qualify as creditable coverage. Such plans are called excepted benefits. The following plans are excepted benefits:

- Coverage only for accident, or disability income insurance, or any combination thereof.
- Coverage issued as a supplement to liability insurance.
- Liability insurance, including general liability insurance and automobile liability insurance.
- Worker's Compensation or similar insurance.
- Automobile medical payment insurance.
- Credit-only insurance.
- Coverage for on-site medical clinics.
- Other similar insurance coverage, specified in regulations, under which benefits for medical care are secondary or incidental to other insurance.

Custodial Care means care that helps a person conduct such common activities as bathing, eating, dressing or getting in and out of bed. It is care that can be provided by people without medical or paramedical skills. Custodial care also includes care that is primarily for the purpose of separating a patient from others, or for preventing a patient from harming himself or herself.

Deductible means that portion of all eligible expenses or charges paid by the covered person before plan benefits are payable. The expenses used to satisfy the deductible of one type of benefit (e.g., medical benefits) may not be used to satisfy the deductible of another type of benefit (for example, dental benefits).

Delta Dental refers to Delta Dental Plan of Oregon, a Moda Health affiliated company, and its related dental companies. Delta Dental is the claims administrator of the City's dental coverage. References to Delta Dental as paying claims or issuing benefits means that Delta Dental processes a claim in accordance with the provisions of the City's plan.

Dental Care means services or supplies provided to prevent, diagnose, or treat diseases of the teeth and supporting tissues or structures, including services or supplies rendered to restore the ability to chew and to repair defects which have developed because of tooth loss.

Dental Implant means a device specially designed to be placed surgically within or on the mandibular or maxillary bone as a means of providing for dental replacement; endosteal (endosseous); eposteal (subperiosteal); transosteal (transosseous).

Dependent means any individual who is or may become eligible for coverage under the terms of a group health plan because of a relationship to a participant.

Durable Medical Equipment means equipment able to withstand repeated use for the therapeutic treatment of an active illness or injury. Durable medical equipment includes an iron lung, wheelchair, or other similar equipment prescribed by a physician for the treatment of accidental injury, but does not include any changes made to a home, auto, or personal property, such as air conditioning or remodeling.

Emergency Medical Condition means a medical condition that manifests itself by acute symptoms of sufficient severity, including severe pain, 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.

Emergency Services means those healthcare items and services furnished in an emergency department and all ancillary services routinely available to an emergency department to the extent they are required for the stabilization of the patient.

Enrollee means an employee, dependent of the employee or an individual otherwise eligible for a group, individual or portability health benefit plan who has enrolled for coverage under the terms of this plan.

Enroll means to become covered for benefits under a group health plan (that is, when coverage becomes effective) without regard to when the individual may have completed or filed any forms that are required in order to become covered under the plan. For this purpose, an individual who has health coverage under a group health plan is enrolled in the plan regardless of whether the individual elects coverage, the individual is a dependent who becomes covered as a result of an election by a participant, or the individual becomes covered without an election.

Exclusion period means a period during which specified treatments or services are excluded from coverage.

Gender Identity means an individual's internal sense of being male, female, a gender different from the gender assigned to the individual at birth, a transgender person or neither male or female.

Gender Transition means the process of changing an individual's outward appearance, including physical sex characteristics, to accord with the individual's actual Gender Identity.

Genetic Information means information about genes, gene products, and inherited characteristics that may derive from the individual or a family member. This includes information regarding carrier status and information derived from laboratory tests that identify mutations in specific genes or chromosomes, physical medical examinations, family histories, and direct analysis of genes or chromosomes.

The **Group** is the organization whose members are covered by this Plan.

Health Benefit Plan means any hospital expense, medical expense or hospital and medical expense policy or certificate, healthcare service contractor or health maintenance organization subscriber contract, any plan provided by a multiple employer welfare arrangement, or other benefit arrangement defined in the federal Employee Retirement Income Security Act of 1974, as amended.

Illness means a disease or bodily disorder that results in a covered expense.

Implant means a material inserted or grafted into tissue.

Injury means a personal bodily injury to you or your covered dependent caused solely by external, violent and accidental means.

Medical Condition means any condition, whether physical or mental, including, but not limited to, any condition resulting from illness, injury (whether or not the injury is accidental), pregnancy, or congenital malformation. However, genetic information is not a condition.

Medically Necessary means those services and supplies that are required for diagnosis or treatment of illness or injury and which, in the judgment of the Claims Administrator, are:

- Appropriate and consistent with the symptoms or diagnosis of the enrollee's condition;
- Appropriate with regard to standards of good medical practice in the area in which they are provided;
- Not primarily for the convenience of the enrollee or a physician or provider of services or supplies; and
- The least costly of the alternative supplies or levels of service that can be safely provided to the enrollee. This means, for example, that care rendered in a hospital inpatient setting is not medically necessary if it could have been provided in a less expensive setting, such as a skilled nursing facility or by a nurse in the patient's home, without harm to the patient.

Services and supplies intended to diagnose or screen for a medical condition are not considered medically necessary in the absence of signs or symptoms of the condition, or abnormalities on prior testing. Medically necessary care does not include custodial care.

Please Note: The fact that a physician or provider prescribes, orders, recommends, or approves a service or supply does not, of itself, make the service medically necessary or a covered service. Refer to the "Excluded Services" section for further information regarding medical necessity. Also see the section "Transplant Services".

Mental Health refers to benefits, facilities, programs, levels of care and services related to the assessment and treatment of mental illness, as defined in this plan.

Mental Health Provider means a board-certified psychiatrist, state-licensed psychologist, state-licensed practicing mental health nurse practitioner, state-licensed clinical social worker or state- licensed psychologist associate.

Mental Illness means all disorders listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision, (DSM-IV-TR) except for:

- Mental Retardation;
- Learning Disorders;
- Paraphilias;
- Gender Identity Disorders in members age nineteen or older;

- V-Codes (this exception does not extend to children 5 years of age or younger for diagnostic codes V61.20, V61.21 and V62.82); and.
- Pervasive Development Disorders

Moda refers to Moda Health, which is a company affiliated with Delta Dental.

Network refers to the hospitals, physicians, dental providers and medical suppliers who contract to provide care to you and your covered dependents. By using a Network Participating Provider, your covered medical and dental expenses may be paid at a higher rate. Payment will be based upon the Contracted Fees between the participating Network and the Claims Administrator.

Nonparticipating refers to hospitals, physicians, providers, professionals and facilities that have not contracted with the Claims Administrator to provide benefits to persons covered under this plan. They will be reimbursed at the allowable fee or maximum plan allowance for the service provided.

Open Enrollment means that time each year in which eligible employees may change elections regarding medical/dental/vision plans and add eligible dependents who may not have been previously enrolled.

Outpatient Mental Health Treatment Episode means a sequence of outpatient visits to a single physician or professional provider, with no interval of sixty (60) or more days without a visit.

Outpatient Surgery means surgery that does not require an inpatient admission or overnight stay.

PacificSource refers to PacificSource Health Plans. PacificSource is the claims administrator of the City's medical, vision and pharmacy coverage. References to PacificSource as paying claims or issuing benefits means that PacificSource processes a claim in accordance with the provisions of the City's plans.

Participant means any employee or former employee who is or may become eligible to receive a benefit under a plan.

Participating refers to hospital, physician, providers, professionals, and facilities that have contracted with the appropriate Claims Administrator to provide benefits to persons covered under this plan.

Pervasive Developmental Disorder means a neurological condition that includes Asperger's syndrome, autism, developmental delay, developmental disability or mental retardation.

Physical Incapacity, for the purposes of this plan, means the inability to pursue an occupation or education because of a physical impairment.

Physician means a doctor of medicine or osteopathy.

Plan means the City of Eugene Employee Benefits Plan, and all documents, including any insurance contracts, administrative service agreements, Handbooks and any related terms and conditions associated with the Plan.

Plan Administrator means the Risk Services Division of the City of Eugene, which has responsibility for the management of the plan.

Plan Sponsor is City of Eugene who has contracted with the Claims Administrators to provide claims and other administrative services.

Plan Year is the 12 month period beginning on January 1 and ending on December 31.

Primary Care Provider (PCP) is defined in the Using the Medical Provider Network section of this handbook.

Professional Provider is defined in the Qualified Professional Providers section of this handbook.

The Plan's **Service Area** is the geographical area where the participating physicians and providers provide their services.

Pre-authorization refers to obtaining approval by the Claims Administrator prior to the date of service for services that have been referred by the PCP or specialist physician.

Residential Chemical Dependency Treatment Program means a residential treatment program providing an organized full-day or part-day program of treatment for chemical dependency disorders in a state-licensed program and facility.

Residential Mental Health Treatment Program means a residential treatment program providing an organized full-day or part-day program of treatment for mental illness in a state-licensed program and facility.

Residential Treatment Program means a state-licensed program or facility providing an organized full-day or part-day program of treatment. Types of residential treatment programs include an overnight 24-hour day program, a day treatment program, or a partial hospitalization program. A residential treatment program does not include any program that provides less than four hours per day of direct treatment services.

