



Program Selection Guide 2012

*Your comprehensive guide to choosing
your OHSU benefits*

See the Quick Guide to Enrolling, page 11



Contact List

If you have questions about a plan	Call this number	Or visit this Web site
Medical Options and Group Plan Numbers		
Aetna #476577 OHSU PPO Plan OHSU PPO Standard Plan 250 PPO Plan 250 PPO Standard Plan	800 541-0429	www.aetna.com
Kaiser Permanente #8553	In Portland: 503 813-2000 Outside Portland: 800 813-2000	www.kp.org
ODS Rx (prescriptions) #10001819	In Portland: 503 412-4060 Outside Portland: 866 939-1660	www.odscompanies.com
Vision Service Plan (VSP) #12157430	In and outside Portland: 800 877-7195	www.vsp.com
Flexible Spending Accounts		
Aetna Dependent Care FSA Health Care FSA #476578	888 238-6226	www.aetna.com www.aetnafsa.com
Dental Options		
Oregon Dental Service (ODS) #10001819	In Portland: 503 265-2965 Outside Portland: 888 217-2365	www.odscompanies.com
Kaiser Permanente #8553	In Portland: 503 813-2000 Outside Portland: 800 813-2000	www.kp.org
Willamette Dental Insurance Inc. Z144	In Portland: 503 452-2000 Outside Portland: 800 460-7644	www.willamettedental.com
Life and Disability Options		
Standard Insurance Company #631050	800 378-2390	
OHSU		
Human Resources Department Benefits Office <i>(for details on all benefits available to OHSU employees)</i>	In and outside Portland: 503 494-7617	www.ohsu.edu/hr/oe or ozone.ohsu.edu/hr/oe E-mail: benefits@ohsu.edu
Employee Tobacco Free Program	503 346-0027	tobacco@ohsu.edu

Employee Benefits Council Members

Dana Director (UA): director@ohsu.edu

Harold Fleshman (ONA): fleshman@ohsu.edu

Dan Forbes (UA): forbesd@ohsu.edu

Tom Heckler (UA/Faculty Practice Plan): hecklert@ohsu.edu

Matt Hilton (AFSCME): hiltonm@ohsu.edu

Steven King (Faculty): kingst@ohsu.edu

Diane Lovell (AFSCME Staff): lovell@oregonafscme.com

Chinetta Montgomery (AFSMCE): montgomc@ohsu.edu

Rob Nosse (ONA): nosse@oregonrn.org

Susanna Rhodes (ONA): rhodess@ohsu.edu

Stephen Robinson (Faculty): robinsns@ohsu.edu

Frank Vehafic (AFSCME Staff): fvehafic@oregonafscme.com

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OHSU Contribution to Employee Benefits

Monthly Benefit Dollars Effective Jan. 1, 2012

Unclassified/ Academic	Medical Opt Out*	Employee	Employee & Spouse/ Domestic Partner	Employee & Child(ren)	Employee & Family
Full-time (.75 – 1.0)	\$100	\$630	\$780	\$750	\$850
Part-time (.50 – .74)	\$50	\$495	\$590	\$570	\$600

House Officers	Medical Opt Out*	Employee	Employee & Spouse/ Domestic Partner	Employee & Child(ren)	Employee & Family
Full-time (.75 – 1.0)	\$100	\$630	\$780	\$750	\$850
Part-time (.50 – .74)	\$50	\$485	\$590	\$570	\$600

ONA- represented**	Medical Opt Out*	Employee	Employee & Spouse/ Domestic Partner	Employee & Child(ren)	Employee & Family
Full-time (.70 – 1.0)	\$50	\$666.82	\$760.14	\$666.82	\$842.66
Part-time (.50 – .69)	\$50	\$500.12	\$570.10	\$500.12	\$632.00

AFSCME- represented	Medical Opt Out*	Employee	Employee & Spouse/ Domestic Partner	Employee & Child(ren)	Employee & Family
Full-time (.75 – 1.0)	\$50.70	\$616.48	\$841.68	\$691.76	\$931.58
Part-time (.50 – .74)	\$ 0.70	\$474.70	\$648.10	\$532.66	\$717.32

* Employees must enroll in core life insurance of \$25,000. The opt out rate reflects the contribution amount employees will receive and can use for dental, life and optional coverage.

The employer contribution for all spouse and domestic partner coverage (including registered, unregistered same-sex and unmarried opposite-sex domestic partners) will be based on the coverage level selected.

Rate Information Chart – 2012

Monthly Rate Information

Medical Coverage	Employee Only	Employee and Spouse/ Domestic Partner	Employee and Children	Employee and Family
OHSU PPO	\$567.94	\$854.00	\$674.48	\$897.60
OHSU PPO Standard	\$596.62	\$897.12	\$708.52	\$942.94
250 PPO	\$691.70	\$1,040.04	\$821.06	\$1,134.58
250 PPO Standard	\$725.44	\$1,090.78	\$861.12	\$1,189.94
Kaiser Permanente	\$784.40	\$1,168.74	\$917.74	\$1,223.66

Dental Coverage	Employee Only	Employee and Spouse/ Domestic Partner	Employee and Children	Employee and Family
ODS Dental Plan	\$43.86	\$95.46	\$106.60	\$154.52
Kaiser Permanente	\$75.04	\$150.08	\$135.08	\$225.12
Willamette Dental Insurance Inc.	\$46.58	\$90.78	\$82.32	\$140.96

Short-Term Disability

Pay Date Options

8th Day	30th Day	90th Day
1.194% of your biweekly earnings	0.283% of your biweekly earnings	0.074% of your biweekly earnings

Long -Term Disability

Pay Date Option

180th Day
0.358% of your biweekly earnings

Monthly Costs for AD&D Coverage

You pay for AD&D coverage on an post-tax basis.

For You		For You and Your Family	
Coverage Amount	Monthly Cost	Coverage Amount	Monthly Cost
\$50,000	\$0.60	\$50,000	\$1.20
\$100,000	\$1.20	\$100,000	\$2.40
\$150,000	\$1.80	\$150,000	\$3.60
\$200,000	\$2.40	\$200,000	\$4.80
\$250,000	\$3.00	\$250,000	\$6.00
\$300,000	\$3.60	\$300,000	\$7.20
\$350,000	\$4.20	\$350,000	\$8.40
\$400,000	\$4.80	\$400,000	\$9.60
\$450,000	\$5.40	\$450,000	\$10.80
\$500,000	\$6.00	\$500,000	\$12.00

2012 Monthly Costs for Life Insurance

OHSU pays for the first \$25,000 of employee life insurance coverage. You pay for employee life insurance of up to \$50,000 total on a before-tax basis. If you select more than \$50,000 of employee life insurance, you pay for coverage on an after-tax basis. You pay for spouse/domestic partner and dependent life insurance coverage on an after-tax basis.

Employee Life Insurance (coverage in thousand dollar amounts)

Evidence of Insurability required for increases in life insurance or amounts greater than \$50,000 guarantee issue at time of initial enrollment.

Age	\$25	\$50	\$75	\$100	\$125	\$150	\$175	\$200	\$225	\$250
<30	0.00	\$0.58	\$1.16	\$1.74	\$2.30	\$2.88	\$3.46	\$4.04	\$4.60	\$5.18
30-34	0.00	0.78	1.56	2.34	3.10	3.88	4.66	5.44	6.20	6.98
35-39	0.00	1.18	2.36	3.54	4.70	5.88	7.06	8.24	9.40	10.58
40-44	0.00	1.36	2.70	4.06	5.40	6.76	8.10	9.46	10.80	12.16
45-49	0.00	2.34	4.66	6.98	9.30	11.64	13.96	16.28	18.60	20.94
50-54	0.00	3.70	7.40	11.10	14.80	18.50	22.20	25.90	29.60	33.30
55-59	0.00	5.26	10.50	15.76	21.00	26.26	31.50	36.76	42.00	47.26
60-64	0.00	7.58	15.16	22.74	30.30	37.88	45.46	53.04	60.60	68.18
65-69	0.00	13.60	27.20	40.80	54.40	68.00	81.60	95.20	108.80	122.40
70+	0.00	24.88	49.76	74.64	99.50	124.38	149.26	174.14	199.00	223.88

Age	\$525	\$550	\$575	\$600	\$625	\$650	\$675	\$700	\$725	\$750
<30	\$11.50	\$12.08	\$12.66	\$13.24	\$13.80	\$14.38	\$14.96	\$15.54	\$16.10	\$16.68
30-34	15.50	16.28	17.06	17.84	18.60	19.38	20.16	20.94	21.70	22.48
35-39	23.50	24.68	25.86	27.04	28.20	29.38	30.56	31.74	32.90	34.08
40-44	27.00	28.36	29.70	31.06	32.40	33.76	35.10	36.46	37.80	39.16
45-49	46.50	48.84	51.16	53.48	55.80	58.14	60.46	62.78	65.10	67.44
50-54	74.00	77.70	81.40	85.10	88.80	92.50	96.20	99.90	103.60	107.30
55-59	105.00	110.26	115.50	120.76	126.00	131.26	136.50	141.76	147.00	152.26
60-64	151.50	159.08	166.66	174.24	181.80	189.38	196.96	204.54	212.10	219.68
65-69	272.00	285.60	299.20	312.80	326.40	340.00	353.60	367.20	380.80	394.40
70+	497.50	522.38	547.26	572.14	597.00	621.88	646.76	671.64	696.50	721.38

\$275	\$300	\$325	\$350	\$375	\$400	\$425	\$450	\$475	\$500
\$5.76	\$6.34	\$6.90	\$7.48	\$8.06	\$8.64	\$9.20	\$9.78	\$10.36	\$10.94
7.76	8.54	9.30	10.08	10.86	11.64	12.40	13.18	13.96	14.74
11.76	12.94	14.10	15.28	16.46	17.64	18.80	19.98	21.16	22.34
13.50	14.86	16.20	17.56	18.90	20.26	21.60	22.96	24.30	25.66
23.26	25.58	27.90	30.24	32.56	34.88	37.20	39.54	41.86	44.18
37.00	40.70	44.40	48.10	51.80	55.50	59.20	62.90	66.60	70.30
52.50	57.76	63.00	68.26	73.50	78.76	84.00	89.26	94.50	99.76
75.76	83.34	90.90	98.48	106.06	113.64	121.20	128.78	136.36	143.94
136.00	149.60	163.20	176.80	190.40	204.00	217.60	231.20	244.80	258.40
248.76	273.76	298.50	323.38	348.26	373.14	398.00	422.88	447.76	472.64
\$775	\$800	\$825	\$850	\$875	\$900	\$925	\$950	\$975	\$1,000
\$17.26	\$17.84	\$18.40	\$18.98	\$19.56	\$20.14	\$20.70	\$21.28	\$21.86	\$22.44
23.26	24.04	24.80	25.58	26.36	27.14	27.90	28.68	29.46	30.24
35.26	36.44	37.60	38.78	39.96	41.14	42.30	43.48	44.66	45.84
40.50	41.86	43.20	44.56	45.90	47.26	48.60	49.96	51.30	52.66
69.76	72.08	74.40	76.74	79.06	81.38	83.70	86.04	88.36	90.68
111.00	114.70	118.40	122.10	125.80	129.50	133.20	136.90	140.60	144.30
157.50	162.76	168.00	173.26	178.50	183.76	189.00	194.26	199.50	204.76
227.26	234.84	242.40	249.98	257.56	265.14	272.70	280.28	287.86	295.44
408.00	421.60	435.20	448.80	462.40	476.00	489.60	503.20	516.80	530.40
746.26	771.14	796.00	820.88	845.76	870.64	895.50	920.38	945.26	970.14

continued on next page

Spouse/Domestic Partner Life Insurance (coverage in thousand dollar amounts)

Evidence of Insurability required for increases in life insurance or amounts greater than \$50,000 guarantee issue at time of initial enrollment.