Telemedical Originating Site includes a hospital, rural health clinic, federally qualified health center, physician's office, community mental health center, skilled nursing facility, renal dialysis center or site where public health services are provided

Telemedicine means the use of medical information exchanged from one site to another via electronic communications for the health and education of the patient or healthcare provider and for the purpose of improving patient care. Telemedicine includes consultative, diagnostic, and treatment services.

Tobacco Use Cessation Program means a program offering an overall treatment program that follows the United States Public Health Service guidelines for tobacco use cessation. Tobacco use cessation program includes education and medical treatment components designed to assist a person in ceasing the use of tobacco products.

Urgent Care means the provision of immediate, short-term medical care for minor but urgent medical conditions that do not pose a significant threat to life or health at the time the services are rendered. See the section Urgent and Emergency Care for more information.

Waiting Period means the period that must pass before the individual is eligible for benefits under the terms of the plan.

Women's Healthcare Provider. Females enrolled under this Plan are permitted to designate a Women's Healthcare Provider as a primary care provider. A Women's Healthcare Provider means a participating obstetrician or gynecologist, physician assistant specializing in women's health, advanced registered nurse practitioner specializing in women's health or certified nurse midwife, practicing within the applicable lawful scope of practice. If a Women's Healthcare Provider is designated as a primary care provider, that provider must meet certain standards and must have requested the Claims Administrator to make that provider available for designation as a primary care provider.

A woman may see a participating Women's Healthcare Provider without referral from her primary care provider for preventive women's health exams and for pregnancy care. Follow-up visits and all necessary treatment related to this routine examination are eligible if the services are covered by the plan (this includes x-rays, laboratory tests or surgery). For care unrelated to this routine examination, the patient will need to see her primary care provider.

City of Eugene

Employee Assistance Program (EAP)

EMPLOYEE ASSISTANCE PROGRAM

The Employee Assistance Program (EAP) can help when you need it! Life is complex and at one time or another, everyone faces confusing situations, difficult interpersonal problems or life changes. Sometimes professional counseling is useful in helping deal with issues before they become overwhelming. This is why the City offers an Employee Assistance Program, through DIRECTION Employee Assistance.

All regular, Limited Duration and Recreation Activity Employees, their immediate families and members of the employee's household are covered by the City's Employee Assistance Program (EAP). DIRECTION for Employee Assistance, offers confidential, professional counseling services to help you successfully address personal problems. The EAP can help you with a broad range of issues, including:

- Anger Management
- Assertiveness
- Chemical dependency
- Communication skills
- Conflict resolution
- Critical Incident Debriefing
- Depression
- Diversity issues
- Eating disorders
- Family Issues
- Financial worries
- Grief and loss
- Leadership coaching skills
- Lesbian/Gay/Bisexual/Transgender issues
- Parenting concerns
- Relationship difficulties
- Sexual Problems
- Stress and anxiety
- Physical Problems Related to Emotions
- Team development
- Work related problems

There is no charge to you for visits to DIRECTION through the Employee Assistance Program. You are eligible for up to four (4) visits per problem per year. In addition, DIRECTION offers a broad range of training programs to assist employees and their family members in gaining valuable life skills. These training programs are offered at no cost and are available throughout the year. Please refer to the DIRECTION website for more information or view the current training calendar on the Employee Benefits website.

If you leave employment with the City of Eugene, you can continue to receive EAP services by self-paying the monthly premium under COBRA coverage. For information on rates, review the Memo for Terminating Employees or the Memo for Retiring Employees on the Employee Benefits website or contact the Employee Benefits Program.

An experienced counselor is just a phone call away. DIRECTION is staffed by licensed psychologists, clinical social workers, and masters level counselors. DIRECTION for Employee Assistance, a service of Cascade Health Solutions, can be reached locally in Eugene at:

DIRECTION for Employee Assistance
Cascade Health Solutions
2650 Suzanne Way, Suite 200Eugene, OR 97408

Phone: 541-345-2800 or 800- 535-1347

Visit the DIRECTION website at: http://www.cascadehealth.org.

City of Eugene

F S A

Flexible Spending Account

and

T R A

Transportation Reimbursement Account

Effective June 1, 2016

FLEXIBLE SPENDING ACCOUNT (FSA)

The City of Eugene offers employees a Flexible Spending Account Program. Take a few moments to read through the following information and learn how the program can go to work for you!

The City's FSA/TRA program is administered by BenefitHelp Solutions. Contact information for questions or manual claim submittal is below.

BenefitHelp Solutions
Attn: FSA
PO Box 67230
Portland OR 97268-1230

FSA Phone: 877-664-4761
TRA Phone: 888-398-8057
Fax: 888-249-5058
Email: fsa@benefithelpsolutions.com

The FSA Group Number: **BCA8656**
Your FSA Member ID Number: **Same as your Delta Dental Member ID Number** (printed on your Delta Dental wallet card)

Understanding Your Flexible Spending Account

A Flexible Spending Account (FSA) allows you to take advantage of a tax break authorized by Congress. Through the FSA Program, you can pay for certain medical, dental, vision, and dependent care expenses with before-tax dollars. Expenses must be tax-qualified-that is, allowable deductions under current IRS regulations.

By setting aside dollars under the FSA Program, you reduce the amount of your compensation that is subject to taxes. As a result, you save money through:

- Lower federal income taxes
- Lower state income taxes
- Lower FICA (social security) taxes

Types of Flexible Spending Accounts

Health Care and Dependent Care

Each year you will have the opportunity to enroll in two different kinds of Flexible Spending Accounts:

- **Health Care Account.** No matter what kind of health care insurance you have, you and your family may incur costs which are not covered by your medical, dental, or vision plans. By participating in the Health Care Account, you may use before-tax dollars to reimburse yourself for these out-of-pocket costs.
- **Dependent Care Account.** Providing care for a small child, elderly relative, or other dependent while you're at work can be a financial strain. Through the Dependent Care Account, you can use before-tax dollars to reimburse yourself for day care for children under age 13 or for adult day care for a disabled spouse or other dependent.

The FSA Worksheets provided with this information will help you decide how much to set aside in an FSA. However, we encourage you to consult with your tax advisor for assistance in determining how much to contribute to a Flexible Spending Account.

Premium Conversion Program

The City of Eugene has a Premium Conversion Program as part of our Flexible Spending Account Program. The Premium Conversion Program automatically covers all employees who are required to pay premiums for health insurance coverage under the City's group health plan by payroll deductions. The portion of the premium that you pay through payroll deductions will be deducted from your compensation on a before-tax basis; in other words, before federal and state income taxes and social security taxes are withheld. This means you will avoid paying taxes on these payroll deductions. As a result, your actual take-home pay may increase because your tax payments have been reduced.

Although the Premium Conversion Program will benefit most employees, you can opt out of this program by signing an election form indicating that you do not want your premiums to be taken on a before-tax basis. Election forms are available from the Risk Services Benefits Program.

Employees who have enrolled their domestic partners in a group health plan maintained by the City are not eligible to participate in the Premium Conversion Program. The employees remain eligible to participate in the Health Care Account and Dependent Care Account aspects of the FSA Program. However, in accordance with IRS rules, qualified expenses incurred by a domestic partner (and the dependents of the domestic partner) are not eligible for reimbursement under these Flexible Spending Accounts unless the domestic partner qualifies as a dependent of the employee for federal income tax purposes.

Eligible Employees

All regular benefitted employees are eligible to participate in the Flexible Spending Account program

Eligible Dependents

Expenses are reimbursable from the FSA Program only if they are qualified expenses that are incurred by:

- You
- Your legal spouse
- Your qualified dependents
- Your non-dependent adult children, through the end of the year in which they turn age 26

In general, a qualified dependent for any year means any of the following individuals if more than one-half of the individual's financial support for the year is provided by you (or, if you are married, by you and your spouse):

- A son or daughter, or a descendant of either
- A stepson or stepdaughter
- A brother, sister, stepbrother, or stepsister
- A father or mother, or an ancestor of either
- A stepfather or stepmother
- A son or daughter of a brother or sister
- A brother or sister of the father or mother
- A son-in-law, daughter-in-law, father-in-law, mother-in-law, brother-in-law, or sister-in-law
- Any other individual who resides with you and is a member of your household

Expenses for a non-dependent adult child can only be incurred through *the last day of the year* in which they turn age 26. Expenses are not eligible for reimbursement if incurred during any part of the year in which they turn age 27. This means expenses cannot be incurred during the Grace Period following the year a non-dependent adult child turns age 26.

For purposes of the Health Care Account, a child of a divorced employee will be treated as a dependent of an employee for a year if more than one-half of the child's support for the year is provided on a combined basis by both divorced parents. This dependent status rule will apply even if the employee is not the custodial parent with respect to the child or is otherwise not eligible to claim a personal exemption deduction with respect to such child for income tax purposes.

For purposes of the Dependent Care Account, a child of a divorced employee will be treated as a dependent of an employee for a year only if the employee has custody of the child for a longer period during the year than the other parent, regardless of whether the employee is otherwise eligible to claim a dependency exemption deduction with respect to such child for income tax purposes.

The IRS does not recognize an employee's domestic partner as being a qualified dependent for tax purposes (unless the employee provides more than one half of the domestic partner's financial support). Accordingly, expenses incurred by a non-tax-dependent domestic partner (or the dependents of a domestic partner) generally are not reimbursable under the FSA Program.

Enrollment

Participation in the FSA Program is optional. Each year you may choose to take advantage of one, both, or neither of the Flexible Spending Accounts depending on your individual needs. To participate, you must complete an enrollment form within 30 days of your employment commencement date or during the open enrollment period held each December. To continue participation, you must re-enroll prior to January 1 each year. If you have a change in status during the year, you may enroll or change enrollment amounts if the enrollment form is completed within 31 days of the change in status event.

The FSA enrollment form is available 24 hours a day from home or work at www.eugene-or.gov/FSAenroll, and can be securely submitted online. You may need your City of Eugene email address and password to complete the form online. Forms are also available from Benefits Staff.

On the enrollment form, indicate which FSA(s) you want to participate in and how much of your **before-tax** salary you want to contribute. Deposits will be made automatically from your paycheck each pay period before taxes are deducted from your gross salary. Once money is set aside into your FSA, it is not subject to federal or state income tax or payroll tax. Since your taxable income is lower, you pay less tax. The difference is extra income for you.

Election Amounts

Health Care Account. You are permitted to deposit $2,500 per calendar year to your Health Care Account.

Dependent Care Account. You are permitted to deposit up to $5,000 per calendar year to your Dependent Care Account.

However, you are cautioned to be careful in regard to the amount which you elect to have set aside in your Flexible Spending Accounts. The primary reason for this caution is the "use it or lose it rule" imposed by the IRS.

Use it or Lose It Rule

By law, any remaining unused funds in your Flexible Spending Accounts are forfeited at the end of the year - you must "use it or lose it." That is why it is important to be conservative when determining how much to put into your FSA each year. You can carry balances from your Accounts forward from month to month, but you cannot carry over to the next year any money remaining in your Accounts as of the end of the year, except as provided under the Reimbursement Grace Period Rule, which is explained below.

Reimbursement Grace Period

Under the IRS grace period rule, if as of the end of a plan year you have a balance remaining in a Health Care or Dependent Care Flexible Spending Account, you can still be reimbursed for any qualified expenses incurred during the grace period (up to the amount of the remaining balance). The FSA reimbursement grace period is the two and one-half month period following the end of the plan year (i.e., through March 15th of the following year). If you have unused funds left in your account as of the end of the plan year, you will have this additional 2½ months to incur healthcare and dependent care expenses that can be submitted for reimbursement under your prior year's account. This gives you more time to exhaust any funds you may have left at the end of the year. You have 90 days after the end of the Grace Period (until June 15th) to submit claims for reimbursement from previous year's account.

Here's an example. For the 2016 plan year, expenses incurred through March 15, 2017 can be reimbursed to you from your 2016 Flexible Spending Account. You would have until June 15, 2017 to submit claims for reimbursement from your 2016 account. Expenses incurred during the grace period that exceed the remaining balance from the prior year can be reimbursed from your Flexible Spending Account for the actual year incurred (i.e., from your 2017 Flexible Spending Account in the example above). Any balance in a Flexible Spending Account for a plan year that still remains unspent as of the end of the grace period cannot be carried forward, and thus will be forfeited pursuant to the use-it-or-lose-it rule discussed above.

The Grace Period does not apply to Transportation Reimbursement Accounts.

Additional Special Guidelines

In order to provide you tax savings, the IRS has imposed several important restrictions on Flexible Spending Accounts:

- Each Account must remain separate. In other words, money in your Health Care Account cannot be used to pay dependent day care expenses, nor can money in your Dependent Care Account be used to pay for health care expenses.
- You must elect the total amount to deposit for a year before the start of each year. The amount you elect remains in effect for the rest of the year unless you have a qualified change in status.
- Health care expenses reimbursed through the Health Care Account cannot also be claimed as a deduction on your personal income tax return. In addition, the amount of expenses which may be claimed for the dependent care tax credit will be reduced, dollar for dollar, by the amount of expenses reimbursed through the Dependent Care Account.

Changing FSA Elections

You may change the amount you deposit into your Flexible Spending Accounts when you re-enroll prior to January 1 each year. Normally, once you begin depositing before-tax salary into your Flexible Spending Accounts, that contribution election must remain in effect for the rest of the calendar year (January 1 through December 31). In other words, you generally will not be able to modify or revoke your election during a year. The same rule applies to your election not to participate in the FSA Program for a year. In that case, you generally cannot enroll until the following year.

An exception to this general rule applies if you incur what the IRS rules refer to as a **"change in status"**. Under this exception, you may modify or revoke an election for a year, or elect to enroll in the FSA Program for the remainder of the year, if you, or your spouse or dependent, incurs such a change in status. However, the modification, revocation or enrollment election must be consistent with and on account of the change in status.

To change your election, complete a new FSA enrollment form available on the Risk Services Benefits website at http://www.eugene-or.gov/FSAenroll, or from Benefits staff. To complete the online enrollment form you will need your City of Eugene network user ID and password. The form must be submitted to the Benefits Program within 31 days of the applicable event.

Change in Status Qualifying Events

For purposes of the Premium Conversion Program and the Health Care Account, the "change in status" events that may allow you to change your FSA election for a year are as follows:

- An event that changes your legal marital status, including marriage, death of your spouse, divorce, legal separation, or annulment
- An event that changes the number of your dependents, including the birth, adoption, placement for adoption, or death of a dependent
- Commencement of employment
- Termination of employment of a dependent. Termination of employment of a City of Eugene employee is not a qualifying event due to continued FSA participation through the final paycheck rule. See "Termination of Employment" for more information.
- The change in employment status, such as a transfer between part-time and full-time employment status
- The commencement of or return from an unpaid leave of absence or leave governed by the Family and Medical Leave Act (FMLA)
- An event that causes a dependent to satisfy or cease to satisfy the requirements for coverage under the City's group health plan due to attainment of age, student status, or similar circumstance
- A change in work location or residence
- A judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody that obligates you to provide group health coverage for your child, or which releases you from such an obligation
- Enrollment in Medicare (Part A or Part B)
- Any other event that the Risk Services Benefits Program determines will permit the making, changing or revocation of any election during a year pursuant to regulations and rulings issued by the IRS

Under the IRS rules, a change in election in regard to the Premium Conversion Program or the Health Care Account by reason of a change in status event will be permitted only if the event affects the coverage of you, your spouse or your dependent under the City's group health plan or another employer-sponsored group health plan.

With respect to the Dependent Care Account, you can modify or revoke your election during a year, or elect to enroll in the program for the remainder of a year, under one of the following circumstances:

- You incur a change in status described above which causes you to incur, or cease to incur, qualified dependent care expenses, such as a child attaining age 13 and thus ceasing to be a "qualifying individual"
- A change in the cost of the dependent care expenses due to a change in the dependent care provider or in the amount of care provided, such as a decrease in the hours of care upon the child's commencement of school
- An increase in the amount charged by the dependent care provider (but only if the provider is not a member of the employee's family or household)
- Any other situation that the Risk Services Benefits Program determines will permit enrolling in, or modifying or revoking an election under, the Dependent Care Account during the year

If you revoke a contribution election with respect to the Health Care Account or the Dependent Care Account during a year (other than in connection with your leaving employment), you will not be deemed to have revoked your participation in the program for the year. Instead, you will be deemed to have changed the amount of your total

contribution for the year to equal the contributions made under the applicable FSA Program through the effective date of the revocation. You will continue to be eligible for reimbursements under the FSA Program for the remainder of the year, even though no further contributions are being made.

You should contact the Risk Services Benefits Program if you have questions as to whether a particular event will allow you to make, change or revoke an FSA Program election during a year.

Qualified Health Care Expenses

Your Health Care Account can be used to pay for medical, dental, and vision expenses for you and your qualified dependents which are not covered by the City's group health plan (or any other group health care plan), and which are considered qualified medical expenses by the IRS. These expenses include:

- Expenses which are covered under your group health plan, but which are not reimbursable because of the annual deductible and co-payment provisions of the plan
- Qualified medical expenses that are not covered under the group health plan, including Over-the-Counter (OTC) products if the OTC product is for medical care and primarily for a medical purpose. For information regarding expenses that are eligible for reimbursement, contact BenefitHelp Solutions

Qualified Dependent Care Expenses

Typically, these include the dependent care expenses listed below as long as the day care is needed so you can work:

- Day care provided by individuals who care for young children up to age 13 in or outside the home
- Nursery school, pre-school, day-care centers or a similar program for children below the level of kindergarten
- Day care programs must comply with State and local government laws and regulations, provide care for more than six individuals who do not live at the center, and receive payment for services
- Before or after school care of a child in kindergarten or a higher grade
- Programs (including summer day camps and specialty day camps) for children up to age 13 while schools are not in session
- Special care for mentally or physically handicapped dependents
- Home care, non-medical nursing, or nurse's aide services for a dependent parent who lives with you (medical care falls under health care expenses)
- Dependent care centers which provide day care for adults, not residential care
- The cost of transportation of a dependent by a qualifying Dependent Care Provider to or from a place where care is being provided. The cost of transportation that is provided by someone other than the Dependent Care Provider is not a qualifying Dependent Care Expense

Additional Dependent Care Account Regulations

In addition to the "use it or lose it" rule discussed earlier, there are other factors you should be aware of before you elect to have amounts set aside in your Dependent Care Account.