Age	\$25	\$50	\$75	\$100	\$125	\$150	\$175	\$200	\$225	\$250
<30	\$0.58	\$1.16	\$1.74	\$2.30	\$2.88	\$3.46	\$4.04	\$4.60	\$5.18	\$5.76
30-34	0.78	1.56	2.34	3.10	3.88	4.66	5.44	6.20	6.98	7.76
35-39	1.18	2.36	3.54	4.70	5.88	7.06	8.24	9.40	10.58	11.76
40-44	1.36	2.70	4.06	5.40	6.76	8.10	9.46	10.80	12.16	13.50
45-49	2.34	4.66	6.98	9.30	11.64	13.96	16.28	18.60	20.94	23.26
50-54	3.70	7.40	11.10	14.80	18.50	22.20	25.90	29.60	33.30	37.00
55-59	5.26	10.50	15.76	21.00	26.26	31.50	36.76	42.00	47.26	52.50
60-64	7.58	15.16	22.74	30.30	37.88	45.46	53.04	60.60	68.18	75.76
65-69	13.60	27.20	40.80	54.40	68.00	81.60	95.20	108.80	122.40	136.00
70+	24.88	49.76	74.64	99.50	124.38	149.26	174.14	199.00	223.88	248.76

Dependent Life Insurance \$4,000

\$1.96 to cover your dependents

\$275	\$300	\$325	\$350	\$375	\$400	\$425	\$450	\$475	\$500
\$6.34	\$6.90	\$7.48	\$8.06	\$8.64	\$9.20	\$9.78	\$10.36	\$10.94	\$11.50
8.54	9.30	10.08	10.86	11.64	12.40	13.18	13.96	14.74	15.50
12.94	14.10	15.28	16.46	17.64	18.80	19.98	21.16	22.34	23.50
14.86	16.20	17.56	18.90	20.26	21.60	22.96	24.30	26.66	27.00
25.58	27.90	30.24	32.56	34.88	37.20	39.54	41.86	44.18	46.50
40.70	44.40	48.10	51.80	55.50	59.20	62.90	66.60	70.30	74.00
57.76	63.00	68.26	73.50	78.76	84.00	89.26	94.50	99.76	105.00
83.34	90.90	98.48	106.06	113.64	121.20	128.78	136.36	143.94	151.50
149.60	163.20	176.80	190.40	204.00	217.60	231.20	244.80	258.40	272.00
273.64	298.50	323.38	348.26	373.14	398.00	422.88	447.76	472.64	497.50

Quick Guide to Enrolling

1. **Review the benefits options available to you.** Pages 15-16 of this guide provide an overview of benefits options. Plan features are included in individual sections for each type of coverage. You can review benefit rates, benefit dollars and calculate your monthly cost using the benefits cost worksheets starting on Page 64.
2. **Determine your benefits selections.**
3. **Complete online enrollment for benefits within 60 days of your date of hire.** Instructions for enrolling through Employee Self Service Benefits are on Page 6.
Once you have enrolled the coverage effective date depends on your classification:

Benefits Enrollment — New Hire

	Enrollment Deadline	Effective Date of Coverage
Unclassified/ Academic	60 days from date of hire	First of the month following enrollment
ONA	60 days from date of hire	First of the month following enrollment
AFSCME	60 days from date of hire	First of the month following 60 days of employment and completion of enrollment
Relief when qualified	31 days from receipt of insurance packet	First of the month following enrollment

Note: Subject to the active work requirement,* your optional life insurance becomes effective on the first of the month following the date you enroll unless evidence of insurability is required.

*Refer to page 72 for definition.

Enrolling through Employee Self-Service Benefits

You can enroll quickly and easily in OHSU benefits through **Employee Self Service Benefits**, an Oracle-based software program. Online enrollment may be done from any OHSU workstation or a home computer via an Internet connection, using your Oracle password.

The self-service logon ID and password is the same as your windows computer ID and password.

To Enroll

From an OHSU workstation: Go to ozone.ohsu.edu/hr/benefits and click on the “Enroll in Benefits” link.

From a home computer: Go to www.ohsu.edu/hr/selfservice and click on the link for Employee Self Service Benefits.

1. Select “Oracle Applications and Employee Self Service”
2. Log in with your OHSU network user name and password.
3. Click on Employee Self Service OHSU. At the next screen, click on Benefits.
4. At the Dependents and Beneficiaries page, follow the online instructions to add any dependents you plan to enroll in benefits coverage and any beneficiaries for your life insurance.
5. Click on Next and follow the screen instructions to make your benefits selections.

Online Access

If you don't have access to a computer in your work area or from home, OHSU workstations are available at the following locations:

Marquam Hill Campus:

- Main Library, BICC (OHSU ID card required)
- Career Development Center, fourth floor, BICC

West Campus:

- Samuel L. Diack Library, OGI
- ONPRC Library

Marquam Plaza:

- HR Benefits Office

Before Enrolling

- Determine your benefits selections.
- Estimate dependent care and/or health care out-of-pocket expenses if you plan to enroll in either of the flexible spending accounts. (Use the worksheets on Pages 70-71 to help with estimating.)
- Know the birth dates and Social Security numbers for all dependents you want to enroll.

Enrollment Deadlines

You must complete benefits enrollment:

- Within 60 days of your date of hire.
- Within 60 days of the date of your change to benefits-eligible status.
- Within 31 days of a qualified family status change.
- During the annual open enrollment period (October).

Note: If you do not enroll during the appropriate enrollment period as defined above, you will be limited to default coverage (see Page 12).

What This Booklet Covers

This booklet covers the key features and provisions of the Plan as of January 1, 2012. It is not intended to cover every detail. In case of a conflict between this guide and the official plan documents of the OHSU benefits program, the official plan documents will govern. Participation in this program does not create an employment contract.

For more information about each plan, contact the medical, prescription, dental, vision, life and disability companies directly. Telephone numbers and Web sites are listed on the inside front cover. You may also view the most current information on the OHSU O-zone (ozone.ohsu.edu/hr/benefits).

This OHSU Program Selection Guide is one part of your summary plan description. Your complete summary plan description also includes:

- Provider Directories. Provider Directories undergo frequent changes. To obtain current information about available providers, contact the plan administrator at the number listed on the inside front cover of this guide.
- Medical, Dental, Vision, Life and Disability Plan Booklet and/or Evidence of Coverage, if applicable.

These materials are available on the OHSU O-zone. All materials, including Provider Directories, are provided free of charge. Any plan changes that occur during the year will be communicated separately from this book.

Termination and Amendment

OHSU reserves the right to amend, modify, or terminate any of its benefits plans at any time without prior notice.

Oregon Child Support Program

Effective October 1, 2003, the Oregon Child Support Program implemented use of a new federal notice, the National Medical Support Notice (NMSN). Oregon will issue the NMSN when employer-related health care coverage is ordered.

The OHSU program requires enrollment of the employee in order for dependents to be added. Upon receipt of the NMSN, OHSU will be required to enroll the employee and add the employee's dependents, waiving open enrollment requirements, as long as the amount of the premium does not exceed the maximum withholding limits as required by law. The premiums for health insurance must be withheld from any money paid to an employee by OHSU.

Women's Health and Cancer Rights Act of 1998

All OHSU medical plans provide benefits for mastectomy-related services, including reconstruction and surgery to achieve symmetry between the breasts, prostheses, and complications resulting from a mastectomy (including lymphedema). For more information, contact the medical plan administrator at the number listed on the inside front cover of this guide.

Childbirth Benefits

Under federal law, OHSU medical plans will cover hospital stays in connection with childbirth for at least:

- 48 hours following a normal vaginal delivery, and
- 96 hours following a cesarean delivery.

These periods apply to both mothers and newborns. Preauthorization is not required for stays up to these lengths. A mother and/or newborn may be discharged earlier if the mother and her or the newborn's physician agree.

Monthly Benefits Dollars and Benefits Costs

Your benefits dollars and benefits costs are split evenly between two pay periods each month. (The exceptions to this are STD and LTD premiums, which are deducted every pay period.)

Benefits dollars and benefits costs are for the month they are paid (e.g., January deductions are taken in January). Retroactive benefits dollars and refunds will be made as necessary according to changes in your monthly eligibility status.

Your contributions to the dependent care or health care flexible spending accounts (FSA) are deducted twice a month based on your total allocation for the plan year and are never in advance (e.g. January deductions are taken in January).

How OHSU Benefits Work

OHSU contributes a set amount of benefit dollars on your behalf each month to help pay for your OHSU benefits. Benefit dollars are based on medical election. Depending on how much your benefit choices cost, you may end up with extra benefit dollars per month or have to pay some of the additional costs through payroll deductions. Extra benefit dollars may be applied to additional benefit coverage. Your benefits dollars are listed on Page 68.

Monthly Benefit Costs

Each benefit option has a monthly cost. In general, the higher the level of coverage and the more eligible family members covered, the higher the cost.

Adding It Up

After you select the benefits you want, add up the total benefits costs and compare the result to the benefits dollars you receive from OHSU. You may use the Benefits Cost Worksheet on Page 69.

If your total cost is:

- ***The same as your benefits dollars***, you won't see a change in your paycheck. Your benefits dollars will cover the full cost of your benefits.
- ***More than your benefits dollars***, you will pay the difference through biweekly payroll deductions.

Fast Facts

Important considerations you need to know when purchasing benefits are:

- You use pre-tax dollars to pay for medical, dental and the first \$25,000 of employee life insurance. If you participate in the dependent care flexible spending account or the health care flexible spending account, your contributions also are made on a pre-tax basis.
- Monthly costs for medical, dental, life insurance, AD&D and FSA are deducted in two pay periods each month (24 times a year). STD and LTD costs are deducted each pay period (26 times a year).
- You make post-tax payments for employee life insurance over \$25,000, domestic partner/children of domestic partner medical and dental insurance, spouse/domestic partner life insurance, dependent life insurance, AD&D, STD, and LTD coverage.

Note: The same-sex domestic partner premiums are paid on an post-tax basis for federal tax and on a pre-tax basis for Oregon state income tax.

OHSU Tax Advantages

When you pay for your benefits on a pre-tax basis, your payments are deducted from your pay before federal, state and Social Security taxes are withheld. Because the income used to determine your taxes is less, the amount withheld from your paycheck is less. As a result, you may take home more money than if deductions were made on an post-tax basis. Keep in mind that some OHSU benefits come out of your allowance on an post-tax basis.

How much can you save? You can use a simple formula to estimate your tax savings:

$$\begin{aligned} &\text{Your pre-tax benefits costs} \\ &\quad \times \\ &\quad \text{Your tax rate} \\ &\text{(federal income tax bracket + Social Security} \\ &\quad \text{+ Oregon state income tax bracket)} \\ &\quad = \\ &\text{Your tax savings} \end{aligned}$$

Changing Your Selections During the Year

The benefits you select provide coverage for you and your enrolled qualified dependents for the entire calendar plan year, January 1 through December 31. Internal Revenue Code Regulations state that you can change your benefits selections during the plan year only if you experience an eligible change in family status. Otherwise, you have to wait until the next open enrollment to make a change.

Eligible changes* in family status include:

- Your marriage or divorce.
- Commencement or termination of domestic partnership.
- Birth or adoption of a child.
- Child by court-ordered judgement.
- Death of your spouse/domestic partner or other covered dependent.
- Change in your (or your spouse's/domestic partner's) employment status, including:
 - You or your spouse/domestic partner take an unpaid leave of absence.
 - You experience a significant change in your or your spouse's/domestic partner's eligibility for health care coverage due to a change in employment status.
- A change in your dependent care situation, such as a change in day care providers, the amount your provider charges changes or the amount of care you require changes.

If you experience a qualified change in family status, you must complete an update form within 31 days to change your benefits selections.

In addition, your change in coverage must be consistent with your change in family status. For example, if you adopt a child, you can add that child to your health care coverage, but you cannot drop your health care coverage.

See the Status Change Summary on Page 77 for more information on coverage changes allowed.

*Refer to Page 74 for definition of dependent eligibility.

Annual Open Enrollment

Annual open enrollment is October of each year. Employees may add, drop, increase or decrease insurance coverage during that time. Changes are effective January 1st of the following plan year.

Default Coverage

If you don't submit your OHSU enrollment by the applicable deadline, you will be limited to default coverage for employee only that includes:

- OHSU PPO
- ODS dental coverage
- Employee core life insurance of \$25,000

If you receive default benefits, you must wait until the next open enrollment to make changes, unless you experience an eligible change in family status. You also will not be able to enroll in other OHSU plans until the next open enrollment period.

Remember ...

You must enroll:

- **Within 60 days of your date of hire.**
- **Within 60 days of the date of your change to benefits-eligible status.**
- **Within 31 days of a qualified family status change.**
- **During the annual open enrollment period in October.**

Benefits Options — Required Coverage

Medical

Medical coverage is required, either through OHSU or another group medical plan.

You must enroll in medical insurance coverage for yourself or you may opt out of medical insurance if you can show proof of coverage under another employer's group medical plan. To opt out, you must list the name of the other employer's group medical plan and policy number in the OHSU Medical/Dental Enrollment. You will receive a reduced amount of benefit dollars (flex credits) if you choose to opt out.

If you are covered under another employer's group medical plan and later lose that coverage, you must enroll in the OHSU medical coverage within 31 days of losing your other group medical insurance. You may enroll yourself and any other eligible qualified dependents at that time. Update forms are available in the Human Resources Department Benefits Office.

Note: Student insurance, Oregon Health Plan, Medicare/Medicaid or individual medical plans are not considered group medical plans.

Dental

You must enroll in dental insurance coverage for yourself or you may opt out of the dental insurance if you can show proof of coverage under another employer's group dental plan. However if you opt out of dental insurance, please be aware that you will not be eligible to participate in an OHSU dental plan for one year unless you have a qualified status change.

Life Insurance

You will receive \$25,000 of core life insurance coverage through OHSU at no cost to you.

Additional employee coverage is available from \$25,000 up to 1,000,000, in increments of \$25,000. The \$25,000 basic coverage is included in the maximum coverage limit.

Benefit Options — Optional Coverage

OHSU also offers a variety of optional benefits, including:

- Spouse/domestic partner and child(ren) medical insurance.
- Spouse/domestic partner and child(ren) dental insurance.
- Spouse/domestic partner life insurance.
- Dependent child life insurance.
- Accidental Death and Dismemberment (AD&D) insurance.
- Short-Term disability (STD) insurance.
- Long-Term disability (LTD) insurance.
- Dependent care flexible spending account.
- Health care flexible spending account.

Long-term Care Insurance

You and your qualified family members also have the opportunity to purchase long-term care insurance at group rates through an OHSU agreement with the Prudential Insurance Company of America. You may enroll in long-term care at any time by calling Prudential at 800 732-0416 to request an enrollment packet.