The first relates to the limitations on the amount of reimbursements from that Account which will ultimately be exempt from income taxation. More specifically, the maximum amount of reimbursements from your Dependent Care Account, which you can exclude from income for any year, is the least of the following amounts:

- $5,000 ($2,500 if you are married but file a separate federal income tax return);
- The amount of your taxable wages for the year; or
- If you are married, your spouse's actual or deemed earned income for the year.

For purposes of the third factor above, your spouse, if not employed, will be deemed to have earned income for any month during a calendar year in which he or she is either physically or mentally incapable of self-care, or is a full-time student during at least five calendar months during that year. The amount of such deemed earned income for each such month is $200 if you have one minor child or other individual qualifying for dependent care coverage, and $400 per month if you have two or more qualifying individuals.

You should keep the above statutory limits in mind when calculating the amount you wish to have set aside in your Dependent Care Account for a year.

Qualified Dependent Care Expenses paid for a period during only part of which the Participant is gainfully employed or in active search of gainful employment must be allocated on a daily basis. However, dependent care expenses for

a Participant who is gainfully employed are not required to be allocated in the case of a short, temporary absence from work, such as for vacation or minor illness, provided that the care-giving arrangement requires the Participant to pay for care during the absence. An absence of two consecutive calendar weeks is a short, temporary absence. Whether an absence that is longer than two consecutive calendar weeks is a short, temporary absence is to be determined by the Plan Administrator on the basis of all the facts and circumstances.

The dependent care expenses for a Participant who is employed part-time generally must be allocated between days worked and days not worked. However, if the part-time Participant is required to pay for dependent care on a periodic basis (such as weekly or monthly) that includes both days worked and days not worked, the allocation of the expense is not required. A day on which the Participant works at least one hour is a day of work.

Federal and Oregon dependent care tax credits that are also available to employees. Most employees will realize greater tax savings by participating in the Dependent Care Account. However, certain employees may be better off not participating in the Dependent Care Account program in order to be eligible for the dependent care tax credits.

Termination of Employment

Dependent Care Account: the plan will allow reimbursement of expenses incurred after termination of an employee's participation through the end of the Plan Year (or the end of the 2½ month grace period for plans adopting the grace period).

If you become reemployed with the City within 30 days of your termination, then your prior FSA elections will be automatically reinstated. If you resume employment more than 30 days following your termination, you will be permitted to make a new FSA election for the remainder of the year.

Health Care Account: If you have elected to participate in a Health Care Account for a year and you leave employment during the year, the remaining monthly contribution will be taken from your final paycheck on a pre-tax basis. If the balance of your account is not taken out of your final paycheck on a pre-tax basis you will need to reimburse the City with after-tax dollars. You will remain a participant in the Health Care FSA program through the end of the plan year and will have until the end of the plan year's grace period to incur eligible expenses.

Leave of Absence

Your treatment under the FSA Program upon the taking of a leave of absence depends upon the particular type of leave. (*Note that you cannot receive reimbursements for Dependent Care expenses incurred during a leave of absence period from the City, unless you need childcare so you can work*.)

Paid Leave of Absence

If you take a paid leave of absence, your participation under the FSA Program will continue on the same basis as if you were otherwise actively employed by the City.

Unpaid Leave of Absence

- **Non-FMLA Unpaid Leave**

  If you take an unpaid leave of absence that is not covered under the Federal Family and Medical Leave Act (FMLA), then in order to continue participation under the program at your full elected annual reimbursement amount, you must submit the required premium amount to the Risk Services Benefits Program by the first of each month. You may also pre-pay the premiums that will become due during your leave or have the deduction taken out in the first pay period after you return to work. The pre-payment may be made by increasing the amount of your payroll deduction for the pay period (or pay periods) preceding your unpaid leave. If you do not pre-pay, you must have the deduction taken out or otherwise remit the premium by the first pay period after your return. Otherwise, you will be deemed to have modified your reimbursement election for the year to equal the premiums previously paid by you for the year. You will continue to be eligible for reimbursements under the FSA Program for the remainder of the plan year (based on the modified election amount).

- **FMLA Unpaid Leave**

  If you take unpaid FMLA leave, you may continue participation under the FSA Programs by pre-paying or otherwise timely remitting the required premium each month as generally described above. You may alternatively elect to suspend participation during the period of your FMLA leave. However, no expenses incurred by you during the period of suspension will be reimbursable under the FSA Program.

  If you elect to suspend your participation during the FMLA leave period, or if your participation is deemed to be suspended because you failed to timely pay the required premium, then you will be treated as having modified your annual reimbursement election as discussed in the unpaid leave provision above. In addition, you may elect to resume full participation upon returning from the FMLA leave. In that event, you can choose to pay the same monthly amount as you were paying prior to the taking of the FMLA leave. If you make this choice, the total amount reimbursable from your Health Care Account and Dependent Care Account for the year will be reduced to take into account the period of FMLA leave for which no premiums were paid.

  For example, if you were contributing $100 per month ($1,200 for the year) to your Health Care Account, and you took one month of unpaid FMLA leave for which you did not make your usual $100 premium payment, then upon your return, you can elect to continue making premium payments in the amount of $100 per month. However, your reimbursement limit for the year will be reduced from $1,200 to $1,100.

  Upon returning from unpaid FMLA leave, you may also instead choose to have reinstated the full reimbursement amount for the year as elected and in effect prior to the FMLA leave (e.g., $1,200 using the above example). In that event, your monthly premiums for the remainder of the year will be increased as necessary to make up for the premiums that had not been paid during the FMLA period.

  In all regards, while you are on FMLA leave, you will have the same election rights under the FSA Programs as available to employees who are not on FMLA leave.

Qualified Reservist Distributions

If you are a “reservist,” and if you are ordered or called to active duty for a period of 180 days or more or for an indefinite period, you may be eligible to request a qualified reservist distribution from your Health Care Account. Taking a qualified reservist distribution ensures that the balance of your Health Care Account will not be forfeited. For this purpose, a “reservist” is a member of the Army National Guard of the United States, the Army Reserve, the Navy Reserve, the Marine Corps Reserve, the Air National Guard of the United States, the Air Force Reserve, the Coast Guard Reserve, or the Reserve Corps of the Public Health Service.

To receive the qualified reservist distribution, you must request a payment by March 15 following the year in which you are called to active duty. The request for the distribution must be accompanied by a copy of the order or call to active duty.

If you request a qualified reservist distribution, you will remain eligible to be reimbursed for qualified medical expenses incurred before the date a distribution is requested. However, you will not be eligible for reimbursement for any medical expenses incurred after the date of the request. Therefore, you will not be permitted to elect COBRA continuation coverage with respect to expenses incurred after the distribution request date.

Under IRS rules, the qualified reservist distribution will be included in your gross income. The City will report the distribution as wages on your Form W-2 for the year in which the distribution is paid to you.

Reimbursement

Reimbursement from your Health Care or Dependent Care Flexible Spending Accounts depends on the type of account you have and whether you have signed up for either the Benefits MasterCard or for AutoPay.

Dependent Care Account: You will need to submit a manual claim form for all dependent care expenses, available at www.eugene-or.gov/employeebenefits. The maximum reimbursement for dependent care expenses as of any time is limited to your current Dependent Care Account balance. For example, if you submit a claim for $100 and there is only $50 in your account, you will then be reimbursed only $50 and the balance will be paid as money accumulates in your account.

Health Care Account: You have several options for reimbursement:

1. Enroll in FSA AutoPay, which will automatically reimburse you for any out of pocket expenses on claims processed through PacificSource or Delta Dental, *without the need to file a claim form*. You pay the provider your out of pocket expense and BenefitHelp Solutions will reimburse you automatically once the claim has been processed through PacificSource or Delta Dental. With this program you will need to file manual claims for any expenses not processed through PacificSource or Delta Dental.
2. Unless you enroll in FSA AutoPay, you will be sent a Benefits MasterCard, which can be used to pay for eligible expenses at the point of service. With this program you do not normally need to submit a manual claim form, but you may be required to submit documentation of the expense to BenefitHelp Solutions. Be sure to save all receipts in case documentation is requested. Your Benefits MasterCard will be deactivated if requested documentation is not received within 45 days of the request. Contact BHS if you have questions about your Benefits MasterCard.
3. Submit manual claims for your expenses either through your online BenefitHelp Solutions Member Account or via mail, email or fax to BHS. A Flexible Spending Account Claim Form, complete with instructions, is available on the Employee Benefits website at www.eugene-or.gov/employeebenefits. If you sign up for Direct Deposit, reimbursement from your FSA will be automatically deposited into your bank account. Otherwise, BenefitHelp Solutions will send you a check for the reimbursement amount.

Additional information on reimbursement from your FSA account is below:

- When you have an eligible expense that is not reimbursed through AutoPay or the Benefits MasterCard, first pay the bill or submit insurance claims for the services and follow the steps below:
  1. Submit your claim through your online member account on the BenefitHelp Solutions website at www.benefithelpsolutions.com, or submit a manual Flexible Spending Account Claim Form, available on the Employee Benefits website at www.eugene-or.gov/employeebenefits or from the Risk Services Benefits Program, to BHS. Contact information for assistance or manual claim submittal is in the front of this handbook.
  2. Attach proof of your expenses - either an Itemized Bill from your medical provider (indicating patient's name, name of the medical provider, and amount of expenses incurred), an Explanation of Benefits (EOB) from your Claims Administrator, or a Statement of Services from your dependent care provider indicating the name and the date(s) of service, and the amount of the incurred expense.
- Requests for reimbursement can be made at any time as long as the accumulated expenses equal at least $25 (several small claims equaling $25 may be filed together). During the last three months of the calendar year and at termination of employment, claims of any dollar amount may be submitted. You will be reimbursed from your Account(s) after BenefitHelp Solutions (BHS) has received your FSA Claim Form and processed your check. Your reimbursement checks will be mailed to your home address; or, you may have your reimbursement funds directly deposited into a checking or savings account.
- For Orthodontia claims, BHS requires a copy of the signed contract between you and the Orthodontist. The City of Eugene's Health Care FSA Plan allows for "up-front" reimbursements for orthodontia.
- You can submit expenses incurred during the 2½ month grace period (through March 15) to either the current plan year or the previous plan year. You have until June 15 of the following year to submit claims to the previous year's account.
  - For example: You still have funds left in your 2016 Healthcare FSA account and have a doctor's appointment on March 1, 2017. You would have until June 15, 2017 to submit the claim for reimbursement from the 2016 plan year.

Tax Return Considerations

You do not need to report reimbursements that you receive from your Health Care Account on your federal income tax return. However, because the monies that you contributed to this Account were made on a tax-favored basis, you also cannot claim these contributions as a medical expense deduction on your personal income tax return.

If you receive reimbursement from your Dependent Care Account for a year, you must report the amount of those reimbursements on your IRS income tax return. To assist you in completing the IRS forms, the Form W-2 that we provide you following the end of each year will disclose the amount of reimbursements actually paid to you during the year.

Reimbursement Denial Appeal

If BenefitHelp Solutions determines that your reimbursement request is to be denied in whole or in part, they will provide you with a written notification of such denial. You may appeal that denial by submitting a written request for review to BenefitHelp Solutions within 180 days of the notice that the claim was denied. If you do not appeal within this time frame you will lose the right to appeal.

A written appeal should state the reasons that the claim should not have been denied and should include any additional facts and/or documents that support the claim. The decision regarding the appeal will be made no later than 60 days after submission of the appeal. This review will be independent of the initial reimbursement request denial.

You will be provided with written notification of the decision regarding the appeal of your reimbursement request denial. If your appeal is to be denied in whole or in part, the notice will include the following:

- The specific reason or reasons for the appeal denial; and
- Reference to the specific plan provisions upon which the appeal denial is based.

Health Care Account Worksheet

The following worksheet can help you estimate your eligible health care expenses and how much, if any, to contribute to a Health Care Account. First, list out-of-pocket medical, dental, and vision care expenses you and your dependents will have incurred this year. Next, try to estimate what health care expenses both you and/or your dependents may have next year (from January 1st through December 31st) by making a comparison to this year's expenses.

Remember generally, if a health care expense is deductible for Federal income tax purposes, it is considered "qualified" for reimbursement under your Health Care Account.

	THIS YEAR'S EXPENSES	**NEXT YEAR'S ESTIMATED EXPENSES**
Medical, dental, vision deductibles	$	$
Medical, dental, vision co-payments	$	$
Prescription drug co-payments	$	$
Over-the-counter drugs and medications* A prescription is required for all over-the-counter drugs, except insulin	$	$
Over-the-counter supplies		
Other medical services not covered by health plan	$	$
Denture replacements	$	$
Other dental services not covered by dental plan	$	$
Replacement of glasses/lenses/frames	$	$
Laser refractive eye surgery	$	$
Other vision services not covered	$	$
Total Estimated Annual Expenses	**$**	**$**

Total your estimated expenses for the upcoming plan year (if enrolling mid-year, estimate expenses from your enrollment date to the end of the plan year). That number is a suggested amount that you may want to contribute to the Health Care Account. Remember, be conservative - unused money will be forfeited as required by IRS regulations.

Dependent Care Account Worksheet

The following worksheet can help you estimate your eligible dependent care expenses and how much, if any, to contribute to a Dependent Care Account. First, list out-of-pocket dependent care expenses you have incurred this year. Next, try to estimate what dependent care expenses you may have next year (from January 1st through December 31st) by making a comparison to this year's expenses.

	THIS YEAR'S EXPENSES	NEXT YEAR'S ESTIMATED EXPENSES
Pre-school or day care expenses	$	$
Babysitting in or outside your home (while you are at work)	$	$
Other non-educational programs to care for children when school is out, such as summer day camps and specialty camps	$	$
Non-medical home care or nursing for a dependent parent or handicapped child	$	$
Total Estimated Annual Expenses	**$**	**$**

Total your estimated expenses for the upcoming plan year (if enrolling mid-year, estimate expenses from your enrollment date to the end of the plan year). That number is a suggested amount that you may want to contribute to the Health Care Account. Remember, be conservative - unused money will be forfeited as required by IRS regulations.

Also remember, your total reimbursements for the year cannot exceed the least of:

- Your income; or
- If you are married, your spouse's income; or
- $5,000 ($2,500 if married and will file separate tax return)

TRANSPORTATION REIMBURSEMENT ACCOUNT (TRA)

Program Summary

The City of Eugene's Transportation Reimbursement Account (TRA) program is similar to the City's Flexible Spending Account program and is administered by BenefitHelp Solutions. This program is allowed under the Transportation Equity Act for the 21st Century (TEA 21), is regulated by Internal Revenue Code § 132(f) and is officially known as the Commute Expense Reimbursement Account (CERA) program. Employees who pay to commute to work have the opportunity to set aside a portion of their salary to pay for certain qualified transportation expenses without being taxed on these amounts.

When you participate in this program, the contributions you make to your TRA will be deducted from your compensation on a before tax basis; before state, federal, and social security taxes are withheld. This means you will avoid paying taxes on these deductions.

Please review the following information before you make your decision to participate in this program.

The City's FSA/TRA program is administered by BenefitHelp Solutions. Contact information for questions or manual claim submissions is in the front of this handbook.

Eligibility

All regular employees are eligible to participate in this program. In addition, AFSCME-represented Limited Duration and Recreation Activity Employees (RAEs) and IATSE-represented employees who are eligible for City-provided health insurance benefits are eligible to participate in the program.

Enrolling in a TRA

Open enrollment is held annually in December of each year. Your TRA account will be effective the first of the month following the completion of the Participation Agreement. New employees must enroll within 31 days of their date of hire.

The FSA/TRA enrollment form is available 24 hours a day from home or work at www.eugene-or.gov/FSAenroll, and can be securely submitted online. You will need your City of Eugene network user ID and password to complete the form online. Forms are also available from Benefits Staff.

IMPORTANT NOTE: Employees who park in City parking lots and have signed up with Republic Northwest Parking to pay a payroll deduction for parking should NOT also enroll in the TRA parking program. They will not have to fill out a TRA enrollment form unless they intend to participate in the Van Pool or Mass Transit features of the program.

Participation Agreement Changes

The Participation Agreement may be revoked or changed at any time, effective the first of the following month. To continue participation in a new plan year, you must re-enroll during the City's FSA/TRA Open Enrollment held each December. The employee's Participation Agreement ends upon termination of employment.

Qualified Transportation Expense

Expenses incurred by the employee to purchase or pay for transit pass expenses, commuter vehicle expenses (van pools), or qualified parking expenses incurred for the purpose of transportation between an employee's residence and place of employment or for parking in conjunction with use of mass transit or van pool qualifies as a transportation expense.

Mass transit is a public system or private enterprise provided by a company/individual who is in the business of transporting people in a commuter highway vehicle, i.e., buses. Such vehicle must have a seating capacity of six or more adults (not including the driver) and at least 80 percent of the vehicle's mileage must be from transporting individuals to and from their place of work. The vehicle must be carrying at least three passengers (not including the driver). This does not include carpooling.

Mass transportation includes transit passes for mass transportation to and from work. Qualified amounts include costs of any pass, token, fare card, voucher, or other item that entitles the employee to use mass transit for the purpose of traveling to or from his/her place of work.

Van pool means that the vehicle must seat at least six adults **plus** a driver and at least 80 percent of the vehicle's mileage is used to commute between home and work. Expenses incurred for transportation in a van pool are eligible provided such transportation is in connection with travel between the individual's residence or park-and-ride lots and place of employment.

Parking expenses are fees for parking at or near your primary work location, the location where you take mass transit, or the location where you pick up the van pool. Only the expense of parking the vehicle is a covered expense through TRA. Fuel, maintenance, and insurance costs are not covered.

TRA Contribution Limits

(Subject to change by the IRS)

Transportation Reimbursement Account	Per Month
Parking	**$255**
Transit Pass and Van Pooling (combined)*	**$80**

*The Transit Pass maximum contribution amount has been reduced by the value of the bus pass purchased for employees by the City.