Overview of Your Benefits Options

As a benefit-eligible employee, you may choose from a variety of benefits options to create a personalized benefits package. You also may enroll your eligible dependents. The chart below summarizes the benefits options available through OHSU.

A Look at your OHSU Benefits Options	
Benefits	Options
Medical (includes vision and prescription drug benefits)	<p>Preferred Provider Organizations</p> <ul style="list-style-type: none"> ■ OHSU PPO Plan ■ 250 PPO Plan ■ OHSU PPO Standard Plan ■ 250 PPO Standard Plan <p>Health Maintenance Organization</p> <ul style="list-style-type: none"> ■ Kaiser Permanente (available only to employees hired before certain dates in 1998) <p>Note: If you can provide proof of coverage under another employer's group plan, you may opt out of medical coverage.</p> <p>Plan features begin on Page 24. Monthly premium rates are on Page 5.</p>
Dental	<p>Traditional Plan</p> <ul style="list-style-type: none"> ■ Oregon Dental Service (ODS) <p>Managed Care Plans</p> <ul style="list-style-type: none"> ■ Kaiser Permanente ■ Willamette Dental Insurance Inc. <p>If you can provide proof of coverage under another employer's group dental plan, you may opt out of dental coverage.</p> <p>Plan features begin on Page 43. Monthly premium rates are on Page 5.</p>

Benefits	Options
Life Insurance	<p>Employee Life Insurance You will receive \$25,000 of employee core life insurance coverage at no cost. Additional employee life is available from \$25,000 up to \$1,000,000 (in increments of \$25,000). The \$25,000 core coverage is included in the maximum coverage limit.</p> <p>Optional Spouse/Domestic Partner Life Insurance Coverage of \$4,000 or increments of \$25,000 up to \$500,000 for your spouse/domestic partner.</p> <p>Optional Dependent Life Insurance Coverage of \$4,000 each is available for your children at initial enrollment or a qualified family status change.</p> <p>Plan features begin on Page 46. Monthly premium rates begin on Page 7.</p>
Accidental Death and Dismemberment (AD&D)	<p>Optional employee coverage Coverage in increments of \$50,000 – \$500,000 for employee</p> <p>Optional family coverage Coverage for each of your qualified dependents is set at a fixed percentage of your employee AD&D coverage amount.</p> <p>Plan features begin on Page 49. Monthly premium rates are on Page 6.</p>
Disability	<p>Optional Short-Term Disability Insurance (STD) Benefits paid are equal to 65 percent of the first \$1,923 of your weekly earnings (coordinated with other sources of income) for up to 180 days from the date of disability, beginning on the pay date option you select:</p> <ul style="list-style-type: none"> ■ 8th day of disability ■ 30th day of disability ■ 90th day of disability <p>Note: You must use all of your sick days before full STD benefits begin, regardless of the pay date option you choose.</p> <p>Optional Long-Term Disability Insurance (LTD) Benefits paid are equal to 65 percent of the first \$8,333 of your monthly earnings, (coordinated with other sources of income), after you have been disabled for 180 days.</p> <p>Plan features begin on Page 56. Monthly premium rates are on Page 5.</p>
Dependent Care Flexible Spending Account (DFSA)	<p>You may contribute up to \$5,000 a year (\$2,500 if you are married and file separate tax returns) to pay for eligible dependent care expenses on a pre-tax basis. Plan features begin on page 64.</p>
Health Care Flexible Spending Account (HFSA)	<p>You may contribute up to \$2,500 a year to pay for eligible health care expenses on a pre-tax basis. Plan features begin on page 62.</p>

Medical Options

3 PPOs

- OHSU PPO
- OHSU PPO Standard
- 250 PPO Plan
- 250 PPO Standard

1 HMO

- Kaiser Permanente
(available only to
employees hired
before a certain
date in 1998)

Highlights Of Your Medical Insurance Options

For many employees, the option to purchase medical coverage is one of the most important benefits provided by OHSU. To help ensure that this important benefit meets your needs, OHSU provides you with a choice of medical plans. The medical options differ primarily in terms of monthly costs, choice of physicians and how your benefits are paid.

Fast Facts

- Because OHSU offers multiple medical plans, you may choose coverage that best fits your and your family's needs.
- If you are an active employee age 65 or older in a .5 FTE position or greater, see Page 40 for important information regarding Medicare.
- OHSU medical insurance coverage is a pre-tax benefit. The portion of the monthly cost for domestic partner and child(ren) of domestic partner coverage is a post-tax benefit.

Opting Out of Medical Coverage

You can opt out of medical coverage if you provide proof of coverage under another employer's group health plan. If you decide to opt out, you will receive a reduced amount of benefits dollars (flex credits).

OHSU Preferred Provider Plan (PPO)

BASICS	OHSU Provider	Non-OHSU Provider
How the plan works	Pays benefits for covered services from any qualified provider or hospital. To receive the highest level of benefits, you must use an OHSU preferred provider, hospital or clinic.	
What the plan pays for most covered services	80%, after the deductible	60% of allowable charges, after the deductible
Annual deductible — <i>applies to all services unless otherwise noted</i>	\$200/person \$600/family	
Annual out-of-pocket maximum — <i>includes deductible</i>	\$1,200/person \$2,600/family	\$2,200/person \$4,600/family
Requirements	Must have PCP and complete one of five requirements	
Lifetime maximum benefit	none	
IN THE DOCTOR'S OFFICE		
Home and office visits	100% after \$25 copayment (deductible waived)	60% of allowable charges
Routine physicals (limited to the plan schedule) — includes well child care	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
OB/GYN annual exams	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
Well baby care	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
IN THE HOSPITAL		
Inpatient physician services	80%	60% of allowable charges
Hospital/facility charges	80%	60% of allowable charges
Emergency care	80% then \$30 copayment; copayment waived if admitted	80% of allowable charges after \$30 copayment; copayment waived if admitted
OTHER COVERED SERVICES		
Maternity	80% of allowable charges	60% of allowable charges
Chemical dependency		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
Mental Health		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
SERVICES PROVIDED BY OTHER PLANS		
Prescription Drug Benefits ODS Rx	Participating pharmacy Plan pays: See chart on page 34 \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family	Non-participating pharmacy Plan pays amount equivalent to PDP costs minus the applicable coinsurance amount No deductible \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family
Vision Benefits Vision Service Plan (VSP) <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	VSP providers: Plan pays: exam paid in full; single vision, lined bifocals and lined trifocals \$25 copayment; up to \$120 allowance for elective contacts No deductible	Non-VSP doctors: Plan pays: exam reimbursed up to \$45, Single vision lenses \$45, Bifocal lenses \$65, Trifocal lenses \$85, Frame \$47, Contacts \$140 (in lieu of glasses)

OHSU Preferred Provider Plan (PPO) Standard

BASICS	OHSU Provider	Non-OHSU Provider
How the plan works	Pays benefits for covered services from any qualified provider or hospital. To receive the highest level of benefits, you must use an OHSU preferred provider, hospital or clinic.	
What the plan pays for most covered services	80%, after the deductible	60% of allowable charges, after the deductible
Annual deductible — <i>applies to all services unless otherwise noted</i>	\$200/person \$600/family	
Annual out-of-pocket maximum — <i>includes deductible</i>	\$1,200/person \$2,600/family	\$2,200/person \$4,600/family
Lifetime maximum benefit	none	
IN THE DOCTOR'S OFFICE		
Home and office visits	100% after \$25 copayment (deductible waived)	60% of allowable charges
Routine physicals (limited to the plan schedule) — includes well child care	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
OB/GYN annual exams	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
Well baby care	100%, no deductible subject to frequency limitations	60% of allowable charges subject to frequency limitations
IN THE HOSPITAL		
Inpatient physician services	80%	60% of allowable charges
Hospital/facility charges	80%	60% of allowable charges
Emergency care	80% then \$30 copayment; copayment waived if admitted	80% of allowable charges after \$30 copayment; copayment waived if admitted
OTHER COVERED SERVICES		
Maternity	80% of allowable charges	60% of allowable charges
Chemical dependency		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
Mental Health		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
SERVICES PROVIDED BY OTHER PLANS		
Prescription Drug Benefits ODS Rx	Participating pharmacy Plan pays: See chart on page 34 \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family	Non-participating pharmacy Plan pays amount equivalent to PDP costs minus the applicable coinsurance amount No deductible \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family
Vision Benefits Vision Service Plan (VSP) <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	VSP providers: Plan pays: exam paid in full; single vision, lined bifocals and lined trifocals \$25 copayment; up to \$120 allowance for elective contacts No deductible	Non-VSP doctors: Plan pays: exam reimbursed up to \$45, Single vision lenses \$45, Bifocal lenses \$65, Trifocal lenses \$85, Frame \$47, Contacts \$140 (in lieu of glasses)

250 PPO Plan

BASICS	Preferred Provider	Non-preferred Provider
How the plan works	Pays benefits for covered services you receive from any qualified provider or hospital. To receive the highest level of benefits, you must use an Aetna Preferred Provider.	
What the plan pays for most covered services	80%, after the deductible	60% of allowable charges, after the deductible
Annual deductible — <i>applies to all services unless otherwise noted</i>	\$250/person \$750/family	
Annual out-of-pocket maximum — <i>includes deductible</i>	\$2,250/person \$4,750/family	\$4,250/person \$8,750/family
Requirements	Must have PCP and complete one of five requirements	
Lifetime maximum benefit	none	
IN THE DOCTOR'S OFFICE		
Home and office visits	100% after \$25 copayment (deductible waived)	60% of allowable charges
Routine physicals (limited to the plan schedule) — includes well child care	100%, no deductible subject to frequency limitations	60% of allowable charges
OB/GYN annual exams	100%, no deductible subject to frequency limitations	60% of allowable charges, subject to frequency limitations
Well baby care	100%, no deductible; subject to frequency limitations	60% of allowable charges, subject to frequency limitations
IN THE HOSPITAL		
Inpatient physician services	80%	60% of allowable charges
Hospital/facility charges	80%	60% of allowable charges
Emergency care	80%, after \$30 copayment; copayment waived if admitted	80% of allowable charges after \$30 copayment; copayment waived if admitted
OTHER COVERED SERVICES		
Maternity	80% of allowable charges	60% of allowable charges
Chemical dependency		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
Mental Health		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
SERVICES PROVIDED BY OTHER PLANS		
Prescription Drug Benefits ODS Rx	Participating pharmacy Plan pays: See chart on page 34 \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family	Non-participating pharmacy Plan pays amount equivalent to PDP costs minus the applicable coinsurance amount No deductible \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family
Vision Benefits Vision Service Plan (VSP) <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	VSP providers: Plan pays: exam paid in full; single vision, lined bifocals and lined trifocals \$25 copayment; up to \$120 allowance for elective contacts No deductible	Non-VSP doctors: Plan pays: exam reimbursed up to \$45, Single vision lenses \$45, Bifocal lenses \$65, Trifocal lenses \$85, Frame \$47, Contacts \$140 (in lieu of glasses)

250 PPO Plan Standard

BASICS	Preferred Provider	Non-preferred Provider
How the plan works	Pays benefits for covered services you receive from any qualified provider or hospital. To receive the highest level of benefits, you must use an Aetna Preferred Provider.	
What the plan pays for most covered services	80%, after the deductible	60% of allowable charges, after the deductible
Annual deductible — <i>applies to all services unless otherwise noted</i>	\$250/person \$750/family	
Annual out-of-pocket maximum — <i>includes deductible</i>	\$2,250/person \$4,750/family	\$4,250/person \$8,750/family
Lifetime maximum benefit	none	
IN THE DOCTOR'S OFFICE		
Home and office visits	100% after \$25 copayment (deductible waived)	60% of allowable charges
Routine physicals (limited to the plan schedule) — includes well child care	100%, no deductible subject to frequency limitations	60% of allowable charges
OB/GYN annual exams	100%, no deductible subject to frequency limitations	60% of allowable charges, subject to frequency limitations
Well baby care	100%, no deductible; subject to frequency limitations	60% of allowable charges, subject to frequency limitations
IN THE HOSPITAL		
Inpatient physician services	80%	60% of allowable charges
Hospital/facility charges	80%	60% of allowable charges
Emergency care	80%, after \$30 copayment; copayment waived if admitted	80% of allowable charges after \$30 copayment; copayment waived if admitted
OTHER COVERED SERVICES		
Maternity	80% of allowable charges	60% of allowable charges
Chemical dependency		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
Mental Health		
Outpatient	80% of allowable charges	60% of allowable charges
Inpatient	80% of allowable charges	60% of allowable charges
SERVICES PROVIDED BY OTHER PLANS		
Prescription Drug Benefits ODS Rx	Participating pharmacy Plan pays: See chart on page 34 \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family	Non-participating pharmacy Plan pays amount equivalent to PDP costs minus the applicable coinsurance amount No deductible \$1,500 out-of-pocket maximum per individual \$2,500 out-of-pocket maximum per family
Vision Benefits Vision Service Plan (VSP) <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	VSP providers: Plan pays: exam paid in full; single vision, lined bifocals and lined trifocals \$25 copayment; up to \$120 allowance for elective contacts No deductible	Non-VSP doctors: Plan pays: exam reimbursed up to \$45, Single vision lenses \$45, Bifocal lenses \$65, Trifocal lenses \$85, Frame \$47, Contacts \$140 (in lieu of glasses)

Kaiser Permanente

BASICS	
How the plan works	Except for emergencies, all care must be provided by Kaiser Permanente's participating providers at Kaiser Permanente facilities.
What the plan pays for most covered services	100% after any applicable copayments
Annual deductible — <i>applies to all services unless otherwise noted</i>	None
Annual out-of-pocket maximum — <i>includes deductible</i>	\$1,000/person \$2,000/family
Lifetime maximum benefit	None
IN THE DOCTOR'S OFFICE	
Home and office visits	\$15 copayment
Routine physicals (limited to the plan schedule) — includes well child care	no copayment
OB/GYN annual exams	\$15 copayment
Well baby care	no copayment, covered as necessary
IN THE HOSPITAL	
Inpatient physician services	Paid in full
Hospital/facility charges	\$200 copayment per admission
Emergency care	\$75 copayment at Kaiser and non-Kaiser facilities (waived if admitted)
OTHER COVERED SERVICES	
Maternity	Covered the same as any other condition
Chemical dependency – Limits are per 12-month benefit period	
Outpatient	\$15 copayment
Inpatient	Unlimited days at inpatient hospital copay.
Mental Health	
Outpatient	\$15 copayment
Inpatient	Unlimited days at inpatient hospital copay.
SERVICES PROVIDED BY OTHER PLANS	
Prescription Drug Benefits	Benefit through Kaiser Permanente: \$15 copayment per formulary prescription at Kaiser pharmacies
Vision Benefits <i>Exam allowed every 12 months, lenses and frames every 24 months</i>	Benefit through Kaiser Permanente: \$15 copayment for exams (not limited). Lenses, frames and/or contacts covered up to \$150 every 24 months.