Use It or Lose It Rule

The "Use it or Lose it" rule works differently for TRA accounts than it does for FSA accounts. By law, any remaining unused funds in your TRA are forfeited if you are no longer participating in a TRA account. However, while unused funds remaining in your TRA account at the end of the plan year cannot be refunded to you, they can be rolled over for use in the next plan year providing you re-enroll in the same TRA program.

Reimbursement

Per IRS regulations, transportation expenses must be submitted for reimbursement within 180 days of the date services are received. Complete the claim form available on the Employee Benefits website, and then submit the claim form and receipt(s) to BHS.

Contact information for questions or manual claim submissions is in the front of this handbook.

City of Eugene

Long-Term Disability Insurance (L T D)

Effective June 1, 2016

LONG-TERM DISABILITY

The City of Eugene Long-Term Disability (LTD) Plan provides you with income protection if you become disabled from a physical disease, mental disorder, accidental bodily injury or pregnancy.

The monthly LTD benefit varies by pay unit. Your benefit will be at least $100 per month, but not more than the maximum listed in the Amount of Benefit section below. LTD benefits are payable after the end of the Benefit Waiting Period. This LTD insurance covers only you, not your dependents. Insurance is provided through Standard Insurance Company of Portland, Oregon. A certificate of coverage for each union/employee unit and LTD Frequently Asked Questions are on the Risk Services Employee Benefits website at www.eugene-or.gov/employeebenefits.

Eligibility

As a regular or Limited Duration employee scheduled to work at least 20 hours per week (or one-half of the hours in a pay period for AFSCME-represented employees), you are eligible for long-term disability insurance coverage. Eligibility for IATSE-represented employees is specified in the most recent labor agreement between the City of Eugene and the unions.

When Coverage Begins

For all groups except IATSE-represented employees, LTD coverage begins on the first day of the month following your first day of active employment as an eligible employee.

For IATSE-represented employees and AFSCME-represented Recreation Activity Employees, LTD coverage begins on the first day of the month following your first day of eligibility as specified in the current labor agreement between the City of Eugene and the unions.

All employees must meet the Active Work Requirement before insurance will become effective.

Active Work Requirement

If you are incapable of Active Work because of physical disease, mental disorder, injury or pregnancy on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible employee.

Active Work means you are performing the material duties of your own occupation at your employer's usual place of business. The Active Work Requirement also applies to any increases in your insurance.

When Coverage Ends

LTD coverage ends automatically on the earliest of the following dates:

- The date the Group Policy terminates.
- The date your employment with the City terminates.
- The last day of the calendar month in which you cease to be eligible for coverage under the LTD plan. However, if you cease to be otherwise eligible for coverage because you are not working the required minimum number of hours, your insurance will be continued during the following periods, unless it ends because of one of the other events described.
    - While the City is paying you at least the same pre-disability earnings paid to you immediately before you ceased to be eligible for coverage.
    - During the Benefit Waiting Period and while LTD benefits are payable.
    - During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.
    - During any other leave of absence approved in advance and in writing by the City and scheduled to last through the last day of the calendar month in which the City ceases to pay you the full amount of your pre-disability earnings.

How to Enroll

You are automatically covered for LTD insurance benefits based on your eligibility. No action on your part is required to enroll.

Definition of Disability

You are considered disabled from your own occupation if, as a result of physical disease, mental disorder, injury or pregnancy, you are not able to perform with reasonable continuity the material duties of your own occupation. **Medical certification of disability is required.**

Until LTD benefits have been paid for 24 months, you are required to be disabled only from your own occupation. After LTD benefits have been paid for 24 months, you must be disabled from all occupations in order to continue receiving benefits. You are disabled from all occupations if, as a result of physical disease, mental disorder, injury or pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

Benefit Waiting Period

The Benefit Waiting Period is the time you must be continuously disabled before you are eligible for LTD benefits. Your Benefit Waiting Period begins on the date you become disabled. You must be seen regularly and be treated by a physician during the Benefit Waiting Period.

If you are an AFSCME-represented employee, your Benefit Waiting Period is the longer of:

- 90 days of continuous disability, or
- the period for which you are eligible for sick leave pay.

For all other employee groups, your Benefit Waiting Period is the first 90 days of continuous disability.

LTD Benefits begin at the end of the Benefit Waiting Period. LTD Benefits end on the earliest of:

- The day of your death;
- The day your disability no longer exists;
- The end of the Maximum Benefit Period; or
- The day benefits become payable to you under any other group long-term disability policy.

Maximum Benefit Period

The **Maximum Benefit Period** is the longest period of time LTD benefits are payable for any one period of continuous disability, whether from one or more causes. Your Maximum Benefit Period is determined as follows:

AGE WHEN DISABILITY BEGINS	MAXIMUM BENEFIT PERIOD
61 or younger	To age 65, or to SSNRA*, or 3 years 6 months, whichever is longest
62	To SSNRA*, or 3 years 6 months, whichever is longer
63	To SSNRA* or 3 years, whichever is longer
64	To SSNRA* or 2 years 6 months, whichever is longer
65	2 years
66	1 year 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

*Social Security Normal Retirement Age

Your Maximum Benefit Period begins at the end of the Benefit Waiting Period. During the Maximum Benefit Period, LTD benefits are paid at the end of each monthly period for which you qualify for LTD benefits. LTD benefits will stop at your death or at any time during the Maximum Benefit Period when you no longer qualify for LTD benefits.

LTD benefits will stop at the end of the Maximum Benefit Period even if you are still disabled.

EXCEPTION FOR MENTAL DISORDERS: Payment of LTD benefits is limited to 24 months for each period of disability caused or contributed to by a mental disorder. However, if you are confined in a hospital at the end of the 24 months, this limitation will not apply while you are continuously confined.

Amount of Benefit

After the Benefit Waiting Period, the LTD Plan provides for a total monthly benefit, including Deductible Income, equal to 60% (66% for EPEA-represented employees) of your basic monthly pay up to a maximum amount. Basic monthly pay equals your monthly rate of earnings, excluding bonuses, overtime pay, commissions and any other extra compensation.

The LTD benefit is considered taxable income because the premiums are paid for by the City of Eugene. Employees who qualify for LTD benefits should contact Standard Insurance if they want taxes to be deducted directly from the LTD benefit.

PAY UNIT	BENEFIT
AFSCME*	60% of your first $6,000 basic monthly pay ($3,600/month maximum benefit)
Non-Represented	60% of your first $16,000 basic monthly pay ($9,600/month maximum benefit)
IAFF	60% of your first $12,500 basic monthly pay ($7,500/month maximum benefit)
IAFF-BC	60% of your first $12,500 basic monthly pay ($7,500/month maximum benefit)
EPEA	66% of your first $6,000 basic monthly pay ($3,960/month maximum benefit)
IATSE	60% of your first $5,000 basic monthly pay ($3,000/month maximum benefit)

* The long term disability benefit for Recreation Activity Employees will be based on the standard hours designated in the payroll system.

Deductible Income

If you become disabled, the amount of your LTD Benefit payable under the plan will be reduced by the following Deductible Income:

- Any income paid as salary, wages or other payment by the City of Eugene or any other employer, except as provided under an approved rehabilitation program
- Any sick pay or other salary continuation paid to you by the City of Eugene, not including vacation pay
- Any amount you receive or are eligible to receive under Worker's Compensation Law or other similar legislation.
- Any state disability plan benefits
- Any amount you, your spouse or your children under age 18 are eligible to receive because of your disability or retirement under the Federal Social Security Act, or any similar plan, act or law
- Any disability benefits you are eligible to receive because of your disability under any other group insurance plan or under a plan arranged and maintained by a union or employee association
- Any benefits you are eligible to receive under the City of Eugene's retirement plan (PERS or OPSRP)
- Any amount received by compromise, settlement or other method as a result of a claim for any of the above

When income benefits are not payable from any of these sources, the entire amount of the guaranteed monthly income will be paid by the plan. When part of the guaranteed monthly income is payable from one or more of these sources, the balance will be paid by the plan.

In all cases, the LTD Plan will pay a minimum monthly benefit of $100. Your LTD benefit during a period of disability will be determined by your monthly pay in effect on your last day of active work before you became disabled.

It is your responsibility to make timely claims for any Deductible Income to which you may be entitled. Otherwise, the benefits from this plan can be reduced by the amount it is reasonable to believe would have become a reduction had you pursued Deductible Income in a timely manner.

You must cooperate in providing necessary information. If, as a result of the annual adjustment or amendment to the Social Security Law, Social Security benefits are increased while you are receiving benefits under this plan, such a Social Security increase will be an extra benefit, and will not be considered Deductible Income.

The following are not considered Deductible Income:

- Any cost of living increase in any Deductible Income. The increase must be effective while you are disabled and are eligible to receive the Deductible Income. (This exception does not apply to any increase in your earnings from any work.)
- Amounts you receive as reimbursement for medical expenses
- Reasonable attorney's fees incurred in connection with your claim for Deductible Income
- Benefits from an individual disability insurance policy
- Early retirement benefits under the Federal Social Security Act which are not actually received
- Group credit or mortgage disability benefits
- Accelerated death benefits paid under a life insurance policy
- Benefits from a deferred compensation plan or IRA

Temporary Recovery

If, after LTD benefits become payable, you have more than one period of disability because of the same condition, these periods will be considered one period of disability if separated by a period of recovery of 180 days or less. However, if you work for six or more months between periods of disability, the new period will not be considered part of the earlier period. No benefits will be payable under this provision after benefits become payable to you under any other group LTD insurance policy.

Exclusions and Limitations

Disability income is not payable if your disability is caused by or is a direct result of:

- War or any act of war. War means declared or undeclared war, whether civil or international, and any substantial armed conflict between organized forces of a military nature
- Intentionally self-inflected injury, while sane or insane

No LTD benefits will be paid for any period disability when you are not under regular care of a physician.

Payment of LTD benefits is limited to 24 months for each period of disability caused on contributed to by a mental disorder. However, if you are a resident patient in a hospital at the end of the 24 months, this limitation will not apply while you remain continuously confined.

Applying for Benefits

You must claim LTD benefits within 90 days after the end of the Benefit Waiting Period, or as soon as possible thereafter, but not later than one year after that 90 day period. Claims not filed with Standard Insurance Company within these limits may be denied. After Standard Insurance Company receives your claim, you will receive a written decision within a reasonable amount of time. If you do not receive this decision within 90 days after your claim is received, you have the right to request a review.

All claim forms are available from the Risk Services Benefits Program, which can also provide you with information regarding claims procedures.

Accidental Losses

Your LTD coverage provides a Minimum Benefit Period if you suffer one of the accidental losses shown in the following table:

Accidental Loss	Minimum Benefit Period
Both Hands or Feet or Sight of Both Eyes	5 years
One Hand and One Foot	5 years
Either One Hand or Foot and Sight of One Eye	5 years
Either Hand or Foot	6 months
Sight of One Eye	6 months

Loss of hand or foot means permanent severance of the hand or foot from the body at or above the wrist or ankle joint; loss of sight of any eye means entire and irrecoverable loss of sight. The loss must be caused solely and directly by an accident, occur independently of all other causes, and occur within 180 days after the accident.

You will receive LTD benefits for the applicable Minimum Benefit Period, subject to certain exclusions. Consult the Risk Services Benefits Program or the prior pages of this booklet for a complete listing of exclusions or additional information.

Rehabilitation Employment

The disability program features a Rehabilitation Program that encourages you to return to work. Under this program, you may work while LTD benefits are payable provided you are considered to be disabled. During the first year you are working, LTD Benefits will be reduced by your work earnings to the extent that your work earnings exceed 100% of your pre-disability earnings when added to your LTD Benefit. Thereafter, 50% of your work earnings will be deducted from your LTD Benefits.

NOTE: All or part of the Benefit Waiting Period can be satisfied while you are working if you are considered disabled during your period of work activity.

The Rehabilitation Program does not force you to return to work; it only encourages you to do so, as long as you have your doctor's permission.

City of Eugene

LIFE INSURANCE

Effective June 1, 2016

LIFE INSURANCE

The City of Eugene Life Insurance Plan, through Standard Insurance Company, offers financial protection for your family. It provides you with two types of benefits: Basic Life Insurance and Accidental Death and Dismemberment (AD&D) Coverage.

Eligibility

As a regular or Limited Duration employee scheduled to work at least 20 hours per week, you are eligible for the basic life insurance and AD&D insurance coverage. Eligibility for regular IATSE-represented and AFSCME-represented Recreation Activity Employees (RAE) employees is specified in the most recent labor agreement between the City of Eugene and the unions.

When Coverage Begins

Your basic life insurance and AD&D coverage begins on the first of the month following your first day of continuous service. For IATSE-represented employees and AFSCME-represented Recreation Activity Employees, coverage begins on the first of the month following your eligibility date.

All employees must meet the Active Work Requirement before insurance will become effective.

Active Work Requirement

If you are incapable of Active Work because of sickness, injury or pregnancy on the day before the scheduled effective date of your insurance, your insurance will not become effective until the day after you complete one full day of Active Work as an eligible employee.

Active Work means you are performing the material duties of your own occupation at your employer's usual place of business. The Active Work Requirement also applies to any increases in your insurance.

When Coverage Ends

Your basic life insurance and AD&D coverage ends automatically on the earliest of the following dates:

- The date the Group Policy terminates;
- The last day of the calendar month in which your employment with the City terminates; and
- The last day of the calendar month in which you cease to be eligible for coverage under the Life Insurance Plan.

However, if you cease to be otherwise eligible for coverage under the Life Insurance Plan because you are no longer working the required minimum number of hours, then your Life Insurance will be continued with premium payment during the following periods, unless your insurance ends due to one of the other events described.

- While the City is paying you at least the same annual earnings paid to you immediately before you ceased to be eligible for coverage.
- While your ability to work is limited because of sickness, injury or pregnancy.
- During the first 60 days of:
  - A temporary layoff; or
  - A strike, lockout, or other general work stoppage caused by a labor dispute between your collective bargaining unit and the City.
- During a leave of absence if continuation of your insurance under the Group Policy is required by a state-mandated family or medical leave act or law.
- During any other leave of absence approved by the City in advance and in writing and scheduled to last through the last day of the calendar month in which the City ceases to pay you the full amount of your annual earnings.

Your AD&D coverage ends on the date your claim for continued life insurance is approved by Standard Insurance Company.

Enrollment

To enroll in the plan, you must complete a form designating your beneficiary and return it to the Risk Services Benefits Program.

Designating Your Beneficiary

In the event of your death while you are a covered employee, your designated beneficiary or beneficiaries will receive your insurance benefit. If you indicate more than one beneficiary, you may specify the percentage to be paid to each person at your death. You may also indicate a primary beneficiary and a contingent beneficiary. The contingent beneficiary will only receive benefits in the event that the primary beneficiary predeceases you.

If you do not name a beneficiary, or if you are not survived by a beneficiary, all death benefits will be paid in equal shares to the first surviving class of persons listed:

- Your spouse;
- Your children;
- Your parents;
- Your brothers and sisters; or
- Your estate.

Changing Your Beneficiary

You can name, add, or change beneficiaries by completing and signing a **Change of Beneficiary** form available from the Risk Services Benefits Program. The change becomes effective when the change form has been received by the Benefits Program.

Payment of Benefit

Payment of benefits will be made automatically into a personalized, interest-bearing checking account. A checkbook is issued and the beneficiary is free to use it as he or she would any other checking account. There are no maintenance or service fees, no per check charges and no redemption fees or withdrawal penalties.

Coverage at Age 70 and Beyond

When you reach age 70, and are still eligible for Basic Life and AD&D as an active eligible employee, your benefit will be reduced to 65% of the amount to which you would otherwise be entitled, and to 45% of that amount at age 75.

Tax Considerations

Current tax laws consider an employer's cost for life insurance coverage in excess of $50,000 as taxable income to employees. If the amount of your basic life insurance results in taxable income to you, the taxable income will be reflected on your year-end W-2 form.

BASIC LIFE INSURANCE COVERAGE

Amount of Basic Life Coverage

The amount of your basic life insurance is determined by your annual scheduled salary, except for regular IATSE-represented and AFSCME-represented Recreation Activity Employees (RAE) employees who have a fixed life insurance benefit. Your annual salary does not include bonuses, commissions, overtime pay, or employer contributions to PERS/OPSRP or deferred compensation. Basic life insurance coverage by employee group is outlined in the table below.

Life Insurance Benefits by Employee Group

GROUP	AMOUNT	MAXIMUM BENEFIT
AFSCME Regular and Limited Duration Employees	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
AFSCME RAE Employees	$25,000	$25,000
EPEA	Two times your annual salary rounded to the nearest $1,000	$120,000
Non-Represented	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
IAFF	One times your annual salary including EMT Certification rounded to the nearest $1,000	$200,000
IAFF-BC	One times your annual salary including EMT Certification rounded to the nearest $1,000	$200,000
IATSE	$25,000	$25,000

Coverage at Disability

You are considered totally disabled if you are unable, due to illness, or accidental injury or pregnancy, to perform the material duties of any occupation for which you are reasonably fitted through your education, training, or experience. Medical certification of disability by Standard Insurance Company is required.

The amount of your continued life insurance will be the benefit that is in effect on the date you become totally disabled. Your life insurance benefits will be subject to age reductions, if applicable, and will be reduced by any Accelerated Benefit you receive.

If you become totally disabled while covered under this life insurance plan and are under age 60, your life insurance will be continued until the earliest of the following dates:

- The date you cease to be Totally Disabled;
- 90 days after the date Standard Insurance Company mails you a request for additional Proof of Loss, if it is not provided;
- The date you fail to attend an examination or cooperate with the examiner;
- The date you reach age 65;
- The date your insurance is converted to an individual life insurance policy; and
- The date the Group Policy terminates.

If you become totally disabled on or after age 60, the length of your coverage will be determined by the terms of the life insurance policy.