OHSU PPO

The OHSU PPO plan has a lower deductible and out-of-pocket maximum than the other two PPO plans and offers the same services. In addition, your monthly employee premiums will be lower if you participate in the OHSU PPO plan.

The OHSU PPO plan provides services through a network of OHSU preferred providers – physicians, the hospital and clinics. You can go to any physician, hospital or qualified provider (OHSU providers or non-OHSU providers).

The Tuality Health Alliance, featuring Tuality Hospital and its associated physicians, is now in-network for the OHSU PPO. OHSU PPO members may receive in-network benefits when they receive services through the Tuality Health Alliance.

The difference is you receive a higher level of coverage when you use an OHSU provider. When you go to a non-OHSU provider, you will pay 40 percent of allowable charges for most services, and you may pay any amounts over and above the allowable charge. Allowable charges are charges that OHSU providers have agreed to accept as payment for medically necessary covered services. For the most current OHSU provider information, visit www.aetna.com/docfind/custom/ohsu and click on Find a Doctor.

See Page 24 for a summary of plan features.

■ **OHSU PPO has requirements to maintain enrollment in 2013**

- Designate a PCP in Oracle Employee Self Service
- If identified for OHSU Care Coordination, you need to actively participate in the program

AND one of the following prior to October 2012

1. Complete OHSU sponsored weight management program
2. Complete OHSU Smoking Cessation Program
3. Complete 1,000 HealthySteps Points
4. Complete HealthyTeamHealthyU
5. Complete Health Risk Assessment on **Aetna.com** and any recommended eLearnings

■ Standard plans have the same schedule of benefits for 2012 but no enrollment requirements

- Premiums are five percent higher than OHSU PPO and 250 PPO

■ **OHSU Care Coordination**

- Collaborative effort between OHSU Benefits and OHSU Clinics
- OHSU Clinics combined medical record with claims data to identify those individuals who would most likely benefit from additional care coordination. Care coordination involves the provider and RN Case Manager working closely with the individual to develop and execute a plan to improve health status.

Receiving Care Out of the Area

Keep in mind that when you receive non-emergency care from a non-OHSU provider, such as when you are living or traveling outside of the OHSU service area, you will pay more out of pocket. Also, if your dependents attend school outside the OHSU service area, your dependents will receive the non-OHSU level of benefits coverage.

250 PPO Plan

You can go to any physician, hospital or qualified provider (Aetna preferred. or nonpreferred) when you need medical care for covered services. The difference is you will receive a higher level of coverage and your out-of-pocket expenses will be lower when you use an Aetna preferred provider. When you go to a nonpreferred provider under the 250 PPO Plan, you will pay 40 percent of allowable charges and you may have to pay any amounts over and above the allowable charges. Allowable charges are charges that 250 PPO Plan preferred providers have agreed to accept as payment for medically necessary covered services. When you receive covered services from Aetna preferred providers, you are not responsible for any amounts that exceed allowable charges.

For the most current provider directory, visit the Aetna Web site at www.aetna.com/docfind/custom/ohsu. You may also request a printed copy of the provider directory by calling Aetna at 800 541-0429.

See Page 26 for a summary of plan features.

■ 250 PPO has requirements to maintain enrollment in 2013

- Designate a PCP in Oracle Employee Self Service
- If identified for OHSU Care Coordination, you need to actively participate in the program

AND one of the following prior to October 2012

1. Complete OHSU sponsored weight management program
2. Complete OHSU Smoking Cessation Program
3. Complete 1,000 HealthySteps Points
4. Complete HealthyTeamHealthyU
5. Complete Health Risk Assessment on Aetna.com and any recommended eLearnings

■ Standard plans have the same schedule of benefits for 2012 but no enrollment requirements

- Premiums are five percent higher than OHSU PPO and 250 PPO

■ OHSU Care Coordination

- Collaborative effort between OHSU Benefits and OHSU Clinics
- OHSU Clinics combined medical record with claims data to identify those individuals who would most likely benefit from additional care coordination. Care coordination involves the provider and RN Case Manager working closely with the individual to develop and execute a plan to improve health status.

OHSU PPO Standard Plan

The OHSU PPO plan has a lower deductible and out-of-pocket maximum than the other two PPO plans and offers the same services. In addition, your monthly employee premiums will be lower if you participate in the OHSU PPO plan.

The OHSU PPO plan provides services through a network of OHSU preferred providers – physicians, the hospital and clinics. You can go to any physician, hospital or qualified provider (OHSU providers or non-OHSU providers).

The Tuality Health Alliance, featuring Tuality Hospital and its associated physicians, is now in-network for the OHSU PPO. OHSU PPO members may receive in-network benefits when they receive services through the Tuality Health Alliance.

The difference is you receive a higher level of coverage when you use an OHSU provider. When you go to a non-OHSU provider, you will pay 40 percent of allowable charges for most services, and you may pay any amounts over and above the allowable charge. Allowable charges are charges that OHSU providers have agreed to accept as payment for medically necessary covered services. For the most current OHSU provider information, visit www.aetna.com/docfind/custom/ohsu and click on Find a Doctor.

See Page 25 for a summary of plan features.

Receiving Care Out of the Area

Keep in mind that when you receive non-emergency care from a non-OHSU provider, such as when you are living or traveling outside of the OHSU service area, you will pay more out of pocket. Also, if your dependents attend school outside the OHSU service area, your dependents will receive the non-OHSU level of benefits coverage.

250 PPO Standard Plan

You can go to any physician, hospital or qualified provider (Aetna preferred. or nonpreferred) when you need medical care for covered services. The difference is you will receive a higher level of coverage and your out-of-pocket expenses will be lower when you use an Aetna preferred provider. When you go to a nonpreferred provider under the 250 PPO Plan, you will pay 40 percent of allowable charges and you may have to pay any amounts over and above the allowable charges. Allowable charges are charges that 250 PPO Plan preferred providers have agreed to accept as payment for medically necessary covered services. When you receive covered services from Aetna preferred providers, you are not responsible for any amounts that exceed allowable charges.

For the most current provider directory, visit the Aetna Web site at www.aetna.com/docfind/custom/ohsu. You may also request a printed copy of the provider directory by calling Aetna at 800 541-0429.

See Page 27 for a summary of plan features.

Exclusions and Limitations

The following list shows some of the limitations and exclusions that apply to all of the OHSU medical plans. For a complete list of limitations and exclusions refer to your medical member handbook or, contact Aetna at 800 541-0429.

- Cosmetic surgery
- Infertility services, including infertility drugs and in vitro fertilization
- Surgery to alter the refractive character of the eye
- Gender identity disorders
- Developmental disabilities not related to a medical condition
- Counseling or treatment in the absence of illness
- Experimental or investigational services
- Treatment of any condition arising out of service in the armed forces of any country
- Some treatments are limited by days, visits or dollar amounts
- Orthognathic surgery for TMJ

Exclusions and Limitations

All the PPO plans offered by OHSU have the same exclusions and limitations.

Kaiser Permanente HMO

Kaiser Permanente HMO is available only to AFSCME-represented employees hired before October 1, 1998, and ONA-represented, academic and unclassified employees hired before January 1, 1998. Kaiser Permanente facilities are located in the Portland metropolitan area, and in Vancouver and Longview, Wash. Except for emergencies (a life- or limb-threatening situation) or by referral, you must receive services at a Kaiser facility or affiliated facility to be covered. Call Kaiser at 503 813-2000 or 800 813-2000 to request a list of Kaiser facilities. You also may visit Kaiser's Web site at www.kp.org.

See Page 28 for a summary of plan features.

Exclusions and Limitations

The following list shows some of the limitations and exclusions that apply to the Kaiser Permanente plan. ***For a complete list, contact Kaiser.***

- Reversal of sterilization
- Acupuncture
- Cosmetic surgery
- Gender Identity Disorder
- Experimental or investigational treatment
- Conditions connected to military service
- Organ and bone marrow transplants (in some situations)

Things to Consider

As you decide which medical plan may be right for your individual and family circumstances, you may want to consider the following:

- Is other group medical coverage available to you or your family members – for example, through the employer of your spouse or domestic partner? If so, do you prefer that coverage or coverage available through OHSU? If you select your spouse's or domestic partner's coverage, you can opt out of medical coverage under OHSU
- How do you decide which PPO plan is right for you? There are a number of things to consider:
 - Which providers are included in the network? The OHSU PPO, OHSU PPO Standard preferred providers are included in the 250 PPO Plan and 250 PPO Standard Plan network.
 - Compare the monthly premium against your anticipated use of medical plan benefits.

Prescription Benefits for the OHSU PPO, OHSU PPO Standard, 250 PPO and 250 PPO Plan Standard

Prescription drug benefits are offered through the Oregon Prescription Drug Program and administered by ODS. This applies to all medical plans except the Kaiser Permanente HMO plan.

You will receive an ODS/OPOP prescription drug card in the mail after initial enrollment. Present this card at participating pharmacies to receive the highest level of benefits. To find an in-network pharmacy, please visit ODS online at www.odskompanies.com or call ODS Pharmacy Customer Service.

The OHSU pharmacy program is designed to provide cost saving incentives if you seek care from an OHSU provider and fill prescriptions at an OHSU pharmacy. Save money by filling your prescriptions through one of the five OHSU retail locations or OHSU mailorder pharmacy. For more information about the OHSU pharmacies and their locations visit www.ohsu.edu/xd/health/services/pharmacy/.

The ODS Preferred Drug List may be used to view medication options, and to help you determine your out-of-pocket costs on commonly prescribed generic, preferred brand and non-preferred brand drugs. The list is developed and maintained based on the recommendations of practicing physicians and pharmacists using national treatment guidelines.

As an ODS member, you have access to myODS, your personalized member website that has information pertaining to your dental and prescription benefits. In addition, myODS allows you to manage your account online. You and your covered family members can access claim status and history, download authorization and claim forms, view your detailed Member Handbook, obtain a prescription price quote and more.

For more information about your ODS prescription benefit call 503-412-4060 or toll-free 866-939-1660 or visit the ODS web site at www.odskompanies.com.

■ Pharmacy Highlights

- Added value tier
 - Currently includes select medications used to treat asthma, heart, cholesterol, high blood pressure, diabetes, depression, and pain/ arthritis
- High cost generic under preferred tier
 - Examples of current high cost generic medications include amnesteem, fentanyl, venlafaxine hcl ER.
- \$100 max copay on all prescriptions
- Individual max of \$1,500 per plan year out of pocket maximum on all tiers.
- The family out of pocket maximum per plan year, is \$2,500 for all tiers.

	Retail (30 day supply)	Mail-order (90 day supply)	Specialty (30 day supply)
OHSU Pharmacies			
Value	\$2	\$6	N/A
Generic	20%, \$100 max	10%, \$100 max	25%, \$100 max
Preferred	30%, \$100 max	20%, \$100 max	25%, \$100 max
Non-Preferred	50%, \$100 max	33%, \$100 max	50%, \$100 max
OPDP Pharmacies			
Value	\$4	N/A	N/A
Generic	25%, \$10 min & \$100 max	N/A	25%, \$100 max
Preferred	35%, \$10 min & \$100 max	N/A	25%, \$100 max
Non-Preferred	50%, \$10 min & \$100 max	N/A	50%, \$100 max

Out of Pocket Maximum

\$1,500 individual maximum on all tiers/ \$2,500 family maximum on all tiers

Prescription Plan Overview

Days Supply

Maximus supply through retail pharmacy 30 days
 Maximum supply through mail-order pharmacy 90 days
 Maximum day supply through specialty pharmacy 30 days

Required Utilization Prior to Refill

Refill after 75 percent utilization

Prior Authorization

Certain prescription drugs and/or quantities of prescription drugs may require prior authorization. Prior authorization programs are not intended to create barriers or limit access to medications. Requiring prior authorization is intended to support cost effectiveness, promote proper use of medications and to ensure the safety of all members. Prior authorizations may be required on medications for a variety of reasons. Including the examples listed below:

- a. Utilization Control Edits.** Medications may have limited use, be prone to overuse or prescribed in quantities outside the recommended FDA Indications.
- b. Cost Effectiveness.** There may be therapeutically equivalent medications that are less expensive.
- c. Prescribing Guidelines.** Medications may require diagnostic testing to ensure safety and efficacy of the treatment.
- d. Benefit Coverage.** Medications may be prescribed for conditions that are excluded under the Plan.

It is recommended that you view the listing of Prescription Medications Requiring Prior Authorization available through your myODS account

Specialty

The plan provides members prescribed specialty medications (including orphan drugs), access to enhanced clinical services and exclusive specialty pharmacy through OHSU Physicians Pavilion or OHSU mail-order pharmacy and BioScrip Pharmacy Services. Certain medications, including most self-injectables, as well as other medications defined as specialty products (e.g., Enbrel, Copaxone, Avonex), must be purchased through the exclusive specialty pharmacy provider to be a covered benefit. If a member does not purchase these drugs at the in-network specialty pharmacy provider, the drug expense will not be covered.

The ODS Pharmacy Customer Service department, members' pharmacist, physician and other medical providers can advise if a prescription requires delivery by an in-network specialty pharmacy provider. Specialty medications are often indicated to treat complex chronic health conditions. Respecting that specialty treatments often require special handling techniques, careful administration and a unique ordering process, enhanced member services are provided by the plan. Information about the clinical services and a list of eligible specialty medications, including where they can be obtained, can be accessed on myODS or through ODS' Pharmacy Customer Service department

Important phone numbers

ODS Pharmacy Customer Service	503 412-4060 or toll-free, 866 939-1660
OHSU mail-order pharmacy	866-770-2666
Walgreens mail-order pharmacy.....	866-487-8744
OHSU Specialty – Physicians Pavilion Pharmacy	866-770-2666
BioScrip Specialty Pharmacy	877 316-8921

If you have any questions, please feel free to contact ODS Pharmacy Customer Service.

This is a summary only. For a complete description please refer to your Member Handbook available at www.odscompanies.com through your myODS account.

Casey Eye Institute

You or your dependents may receive care for your vision needs through the excellent providers at OHSU's Casey Eye Institute. Both the contact lens and optical services at CEI participate in the VSP program. To schedule an eye exam, call 503 494-4029 for adults and 503 494-4960 for children under age 16.

Providers at Casey Eye Institute may be available to provide medical services related to illness, injury or disease not covered by VSP if you are enrolled in the OHSU PPO, OHSU PPO Standard, 250 PPO and 250 PPO Standard.

Vision Benefits

If you select the OHSU PPO, OHSU PPO Standard, 250 PPO or 250 PPO Standard plan, your vision care services are insured through Vision Service Plan (VSP). The following page lists the main features of your vision plan. If you are enrolled in the Kaiser Permanente HMO, your vision benefits are through Kaiser.

Find the Right VSP Doctor For You

To receive the highest level of benefits you must see a VSP doctor. You can locate a VSP doctor by calling 800 877-7195. You also may visit the VSP Web site at www.vsp.com to select a doctor. Select Members. Next, under View Your Benefits select Benefits Overview. To register follow the steps to complete registration. The website will provide you with benefit details, an out of network reimbursement form, help finding a VSP provider by location and other resources.

Once you have located a VSP doctor, you may call the office to make an appointment. You do not need an ID card to access services. Identify yourself as a VSP member and provide the covered member's Social Security Number. The VSP doctor will call VSP to verify eligibility and plan coverage.

When you receive services from a VSP doctor, you will not need to submit a claim form.

When Seeing a Non-Network Doctor

If you obtain services from a non-Network doctor, you must request reimbursement from VSP by submitting the bill to VSP within six months from your date of service. Out of network reimbursement forms are available on the Website www.vsp.com/member or call VSP 800 877-7195.

Submit non-VSP doctor claims to:

VSP
P.O. Box 997105
Sacramento, CA 95899

VSP Benefits

	Services From a VSP Member Doctor	Maximum Reimbursement for Services From Non-Member Providers
Examination Every 12 months, from last date of service	Paid in full	Paid up to \$45
Materials Single vision lenses Lined Bifocal lenses Lined Trifocal lenses Lenticular lenses	\$25 copayment; lenses and frames every 24 months from last date of service Paid in full Paid in full Paid in full Paid in full	\$45 a pair \$65 a pair \$85 a pair \$125 a pair
Frames	\$120 retail allowance; 20% off the amount over allowance	\$47
Contact lenses (in lieu of lenses and a frame)		
Elective	Up to \$140 allowance for contacts, evaluation and fitting (materials copay does not apply)	Up to \$140 allowance
Medically necessary	Paid in full after \$25 copay (after approval from VSP)	\$210 after \$25 copay (after approval from VSP)
Laser Eye Surgery	Laser Vision Correction <ul style="list-style-type: none"> • Average 30-40% off the regular price or 5% off the promotional price from contracted facilities • After surgery, use your frame allowance (if eligible) for sunglasses from any VSP doctor 	None
Extra discounts and savings	Glasses and Sunglasses <ul style="list-style-type: none"> • Average 30% savings on lens options like progressives, scratch-resistant and anti-reflective coatings • 30% off additional glasses and sunglasses, including lens options* Contacts <ul style="list-style-type: none"> • Current soft contact lens wearers may be eligible for a special program that includes a contact lens exam and initial supply of lenses. 15% off the cost of contact lens exam (fitting and evaluation) 	None

Employee Assistance Plan (EAP)

BalanceWorks®, an enhanced EAP and Work and Family Life benefit, is provided to you and your eligible family members by eni. eni is a leading behavioral healthcare provider offering dynamic work/life balance solutions.

eni's BalanceWorks® provides confidential, professional assistance to you and your family. An EAP can help resolve personal situations and concerns that may affect your well-being. It also provides assessment of treatment needs, brief counseling, and referral to the appropriate level of care.

You can reach a Balance Works EAP counselor 24/7 by calling (1-800-EAP-CALL) or visit the website www.mybalanceworks.com.

1. **Set up your online account**
2. **Click on the new user link in the "First time login in?" box on the right and enter:**
 - a. Member ID: 17346241
 - b. Group ID: 8574

BalanceWorks® features at a glance:

Counseling Services:

- 24/7 access to a licensed health care professional and referral to an EAP counselor for up to 3 in-person visits
- Legal and financial consultations: Access to free legal and financial consultations over the phone and in-person, referrals and discounted fees.
- Child/elder care resources: Limitless resources are available to find the child and elder care you need.
- Your own personal assistant: your BalanceWorks personal assistant (PA) is a work/life expert that acts as a human search engine to complete personal tasks and projects at your request. 866 939-1660

Medicare Eligibility and Your Medical Options

If you are an active employee age 65 or older in a .5 FTE position or greater:

- Age 65 remains the starting date for Medicare eligibility. Remember you do not have to be retired to enroll in Medicare.
- Anyone who is age 65 may sign up for Medicare Part A (Hospital Insurance). Be sure to contact Social Security at www.socialsecurity.gov or call 1-800-772-1213.
- If you do not enroll in Medicare Part A prior to retirement, you may incur late enrollment.
- OHSU's health insurance plan is the primary insurance carrier and Medicare is a secondary insurance for active employees.
- Medicare Part B (Medical Insurance): If you have an employer's group medical coverage, you can sign up for Medicare Part B during a special enrollment period. Be sure to contact Social Security at www.socialsecurity.gov or call 1-800-772-1213 for more details.
- Medicare Part D (Prescription Insurance): Your employer's group prescription coverage offers prescription coverage greater than the standard level of coverage set by Medicare. Active employees may keep this coverage and enroll in Part D later.

Dental Options

You have three choices for dental insurance:

Traditional

- Oregon Dental Service (ODS)

Managed Care

- Kaiser Permanente
- Willamette Dental Insurance Inc.

Highlights of Your Dental Options

Dental care is an important part of maintaining good health. ODS includes three dental options to meet a range of needs.

You may choose a traditional dental plan under ODS. Or, depending on where you live, you may select one of the managed care dental plans.

Fast Facts

- Because OHSU offers three dental plans, you may choose the coverage that best fits you and your family's needs.
- OHSU dental insurance coverage is a pre-tax benefit. The portion of the monthly costs for domestic partner and child(ren) of domestic partner coverage is a post-tax benefit.

Note: The same-sex domestic partner premiums are paid on a post-tax basis for federal tax and on a pre-tax basis for Oregon state income tax.

Dental Options

The following page lists the main features of your OHSU dental options. After you enroll, you will receive more information from the plan you select. Be sure to refer to that information throughout the year for details about your dental plan.

Opting Out of Dental Coverage

You can opt out of dental coverage if you provide proof of coverage under another employer's group dental plan.

A Comparison of Your Dental Options

Plan Features	Oregon Dental Service	Kaiser Permanente	Willamette Dental Insurance Inc.
Basics			
How the plan works	Pays benefits for covered services you receive from any licensed dentist. Diagnostic and preventive services are covered in full. For other covered services, the plan pays a percentage of the cost after you meet the annual deductible.	Pays benefits for covered services you receive from a participating Kaiser dentist at a Kaiser Permanente facility. Supplemental charge of \$25 for emergency or urgent services.	Pays benefits for covered services you receive from a dentist at a Willamette Dental Group office. Copay of \$50 for emergency or urgent services. Co-pay of \$30 for some specialist office visits.
Annual deductible	\$50 per person \$150 per family	None	None
Annual max benefit	\$1,500	None	None
Covered Services			
Diagnostic and preventive services (such as exams, X-rays and cleanings)	Paid in full, no deductible	Paid in full	Paid in full
Routine fillings	80%, after deductible is met	Paid in full	Paid in full
Root canals	80%, after deductible is met	Paid in full	Paid in full
Prosthetic care (such as crowns, bridges and dentures)	50%, after deductible is met	Balance paid in full after \$75 copayment per unit; \$25 copayment for relines and rebases	Balance paid in full after \$75 copayment per unit
Orthodontia services	50%, after deductible is met, up to \$1,500 lifetime maximum	Not covered	Paid in full after <ul style="list-style-type: none"> • \$150 copay for pre-, orthodontia services; • \$1,200 copay for comprehensive orthodontia no lifetime maximum; pre-orthodontia copay credited towards \$1,200 copay if patient proceeds with treatment

Things to Consider

As you decide which dental insurance plan is right for your individual and family situation, you may want to consider the following:

- Which dental plan best fits your family's needs? Do you require only annual exams and cleanings? Do you anticipate any significant dental expenses, such as orthodontic services? Remember, ODS and Willamette Dental Insurance, Inc. provide orthodontic benefits; Kaiser Permanente does not.
- Are Kaiser Permanente and Willamette Dental Insurance, Inc. dentists conveniently located?
- Is it important to you to have the freedom to choose any dentist? Under ODS, you can see any licensed dentist, but your out-of-pocket costs usually are higher. If you select Kaiser Permanente or Willamette Dental Insurance, Inc., you must see a participating dentist to receive benefits under the plan. However, your costs usually are lower in a managed care dental plan.
- If you have dental work in progress, check with the insurance company you are considering using before you change dental insurance plans.

Oregon Dental Service

ODS is a traditional dental plan. This means you may receive care from any licensed dentist. Most – not all – dentists in Oregon participate in ODS. If you receive care from a nonparticipating dentist, you may pay more for covered services if the dentist charges more than ODS will pay. For more information about participating dentists, call ODS at 503 265-2965 or 888 217-2365, or visit the ODS Web site at www.odskompanies.com.

Many of the dentists in the OHSU Faculty Dental Practice participate in the ODS plan. Faculty members of the OHSU School of Dentistry provide a full range of dental services, from general preventive care to leading-edge specialty care, conveniently located on the Marquam Hill Campus. For more information or to schedule an appointment, call 503 494-4316.

Special Waiting Period

If you did not enroll yourself and/or your dependents in ODS when you first were eligible to participate, ODS will cover only emergency and preventive care during the first 12 months of coverage. In addition, you and your dependents must wait 24 months to be eligible for orthodontia benefits. The plan also will not cover orthodontic work you received before you were eligible for benefits.

Kaiser Permanente

Kaiser Permanente is a managed dental care plan. This means you must receive dental treatment from a Kaiser dentist at a Kaiser Permanente office to receive benefits from the plan. Dental offices are located from Salem, Ore., to Longview, Wash. To see if there is a Kaiser Permanente dental office near you, call Kaiser Permanente at 503 813-2000 or 800 813-2000 and request a provider directory, or visit the Kaiser Web site at www.kp.org.

If you require emergency dental care when you are out of the Kaiser Permanente service area, you must pay the full cost. To request reimbursement for the cost of that care, you must submit a claim form and receipt to a Kaiser Permanente office.

Willamette Dental Insurance Inc.

Willamette Dental Insurance, Inc., is a managed dental care plan. Willamette Dental Group, P.C., (WDG) Oregon and Idaho, and Willamette Dental Group in Washington, provide the care for the dental plans offered by Willamette Dental Insurance, Inc. When you enroll in the Willamette Dental Insurance, Inc. plan, you may select a primary care dentist at any of the WDG clinics. You may choose different clinics or dentists for each family member. To find a WDG clinic or dentist near you, call Willamette Dental at 503 952-2000 or 800 460-7644 and request a provider directory, or visit the Willamette Dental Web site at www.willamettedental.com.