Converting Your Coverage

You may be eligible to convert your basic life insurance coverage to an individual policy if your coverage ends because:

- You are no longer actively at work;
- Your employment with the City of Eugene terminates;
- Your continued life insurance during total disability ends;
- You are no longer a regular employee; or
- The amount of your basic life insurance is reduced.

You must apply for your conversion policy and start paying premiums within 31 days after your basic life insurance stops. You will not have to provide proof of good health. Standard Insurance Company or the Risk Services Benefits Program can provide you with the necessary conversion form.

Amount of Conversion Coverage

If your life insurance ends because you are no longer actively at work or your employment with the City of Eugene terminates, you may convert up to the amount of your basic life insurance benefit.

If you die during the conversion period, Standard Insurance Company will pay a death benefit equal to the maximum amount of life insurance you had a right to convert, whether or not you applied for an individual policy.

Accelerated Benefits

The City of Eugene's life insurance through Standard Insurance Company includes an Accelerated Benefit enhancement. This benefit will allow you to receive up to 75% of your Life Insurance benefit early under certain conditions.

To qualify for this benefit, you must:

- Be diagnosed as being terminally ill with a life expectancy of less than 12 months;
- Apply and qualify for Continued Life Insurance; and
- Have at least $10,000 of life insurance in effect.

If your application for Accelerated Benefits is approved by Standard Insurance Company, you are allowed to receive up to 75% of your available Life Insurance benefit. The minimum Accelerated Benefit is $5,000 or 10% of your Life Insurance, whichever is greater. These funds could be used in defraying the cost of special medical treatment, family needs, etc.

Your Group Life Insurance Certificate contains all of the terms and conditions of the Accelerated Benefit. If you have any questions on this benefit, please contact the Risk Services Benefits Program.

Special Coverage for Police Officers and Fire Fighters

State of Oregon Mandated Life Insurance Coverage (ORS 243.005)

All police officers and fire fighters receive $10,000 life insurance coverage mandated by Oregon law (ORS 243.005). The $10,000 statutory coverage is included as part of the total life insurance benefit available to police and fire fighters while they are actively employed. **Volunteer police, reserve officers, civil deputies, and clerical personnel are not eligible to receive this coverage.** The $10,000 statutory life insurance is not convertible.

Benefits will be paid only if:

- Death results from an injury sustained during working hours as a police officer or firefighter; or
- Death occurs within 365 days after the date of the injury.

State of Oregon Public Safety Memorial Fund (ORS 243.950)

The Public Safety Memorial Fund provides benefits to family members of Oregon's public safety officers who are killed or permanently disabled in the line of duty. Police officers (including reserve officers) and fire service professionals are considered public safety officers under the statute. The statute defines "family member" as: spouse; child; and, a person who qualifies as a dependent for state income tax purposes.

Benefits include a death benefit of $25,000 to an eligible beneficiary of a public safety officer, as well as health and dental insurance benefits. Other benefits such as educational scholarships and mortgage payments may also be available. (This benefit is not underwritten by Standard Insurance Company.)

Federal Public Safety Officers' Benefits Program

The Federal Public Safety Officer's Benefits (PSOB) Act provides death benefits to eligible survivors of a public safety officer whose death is the direct and proximate result of a traumatic injury sustained in the line of duty. As of October 1, 2015 the benefit amount is $339,881. (Each October 1st, the benefit is adjusted by the percentage of change in the Consumer Price Index.)

The PSOB also provides the same benefit to a public safety officer who has been permanently and totally disabled as the direct result of a catastrophic personal injury sustained in the line of duty. To qualify, the injury must permanently prevent the officer from performing any gainful work. (This benefit is not underwritten by Standard Insurance Company.)

More information is available on the Bureau of Justice Assistance website at:
http://www.ojp.usdoj.gov/BJA/grant/psob/psob_main.html.

ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

Amount of Coverage

Depending on the type of loss you suffer, the amount of your Accidental Death and Dismemberment (AD&D) benefit is either the equal to the Full Amount, or one-half the Full Amount. The loss must occur within 365 days after the date of the accident, be caused solely and directly by the accident, and occur independently of all other causes. The tables below list the maximums by employee group and the amount of AD&D coverage.

Accidental Death & Dismemberment Benefits by Employee Group

GROUP	AMOUNT	MAXIMUM BENEFIT
AFSCME Regular and Limited Duration Employees	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
AFSCME RAE Employees	$25,000	$25,000
EPEA	Two times your annual salary rounded to the nearest $1,000	$120,000
Non-Represented	One times your annual salary rounded to the nearest $1,000 (Minimum of $25,000)	$250,000
IAFF	One times your annual salary including EMT Certification rounded to the nearest $1,000	$200,000
IAFF-BC	One times your annual salary including EMT Certification rounded to the nearest $1,000	$200,000
IATSE	$25,000	$25,000

Amount of AD&D Coverage

TYPE OF LOSS	BENEFIT COVERAGE AMOUNT
Life	Full Amount
Both Hands	Full Amount
Both Feet	Full Amount
Sight of Both Eyes	Full Amount
1 Hand; 1 Foot	Full Amount
1 Hand; Sight of 1 Eye	Full Amount
1 Foot; Sight of 1 Eye	Full Amount
1 Hand	½ Full Amount
1 Foot	½ Full Amount
Sight of 1 Eye	½ Full Amount

Loss of hands and feet means permanent severance at or above the wrist or ankle. Loss of sight means total and permanent blindness. The maximum amount of AD&D benefit which Standard Insurance Company will cover for all losses will not exceed the Full Amount.

Who Receives AD&D Benefits

You receive AD&D benefits if you are seriously injured in an accident and have a loss, as described above. Your beneficiary will receive AD&D benefits if you die in an accident.

Seat Belt Benefit

The Seat Belt benefit matches the accidental death benefit up to a maximum of $50,000. This benefit is payable for death resulting from an automobile accident while you were wearing a seat belt. A copy of the police report must show that an approved seat belt (per National Highway Traffic Safety Council) was in use at the time of the accident.

What is not Covered

AD&D will not cover losses caused or contributed to by any of the following:

- Insurrection, war or act of war, whether declared or undeclared;
- Suicide or any other intentionally self-inflicted injury, while sane or insane;
- Committing or attempting to commit an assault or a felony or your active participation in a violent disorder or riot (except while performing your official duties);
- The voluntary use of any poison, chemical compound or drug (including prescribed medications), unless used or consumed in accordance with the directions of a physician;
- Any illness or pregnancy existing at the time of the accident;
- Heart attack or stroke; or
- Medical or surgical treatment for any of the above.

SUPPLEMENTAL LIFE INSURANCE

The City of Eugene also offers an optional life insurance program called Portable Term Supplemental Life Insurance. This plan, provided through Voya ReliaStar Life Insurance Company, is voluntary and the premiums are paid by the employee through payroll deductions. Detailed information on this program is found on the Employee Benefits website: www.eugene-or.gov/employeebenefits.

Eligibility

All regular, benefitted IATSE, Limited Duration and AFSCME-represented Recreation Activity Employees are eligible to apply for Portable Term Supplemental Life Insurance coverage. You can apply for coverage during your first 30 days of employment to receive a Guaranteed Issue amount, or at any time of the year for non-Guaranteed Issue amounts.

Guaranteed Issue Coverage Amount: Within the first 30 days of employment, you can apply for an amount equal to one-times your annual salary (to a maximum of $100,000) without completing a Proof of Good Health form or having your application reviewed by Voya/ReliaStar Underwriting.

Effective Date

For "Guaranteed Issue" applications, coverage is effective the first of the month after the Risk Services Benefits Program receives the application. For all other applications, insurance will become effective on the first of the month after ReliaStar approves your application. Approval of underwritten coverage is subject to satisfactory answers to several health-related questions.

Amount of Coverage

Insurance is available for you and/or your spouse or domestic partner from $20,000 to $500,000 in $10,000 increments. Coverage for your spouse or domestic partner is independent from yours but with the same benefits and rates. Children's coverage is also available as a rider, in amounts of $5,000, $7,500, and $10,000.

Accidental Death and Dismemberment (AD&D) is an optional benefit that pays an additional amount if life, limb or sight is lost due to an accident. AD&D allows your beneficiary to collect twice the amount of your policy to a maximum of $250,000 in the event death was a result of an accident. A benefit is paid to the insured if a loss of limb or sight occurs due to an accident.

Other Features

- **An Accelerated Life benefit** is included under Portable Term Life. This allows you to collect 50% of your policy up to a maximum of $50,000 if you have been diagnosed with a terminal illness.
- **Disability Waiver of Premium – If Voya/ReliaStar determines that you are totally disabled your portable term life insurance premium will be waived if the disability meets certain criteria.**
- **Portability** – If an employee terminates employment or retires, Portable Term Life coverage may be continued by remitting premiums plus an administration fee directly to ReliaStar Insurance Company. Contact the Benefits Program for more information, and to obtain an Voya/ReliaStar Supplemental Life Coverage Continuation Request form.

Cost

The employee pays the entire cost of the insurance. The premiums are deducted from your paycheck. Premium rates depend on your age and the amount of insurance you purchase. Rate information and enrollment forms are available on the Employee Benefits website at www.eugene-or.gov/employeebenefits or by contacting Benefits Program staff.