If you are traveling outside of Oregon, Washington or Idaho and need emergency dental care, you may go to any licensed dentist to obtain emergency treatment. Emergency dental treatment is reimbursed up to \$150. Upon arriving home, please contact Willamette Dental Patient relations Department for reimbursement. Follow-up care should be scheduled with your Willamette Dental primary care dentist.

Life and AD&D Coverage Options

Life Insurance Options

Life insurance pays benefits if you die or if a dependent dies while covered by the plan. Adequate life insurance can provide important financial protection for you and your family. This section describes your OHSU life insurance options.

You will receive \$25,000 of employee core life insurance at no cost to you. You also may purchase additional coverage for yourself or for your spouse/domestic partner and dependent.

Fast Facts

- ***At your initial enrollment you may purchase \$25,000 of additional employee life insurance without evidence of insurability,*** for a total of \$50,000 of life insurance. You may also purchase up to \$50,000 of spouse/domestic partner life insurance without evidence of insurability.
- ***When your coverage takes effect.*** Subject to the active work requirement,* your life insurance becomes effective on the first of the month following the date you enroll unless evidence of insurability is required.

When Evidence of Insurability is Required

You must submit evidence of insurability to Standard Insurance Company by completing the Medical History Statement Form if you select: additional employee life insurance over \$25,000; spouse/domestic partner life insurance over \$50,000; any amount if you enroll after 60 days of first becoming eligible. The form is available online at ozone.ohsu.edu/hr/benefits/benefits_forms.shtml or from the HR Benefits Office. If Standard Insurance Company approves your increase, coverage will take effect on the first of the month following the approval if you meet the active work requirement on that day.

* Refer to page 72 for definition of active work requirement.

Employee Life Insurance

OHSU pays for the first \$25,000 of employee life insurance coverage (core life). You may purchase up to a total of \$50,000 of employee life insurance without evidence of insurability during initial enrollment. If you want more coverage, you may purchase additional protection – from \$25,000 up to \$1,000,000, in increments of \$25,000. Any increase in life insurance after initial enrollment requires evidence of insurability. If you want to purchase more than \$25,000 in additional coverage, you must provide Standard Insurance Company with evidence of insurability, which must be approved before coverage will take effect.

Optional Spouse/Domestic Partner Life Insurance

You also may select life insurance for your spouse or domestic partner. This coverage is available in increments of \$25,000, up to \$500,000.

As with employee life insurance, you may purchase up to \$50,000 of spouse/domestic partner life insurance without providing evidence of insurability during initial enrollment or within 31 days of a qualified family status change. If you want more than \$50,000 of insurance or if you enroll late, Standard Insurance Company must approve your spouse's/domestic partner's evidence of insurability before coverage will take effect.

Optional Dependent Life Insurance

You may select \$4,000 of dependent life insurance for your spouse, domestic partner and child(ren). This is separate from employee and spouse/domestic partner life insurance.

After the initial enrollment period, you may enroll your spouse/domestic partner and child(ren) in dependent life insurance within 31 days following a qualified family status change or during open enrollment.

Living Benefit

If you or your spouse/domestic partner becomes terminally ill with a life expectancy of 12 months or less, as determined by a physician, a one-time lump sum living benefit is available.

The minimum benefit is the lesser of \$5,000 or 10 percent of the life insurance amount, and the maximum is 75 percent of the life insurance coverage amount – you decide how much you need. You or your beneficiary would receive the balance of the life insurance benefit, less any interest charges, when you or your spouse/domestic partner dies.

Suicide Exclusion

If you or your spouse/domestic partner's death results from suicide or other intentionally self-inflicted injury, the benefit payable will exclude any amounts of optional employee life insurance or optional spouse/domestic partner life insurance which have not been in effect continuously for at least two years on the date of death.

Things to Consider

As you make your life insurance enrollment decisions, you may want to ask the following questions:

- When was the last time you really thought about the amount of income your beneficiaries would have if you were to die? You can determine your life insurance needs by adding up expenses that your beneficiaries will have. Subtract any income, including benefits from other life insurance policies, that would be available to them from this total.
- Do you have an individual life insurance policy? Do you have the opportunity to purchase this coverage elsewhere, such as through your spouse's/domestic partner's employer? If so, how does the other life insurance compare to OHSU's life insurance?
- What ongoing expenses would your family have in the future (such as everyday living expenses or college)? What outstanding debts would your family have (for example, house payments)?

Accidental Death and Dismemberment (AD&D) Coverage

OHSU offers you AD&D coverage to provide financial protection if you or a covered family member experiences a covered loss due to an accident. AD&D benefits are paid in addition to any life insurance benefits.

Fast Facts

- ***AD&D means added financial protection.*** If you die as a result of an accident, your beneficiary will receive your AD&D benefits in addition to any life insurance you select.
- If you are covered by the AD&D plan at the time of your death, your family members may be eligible to receive:
 - A career adjustment benefit
 - Higher education benefit
 - Seat belt benefit
 - Public transportation benefit
 - Occupational assault benefit
 - Airbag benefit
 - Childcare benefit

AD&D Coverage

If you select AD&D for yourself, you also may cover your eligible family members.

Employee Coverage

For AD&D benefits to be payable, satisfactory proof of loss must be provided, the accident must occur while you are insured under the group policy, the loss must occur within 365 days after the date of the accident, and the loss must be caused solely and directly by accidental bodily injuries and independently of all other causes.

If you lose ...	You will receive ...
<ul style="list-style-type: none"> ■ Both hands, both feet, sight in both eyes; ■ One hand and one foot; ■ Either hand or foot and sight in one eye; ■ Speech and hearing in both ears; or ■ Quadriplegia 	100% of your AD&D benefits
<ul style="list-style-type: none"> ■ Sight in one eye; ■ Either hand or foot; ■ Speech or hearing in both ears; ■ Paraplegia; or ■ Hemiplegia 	50% of your AD&D benefits
<ul style="list-style-type: none"> ■ A thumb and index finger of the same hand 	25% of your AD&D benefits (this is not payable if an AD&D benefit is payable for loss of your entire hand)

Your beneficiary will receive 100 percent of your AD&D coverage if you die as a result of an accident.

No more than 100 percent of your AD&D coverage amount will be paid for losses incurred as the result of one accident.

Family Coverage

If you select AD&D, you also may cover your family, at the amounts shown below.

If AD&D covers ...	Family AD&D coverage will be ...
Your spouse/domestic partner only	60% of your AD&D benefit
Your spouse/domestic partner and/or child(ren)	50% of your AD&D benefit for your spouse/domestic partner 15% of your AD&D benefit for each child
Your children only	20% of your AD&D benefit for each child

Example

Mark selects \$100,000 of AD&D in addition to \$75,000 in employee life insurance. He also covers his spouse and three children. If Mark loses sight in both eyes he will receive:

- 100 percent of his AD&D benefit.

Things to Consider

As you make your optional AD&D enrollment decisions, you may want to consider the following:

- What expenses would your family have in the future (such as college)?
- What outstanding debts would your family have (for example, house or car payments)?
- Do you have other AD&D coverage?
- Do you have the opportunity to get this coverage elsewhere, such as through your spouse's or domestic partner's employer?

AD&D and Life Exclusions

No AD&D insurance benefits will be paid for losses caused or contributed to by war or act of war; suicide or other intentionally self-inflicted injury; committing or attempting to commit an assault or felony; active participation in a violent disorder or riot (except while performing official duties); voluntary use or consumption of any poison, chemical compound, or drug (unless under the direction of a physician); sickness or pregnancy existing at the time of the accident; heart attack or stroke; medical or surgical treatment for any of the aforementioned; travel or flight in or descent from any kind of aircraft as a pilot or crew member (except in OHSU owned, leased, or operated aircraft while on state business).

MEDEX Travel Assist

MEDEX Travel Assist consists of a broad array of services, including security-related advice and referrals for members traveling outside of the United States. Whether you travel for business or pleasure, whether it's 200 or 10,000 miles from home, the program works to protect you every hour, every day of the year. If you need help, call 800 527-0218. Professional coordinators at the Assistance Center will act quickly and efficiently to serve you.

Disability Coverage

OHSU's leave policy allows you to accumulate leave days (sick, vacation and compensatory). But if you ever become disabled, you could quickly use this accrued leave and be left without an adequate income. That's why OHSU offers optional disability coverage. Disability plans provide an important source of income if you become disabled.

Fast Facts

- **STD and LTD coverage options.** With OHSU, your STD benefits will help replace up to 65 percent of the first \$1,923 of weekly pre-disability earnings, payable through 180 days of disability. If you select LTD coverage, LTD benefits will help replace up to 65 percent of the first \$8,333 of monthly predisability earnings, beginning after 180 days of disability.
- **Disability benefits are coordinated.** This means your accrued leave days (sick, vacation, holiday and compensatory time), STD and LTD benefits will work together to provide a continuous source of income if you become disabled. You must use all of your sick leave when you apply for STD and LTD. STD runs concurrently with FMLA/OFLA.
- **Pre-existing condition exclusions.** Both STD and LTD benefits are subject to pre-existing condition exclusions. A pre-existing condition is a mental or physical condition, whether or not diagnosed (or misdiagnosed), for which you have or a reasonably prudent person would have consulted a licensed medical professional, received medical treatment services or advice, undergone diagnostic procedures including self-administered procedures, or taken prescribed medications during the three-month period before your disability coverage took effect.
 - For LTD, you are not covered for a disability due to a pre-existing condition unless, on the date you become disabled, you have been continuously insured under an OHSU LTD disability plan for 12 months and have completed one full day of active work after this 12-month period.
 - For STD, the pre-existing exclusion applies only to late enrollees or when switching STD plans.

Disability Options

Optional Short-Term Disability (STD)

Helps replace 65 percent of your weekly earnings. Your benefits begin based on the waiting period option you select:

- 8 days
- 30 days
- 90 days

Full benefits begin only after you use all your sick leave hours, regardless of the waiting period option you select.

Optional Long-Term Disability (LTD)

Helps replace 65 percent of your monthly income after you have been disabled for 180 days.

Remember ...

OHSU disability coverage is paid with post-tax dollars which means the benefit received is tax-free.

Things to Consider

As you make your optional disability enrollment decisions, you may want to ask the following questions:

- Should you enroll in STD, LTD or both disability options? To choose the coverage that's right for you, ask yourself:
 - What are your day-to-day expenses? Would you incur any additional expenses if you became disabled?
 - What are your other possible sources of income if you became disabled (for example, your spouse's income and personal savings)?
- How many sick days have you accrued? This may help you select the STD waiting period option.
- Have there been any changes in your family's financial situation that may affect your need for disability protection? For example, has your spouse started or ended employment? Do you now have any dependents for whom you are financially responsible?

Optional Short-Term Disability

If you become disabled and unable to work because of a nonwork-related illness or injury or because of pregnancy, while insured for STD you may receive full STD benefits after you've used all your sick leave and other salary continuation (other than vacation pay). STD will help replace 65 percent of your pre-disability earnings (regular pay plus shift and weekend differentials) through 180 days of disability. The amount of STD benefits you will receive will be reduced by the amount of other income you receive during this time (ie. Work earnings, or amounts you are eligible to receive because of your disability). The minimum weekly benefit is \$25; the weekly maximum benefit is \$1,250. The date your STD benefits begin depends on which of these waiting period options you select:

- 8-day
- 30-day
- 90-day

You may receive disability benefits for up to 180 days (less your waiting period selection) from the date of disability or until you no longer are disabled, whichever occurs first.

Definition of disability. You are unable as a result of physical disease, injury, pregnancy or mental disorder to perform with reasonable continuity the material duties of your own occupation and you suffer a loss of at least 20 percent of pre-disability earnings when working in your own or any other occupation.

Benefit Start Date

There are no disability benefits paid during the waiting period. The minimum weekly STD benefit is \$25 while you are receiving sick leave benefits.

- 8 day waiting period option
1-7 days, no STD benefits
- 30 day waiting period option:
1-29 days, no STD benefits
- 90 day waiting period option:
1-89 days, no STD benefits

Full STD benefits begin only after you use all your sick days, regardless of the waiting period option you select.

If you later change your waiting period option to a shorter waiting period, the change will be subject to a new pre-existing condition exclusion.

Example

Bob earns \$500 a week and has accumulated 42 days of sick leave. He selects STD coverage and the 30 day waiting period option. If Bob becomes disabled and he is not eligible for other sources of income, he will receive:

- His normal sick leave benefit (\$500 a week less taxes) for the first 42 days of his disability. Even though Bob selected the 30 day waiting period option, he must use all of his sick days before receiving full STD benefits.
- Minimum STD benefits of \$25 a week from the 30th to 42nd day of disability. Bob will receive the minimum STD plan benefit until he uses all his sick days.
- STD benefits of \$325 a week ($\$500 \times 65\%$) starting the 43rd day of disability. Bob will continue receiving STD benefits until he has been disabled for a total of 180 days or no longer is disabled. If Bob is still disabled after 180 days, he may receive LTD benefits if he selected the LTD coverage option.

Note: STD payments are not taxable. In the example above, starting on the 43rd day of disability, Bob would receive a weekly check of \$325 from the STD plan.

Optional Long-Term Disability

If you select LTD coverage, you may receive a total of 65 percent of your monthly pre-disability earnings (regular pay plus shift and weekend differentials) after you have been disabled for 180 days (the benefit waiting period).

Your LTD benefits are coordinated with other income and benefits you are eligible to receive. The amount of LTD benefits you receive will be reduced by the amount of other income you receive (such as work earnings and Social Security payments), so that the total combined payment you receive will equal 65 percent of your monthly pre-disability earnings. This means if you or your family qualifies for payments from other sources of disability income, such as Social Security, workers' compensation and pension, your LTD benefits will coordinate with these other sources to pay an amount equal to the amount you would receive from the LTD plan.

The minimum monthly benefit is \$50; the maximum monthly benefit is \$5,417. Your LTD benefits will continue until you no longer are disabled or for the maximum benefit period (see chart below). LTD benefits for a disability caused or contributed to by a mental illness are limited to 24 months for each period of disability.

Maximum Benefit Period

Determined by your age when disability begins, as follows:

Age	Maximum Benefit Period
61 or younger	to age 65, or 3 years 6 months, whichever is longer.
62	3 years 6 months
63	3 years
64	2 years 6 months
65	2 years
66	1 years 9 months
67	1 year 6 months
68	1 year 3 months
69 or older	1 year

Definition of disability. During the benefit waiting period and for the next 24 months you must be as a result of physical disease, injury, pregnancy or mental disorder, unable to perform with reasonable continuity the material duties of your own occupation and you suffer a loss of at least 20 percent of indexed pre-disability earnings when working in your own or any other occupation.

Thereafter, you must be as a result of physical disease, injury, pregnancy or mental disorder, unable to perform with reasonable continuity the material duties of any occupation which, due to education, training or experience, you can be expected to earn at least 65 percent of your indexed pre-disability earnings within 12 months following your return to work.

Example

Sara earned \$1,000 biweekly when she became disabled. Sara's monthly earnings were \$2,168 ($\$1,000 \times 26/12$).

Sara's monthly LTD benefit was \$1,408 ($\$2,168 \times 65\%$). Sara also qualifies for disability benefits from Social Security of \$578 per month. By coordinating her disability benefits from both sources – the LTD plan and Social Security – she will receive a benefit equal to 65 percent of her pre-disability monthly earnings. Here's how Sara's LTD benefits coordinate with Social Security benefits:

Sara's LTD benefit: \$1,408 per month

-

Sara's Social Security benefit: \$578 per month

=

Her benefit paid by the LTD plan: \$830 ($\$1,408 - \578).

LTD payments are not taxed. In this example, Sara would receive a monthly check from the LTD plan of \$830.

Working While You Are Disabled

If you return to work part time, but due to your medical condition you still are considered partially disabled, you may continue to receive partial LTD payments. Combined, your paycheck plus your partial disability benefits may add up to more than you would get as a total disability benefit alone.

Disability Exclusions and Limitations

STD and LTD benefits are not payable if your disability is caused or contributed to by war or any act of war; an intentionally self-inflicted injury; a pre-existing condition (as defined previously); committing or attempting to commit an assault or felony or actively participating in a violent disorder or riot (unless performing official duties); loss of your professional license, occupational license, or certification.

STD and LTD benefits are not payable for any periods you are: not under the ongoing care of a physician in the appropriate specialty; away from work under the terms of your employment; in prison; not participating in good faith in a plan, program or course of medical treatment or vocational training or education approved by Standard Insurance Company, able to work and earn at least 20% of pre-disability earnings but elect not to work.

No STD benefits are payable for a work-related disability. LTD benefits are limited to 24 months for a disability caused or contributed to by a mental disorder (unless you are hospital-confined at the end of those 24 months - the limitation will not apply while you remain continuously confined).

Flexible Spending Accounts (FSA)

OHSU offers two flexible spending accounts: a Health Care Flexible Spending Account (HFSA) and a Dependent Care Flexible Spending Account (DFSA). Both of these accounts allow you to set aside a portion of your pay on a pre-tax basis. This money is then reimbursed to you for eligible out-of-pocket health care or dependent care expenses once you have submitted the required receipts and forms. Setting aside pre-tax dollars lowers your taxable income and the taxes you owe.

Fast Facts

- ***You must enroll each year to participate.*** You may choose to enroll in either one, both or neither of the flexible spending account options. If you participated in the DFSA or HFSA in 2011, you must re-enroll in order to participate in 2012. You may enroll in either flexible spending account online through Employee Self Service Benefits.
- ***Use it or lose it.*** Budget carefully for your 2012 health care and/or dependent care expenses. Because of the significant tax advantages an FSA offers, the IRS requires that you forfeit any allocations remaining in your account after the end of the plan year and the 90-day close-out period. Use the worksheets on Pages 71-73 to determine your expenses.
- ***“Irrevocability of elections”.*** Once the plan year (calendar year) or your participation within the plan year starts, changes to your FSA may only be made if you experience a family status change that is consistent with the plan guidelines. If you believe you have experienced a family status change, please contact the OHSU Benefits Office for assistance. Please reference Page 77-78 for HFSA and DFSA qualifying events. You have 31 days from the change event to complete a revised HFSA or DFSA enrollment form and submit it to your Human Resources Department Benefits Office for approval.
- ***Flexible spending accounts are governed by IRS regulations*** and are subject to change. Please contact Aetna at 888 238-6226 with questions.
- ***Effective January 1, 2011,*** you will need a doctor’s prescription when you use your healthcare flexible spending account (FSA) dollars to pay for certain over-the-counter (OTC) medicines. OTC medicines are drugs that you normally buy without a doctor’s prescription. Here’s how to use your FSA for affected OTC expenses after January 1, 2011:
 - Ask your doctor for a prescription even though it is an OTC product.
 - Pay for the item at the time of purchase.
 - Download an FSA form at www.aetna.com
 - Send cash register receipt, the prescription for OTC and the completed claim form to the address on the form.
 - For a complete list of OTC products please visit www.aetnafsa.com

Health Care Flexible Spending Account (HFSA)

The health care flexible spending account lets you set aside a portion of your pay, on a pre-tax basis, to pay for certain out-of-pocket health care expenses incurred by you, your spouse and your tax dependents. The reimbursements issued to you from your HFSA are not taxed; therefore, your HFSA lowers your taxable income and increases your spendable income.

What You Can Contribute

You may contribute before-tax dollars or any excess benefits dollars to the HFSA. The maximum annual contribution is \$2,500.

Your contributions can come from:

- A part of your pay on a pre-tax basis.
- Benefits dollars left over after you've made your other benefits selections.

The Plan year maximum (\$2,500) is prorated for periods less than 12 months. Minimum contribution is \$240 annually.

Any earnings you contribute to your account are deducted from your paycheck before federal and state income taxes, medicare and social security are withheld. Contributions are deducted from the first two pay periods each month throughout the calendar year and are deposited into your account.

The HFSA is separate from the DFSA. Even if you enroll in both accounts, you may not move money from one account to the other or use the money in one account to pay expenses related to the other account.

For the HFSA, you may elect to pay monthly contributions to the plan while on leave of absence (post-tax) or catch-up upon return from leave (pre-tax). The default option is to catch-up upon return from leave.

For assistance or questions on enrollment or your account, please call Aetna at 888-238-6226.

HFSA Options

You may contribute before-tax dollars to a health care flexible spending account.

The maximum annual contribution is \$2,500. The amount is pro-rated for periods of participation less than 12 months.

Federal Tax Return

If you participate in the HFSA, you cannot take a tax deduction on your federal tax return for expenses submitted and reimbursed from your HFSA.

What's not Eligible

Expenses that are illegal under federal law are not eligible for reimbursement from an HFSA:

- Cosmetic procedures such as liposuction and teeth whitening.
- Multivitamins and health club memberships
- Your premium contributions for health care coverage
- Expenses incurred for your domestic partner and your domestic partner's children
- OTC medications without prescription

Incurred Expense

The date you, your spouse, or dependents receive the medical service or materials, not the date billed, charged or paid.

Claims Procedures for the HFSA

Visit the Aetna website prior to enrollment to review the complete list of Eligible Expenses. Go to: www.aetna.com or www.aetnafsa.com.

- **Automated FSA Reimbursement.** Many of your FSA claims may be automatically processed. With this feature, you would not have to submit claims or receipts to receive your reimbursement.
- **Aetna Navigator.** View claim information online 24-hours a day, seven days a week at www.aetnavigators.com. You can even get E-mail notifications of initiation of payment.
- **Aetna Voice Advantage.** Call 888 238-6226 to get FSA claim forms, payment and account balance information.
- Eligible expense must be incurred during the Plan Year (January 1 to December 31), grace period (January 1 to March 15 following the plan year), or your period of participation if less than the full 12 months.
- You will be required to process any covered expenses through your health insurance or other available coverage prior to submitting these items to your HFSA.
- If you intend to claim expenses for orthodontia, please contact Aetna prior to enrollment to have a reimbursement plan prepared. Your valid expenses must be verified and the reimbursement process explained.
- When preparing claims for reimbursement, you may be required to provide independent third-party documentation of your expenses. The documentation must include all of the following: name of patient, date(s) of service, type of service, provider name and business contact information, total charges, amount paid by insurance, and amount due from patient. Please visit the Aetna website for further details.
- If submitting reimbursement for expenses such as massage therapy or nutritional supplements, you may be required to provide a prescription from your provider stating the item prescribed and the specific medical condition being treated.

Dependent Care Flexible Spending Account (DFSA)

If you pay someone to take care of your children or other tax dependents who live in your home in order for you (and your spouse) to work, the Dependent Care Flexible Spending Account (DFSA) can help reduce the impact of these expenses by allowing you to pay for them on a pre-tax basis.

The DFSA allows you to save money on eligible out-of-pocket dependent care expenses for:

- Your child(ren) age 12 and younger who live with you at least six months of the year.
- Your spouse, parent or child or other tax dependent of any age who lives with you and is mentally or physically incapable of self care. If your spouse is a full-time student or is incapable of self-care due to a disability, special calculations and verification may be needed.

By participating in the DFSA you can reduce your taxable income, which means you pay less tax.

What You Can Contribute

Your contributions to the DFSA can come from:

- A part of your pay on a pre-tax basis.
- Benefits dollars left over after you've made your other benefits selections.

Any earnings you contribute to your account are deducted from your paycheck before federal income, state income, medicare and social security taxes are withheld. The maximum contribution to all dependent care flexible spending accounts in which you and/or your spouse participate cannot exceed the smallest of any of the following amounts that apply:

- \$5,000 annually (\$208.33 per paycheck) per household if you are married filing jointly or are single filing as head of household,
- \$2,500 annually if you are married filing separate tax returns,
- The lesser of your annual earnings or your spouse's annual earnings,

For assistance or questions regarding these calculations, please call Aetna at 888-238-6226.

Provider of Care

A provider of care must have a valid Employer ID Number or Social Security Number and may not be your tax dependent or minor child. Please speak with your provider prior to enrollment to advise them of this requirement as their Tax ID or SSN is required with each claim submission.

Another Look at the Pre-Tax Advantage

By contributing to the DFSA, you may reduce your taxes and, as a result, increase your take-home pay. Here's another look at the guidelines used to estimate your tax savings:

$$\begin{array}{r}
 \text{Your pre-tax benefits costs} \\
 \times \\
 \text{Your tax rate} \\
 \text{(federal income tax bracket + Social Security + Medicare +} \\
 \text{Oregon state income tax bracket)} \\
 = \\
 \text{Your monthly tax savings}
 \end{array}$$

Example

Mary contributes \$100 a month to the Dependent Care FSA and her tax rate is 31.65%. Her tax savings would be:

$$\begin{array}{r}
 \$100 \\
 \text{Mary's pre-tax benefits costs} \\
 \times \\
 31.65\% \\
 \text{Mary's tax rate} \\
 \text{(federal income tax bracket + Social Security + Medicare +} \\
 \text{Oregon state income tax bracket)} \\
 = \\
 \$31.65 \\
 \text{Mary's monthly tax savings}
 \end{array}$$

DFSA Expenses

Please visit the Aetna website prior to enrollment to review the complete list of Eligible Expenses as well as Rules and Filing Instructions for the DFSA.

www.Aetna.com or www.aetnafsa.com

Eligible Expenses

- Expenses for a sitter, to allow you and your spouse to work, excluding a relative under age 19 (payment to a sitter for a night out is not eligible)
- Expenses for a licensed day care center
- Expenses for a practical nurse for a dependent who lives in your home and is physically or mentally incapable of selfcare
- Expenses for a nanny who cares for an eligible dependent (any portion that is applied to keeping a home or other chores not may not be claimed - custodial care portion only)

What's Not Covered (DFSA)

- Expenses incurred by a domestic partner or domestic partner's child(ren) are not eligible for reimbursement because the IRS requires that these expenses be paid on an after-tax basis.
- Kindergarten, overnight camp and any expenses for which the primary purpose is education are not eligible for reimbursement.
- Expenses that are detailed by the service provider as service other than care – such as transportation, registration, supplies and other fees – are not eligible for reimbursement.
- Expenses incurred for any period when not working, including a leave of absence, are not eligible.
- Expenses allocated to purposes other than custodial care are not eligible.
- Expenses prior to the effective date of enrollment or after date of termination are not eligible.

Expenses must be for valid work-related care. For more information about eligible expenses, refer to IRS Publication 503. Most public libraries make the publication available. You also may call the IRS at 800 829-3676 to request a copy of the publication or visit www.IRS.gov.

Important Facts

For a DFSA, the date of expense is based on the dates of care, not the date billed, charged or paid.

You will be required to provide independent third-party documentation stating the dependent's name, inclusive dates of care, provider's name, tax ID number, and phone number, and amount charged. Copies of cancelled checks are not valid documentation.

You may not submit claims in advance of the dates of care. For example, if your child's preschool requires a deposit towards September care due at the end of June, you may not file the claim until September.

Submitting for Reimbursement

Claim forms are available from Aetna, the FSA service provider.
www.aetna.com
888 238-6226

You have 90 days from the end of your period of participation within the Plan Year to submit your expenses. For full year participants the deadline to request reimbursement is 90 days from the end of the grace period. For inactive employees, the deadline for submission is 90 days from the date of termination.

The Plan Year

The OHSU plan year is January 1 through December 31.

The grace period for the OHSU plan year is January 1 through March 15th of the following year.

How to Use the Health Care and Dependent Care Flexible Spending Accounts

Here's how the plan works, step by step.

Step 1. You decide how much you want to contribute for the plan year within the contribution limits. To help you determine your health care or dependent care expenses for the coming calendar year, January 1 through December 31st refer to the FSA worksheets on Pages 72-73. Participants will receive an enrollment confirmation letter from Aetna in January.

Step 2. The amount you want to contribute during the plan year is deducted from your paycheck twice a month in equal amounts throughout the calendar year. The money comes out of your paycheck before federal income, state income, social security and medicare taxes are withheld, and goes into your FSA account.

Step 3. You incur health care and dependent care expenses. Incur is defined as the date the service or materials are provided to you or your dependents, not the date the expense is billed charged or paid.

Step 4. For the HFSA benefit the expense, if covered, must be submitted to your health, dental or vision insurance prior to submitting it for reimbursement from your HFSA.

Step 5. You complete a claim reimbursement form and submit it, along with appropriate documentation for each eligible expense, to Aetna.

Step 6. The DFSA reimbursement will be up to the amount held in your account at the time of your reimbursement request. The HFSA reimbursement will be up to the amount of your active annual allocation, less any previous claims.

Use It or Lose It

Because of the significant tax savings an FSA offers, IRS regulations state that you will forfeit any dollars left in your account for which you have not incurred valid expenses during the plan year or corresponding grace period. You have 90 days from the end of the grace period; 90 days from the end of the plan year; 90 days from attaining a noneligible status; or on the date of termination to submit your reimbursement forms for eligible expenses incurred during the plan year or grace period. To be eligible for reimbursement, you must incur the expenses during your participation in the plan, even if you wait to submit your reimbursement request until 90-days from the end of the plan year or grace period. Any money remaining in your accounts after the 90-day deadline is forfeited. To help avoid losing any money, use the FSA worksheets starting on Page 72 to determine your expenses for the coming calendar year.

Tax Implications of Flexible Spending Accounts

Health Care Flexible Spending Account

If you have eligible health care expenses, you owe it to yourself to think about contributing to a HFSA. Since you never pay taxes on the money reimbursed through the plan, you cut your tax bill. As a result, you may increase your take-home pay. This is one way to lower your taxes for eligible out-of-pocket health care expenses. Keep in mind, if your out-of-pocket health care expenses exceed 7.5 percent of your adjusted gross income (not including expenses for which you have been reimbursed from your HFSA), you may also apply for the federal tax deduction for health care expenses.

Dependent Care Flexible Spending Account

You cannot claim expenses reimbursed through the DFSA on your income tax return, so you will need to decide which option works best for you. Depending on your income, you may save more money by using the DFSA than by taking the tax credit. So, before you make your decision, you may want to talk to a tax adviser.

Any amounts reimbursed from your DFSA during the year cannot be used toward the Child and Dependent Care Credit on your federal income taxes. This means, you have a choice between:

- Using the DFSA account to receive a portion of your federal tax savings on each paycheck throughout the year, or
- Paying qualifying expenses on an after-tax basis and applying for the tax credit when you file your income taxes following the end of the year.

You can use both the DFSA and the tax credit, but your tax credit will be reduced dollar for dollar by any reimbursements you receive from the DFSA. You must report the amounts you are reimbursed on your tax return. Be sure to keep a record of the name, address and taxpayer identification number of the person who provides care for your dependents.

Any amounts claimed under a DFSA will be reported on your W-2 at the close of the calendar year. The amounts reported on your W-2 will be included in your tax return and will reduce your Child Care Credit deductions. For many working families the DFSA allows for greater tax savings than claiming the Child Care Credit on the Federal Tax Return. All participants are strongly encouraged to consult a tax adviser regarding their particular situation.

Things to Consider

As you make your optional FSA enrollment decisions, you may want to ask the following questions:

- Can you determine your eligible health care or dependent care expenses? It is important to be conservative and determine the expenses you expect to incur in 2011 so you can contribute the appropriate amount to your account.
- Does it make more sense to take a deduction or a full child care tax credit instead? Your tax adviser may be able to help you determine if it is more advantageous for you to use one or both of the flexible spending accounts or to take the deduction or tax credit when you file your income taxes.
- Do you expect to have a valid change of status event occur during the year? If you experience a valid change of status event, an update form must be submitted within 31 days of the event. The change of deduction must be consistent with the event you have experienced.
- Have you visited the Aetna website www.aetna.com or www.aetnafsa.com to review the Eligible Expense List and Filing Instructions? It is imperative that you know what expenses you may claim and how to claim them prior to enrolling in a “Use it or Lose it” benefit.

Benefits Cost Worksheet

Use this worksheet to estimate your monthly cost of coverage.

1. In the Benefit Dollars column, write the amount of your monthly Benefit Dollars (page 5).
2. In the Benefits Costs column, write the monthly cost of each *OHSU* benefit you select.
3. Subtract your total Benefit costs from your Benefit Dollars.
 - If your Benefit Costs are less than the Benefit Dollars, you may receive the excess Benefit Dollars in your paycheck. (AFSCME-represented employees may only apply excess benefit dollars to other benefits.)
 - If your Benefit Costs are more than your Benefit Dollars, you will pay the difference through automatic payroll deductions.

	Plan Name or Coverage Amount	Benefits Costs	Benefits Dollars (Flex Credits)
Monthly benefits dollars (flex credits)			\$ _____
Monthly pretax benefits costs*			
Medical Plan (Write \$0 if you opt out of medical coverage.)	_____	_____	
Dental Plan	_____	_____	
Employee Life Insurance up to \$50,000 in coverage.	_____	_____	
Contribution to Dependent Care FSA	_____	_____	
Contribution to Health Care FSA	_____	_____	
Sub-total pretax benefits costs			- _____
Sub-total benefits costs or excess dollars for post-tax benefits			\$ _____
Monthly post-tax benefits costs*			
Employee Life insurance over \$50,000	_____	_____	
Spouse/Domestic Partner Life Insurance	_____	_____	
Accidental Death and Dismemberment Employee coverage	_____	_____	
Family coverage	_____	_____	
Short-Term Disability	_____	_____	
Long-Term Disability	_____	_____	
Sub-total post-tax benefits costs			- _____
Sub-total benefits costs or excess dollars			\$ _____
Total benefits costs or excess dollars (To determine the estimated biweekly amount, divide by 2).			\$ _____

*You use pre-tax dollars to pay for the cost of your medical coverage, dental coverage and the first \$50,000 of employee life insurance. And, if you participate in either or both flexible spending account(s), your contributions are made on a pre-tax basis. You use post-tax dollars to pay for your other voluntary benefits.

Healthcare Flexible Spending Account (HFSA) Computation Worksheet

No one wants to forfeit leftover amounts in a health care flexible spending account. However, the IRS says you must claim all your contributions with valid expenses or lose them. By completing this worksheet, you can project your medical expenses for the plan year more carefully. Expenses prior to the effective date of enrollment or after date of termination from the plan are not eligible for reimbursement.

Eligible Health Expenses

Please note these categories are for planning purposes only and do not limit your use of the benefit. The health care expenses not covered by your medical plan or another plan must be for you or your dependents. Payroll deductions for health insurance premiums are not considered eligible expenses.

What You Can Contribute

You may contribute pre-tax dollars or any excess benefit dollars to the HFSA. The maximum annual contribution is \$2,500.

	Annual Expenses for You and Your Family
a. Co-payments and deductibles for health services	\$ _____
b. Co-insurance expenses (percent paid on major procedures)	\$ _____
c. Prescription and over-the-counter drugs and medicine with a doctor prescription	\$ _____
d. Vision care (exams, eyeglasses, contacts and supplies, etc.)	\$ _____
e. Dental care (exams, crowns, orthodontics, etc.)	\$ _____
f. Mental health treatment and therapy	\$ _____
g. Other eligible health care expenses (list other items)	
_____	\$ _____
_____	\$ _____
_____	\$ _____
Eligible Health Expenses Annual Total:	\$ _____

If you have questions about eligible expenses, please call Aetna at 888 238-6226 or visit the Aetna website at www.aetna.com

DFSA Computation Worksheet

No one wants to forfeit leftover amounts in a dependent care flexible spending account. However, the IRS says you must use all your contributions or lose them. By completing this worksheet, you can project your dependent care expenses for the plan year more carefully. Expenses prior to the effective date of enrollment or after date of termination from the plan are not eligible for reimbursement.

Month	Preschool and Day Care Expenses	Babysitting inside or out- side your home	Other custodial (non-education) expenses	Monthly Total
January				
February				
March				
April				
May				
June				
July				
August				
September				
October				
November				
December				
Total Estimated Expenses				

If you have questions about eligible expenses, please refer to Page 66 and call Aetna or toll-free at 888 238-6226. You may also visit the Aetna Web site at www.aetna.com

Definitions

Active Work Requirement

Initial enrollment requires you to be physically on the job (e.g., not on leave), performing the material duties of your occupation at OHSU, and receiving pay for that date to be considered actively at work. If you are incapable of active work because of sickness, injury or pregnancy on the date before the scheduled effective date of your insurance or an increase in your insurance, your insurance or increase will not become effective until the day after you complete one full day of active work.

Default Coverage

Your default benefits are the employee only coverage for the OHSU PPO medical plan, ODS dental plan and \$25,000 employee life insurance.

Benefit Dollars

Benefit dollars are the monthly amount OHSU provides benefit eligible employees to apply toward the purchase of their benefits package. Benefit dollars vary depending on the employee group, collective bargaining agreement, or coverage level. Employees in full-time and part-time positions will receive different contribution amounts. Benefit dollars are based on medical election.

Eligible Dependent

Eligible dependents are defined as:

- A legally married spouse as determined by state law to the extent consistent with the definition of “spouse” in the Federal Defense of Marriage Act.
- A registered domestic partner as determined by state law.
- A same-sex or opposite-sex domestic partner who:
 - Currently resides with the employee.
 - Shares joint financial responsibility for basic living expenses, including food, shelter and medical expenses.
 - Is not related by blood to a degree of closeness that would prohibit marriage or registration.
 - Is eighteen years of age or older
 - Is not, and domestic partner is not, married to anyone else or in a domestic partnership (registered or not) with anyone else.
- An unmarried child under the age of 26 who is:
 - A biological or adopted child of the employee.
 - A biological or adopted child of the employee’s spouse or domestic partner who maintains primary residence in the home of the employee or for whose medical care the spouse/domestic partner is responsible by court decree.

- A child living in the home of the employee or spouse/domestic partner who is a legal ward for whom the employee has permanent legal guardianship.
- A child aged 26 or older who otherwise meets the aforementioned requirements and is incapable of self-sustaining employment by reason of mental or physical disability. The child must have been covered by the plan at the time of his or her 26th birthday and the physical or mental disability must have existed prior to the child attaining age 26.

Ineligible Employee

Ineligible employees are defined as individuals who: (1) are engaged as independent contractors; (2) hold less than .5 FTE or who are paid for less than fifty percent of the available hours in the designated pay periods for a qualifying month; (3) are working on a temporary appointment; (4) are flex staffers, resource nurses or graduate research assistants; or (5) are provided student health care services in conjunction with their enrollment at OHSU.

Month

A qualifying month for eligibility requires wages paid on fifty percent of the regular full-time hours in the designated pay periods for all paydays in the calendar month.

An insurance coverage month is the current calendar month.

Open Enrollment

Open enrollment is a period during which employees are permitted to make changes to their insurance coverages and other benefits without experiencing a qualified family status change. Open enrollment periods are offered during the month of October each year.

Opting Out

You opt out when you elect not to participate in the OHSU group medical or dental plan. You must provide proof of coverage through another employer's group medical or dental plan before you may opt out. If you choose to opt out, you will receive reduced benefit dollars. If you opt out of dental insurance, please be aware that you will not be eligible to participate in an OHSU dental plan for 2 years unless you have a qualified status change.

Plan Year

Group coverages are contracted for a 12-month period or plan year. OHSU's plan year is based on a calendar year and runs from January 1 through December 31 of each year.

Pre-Existing Condition For Disability

A pre-existing condition includes those instances where a prudent person would have sought medical treatment for symptoms.

Qualified Family Status Change

A qualified family status change is defined as one of the following events: marriage, affidavit of domestic partnership, divorce (final date), termination of domestic partnership, birth or adoption, death, loss of dependent status, or change in employment status for employee or spouse/ domestic partner.

Qualifying Month

A qualifying month for eligibility requires wages paid on 50 percent of the regular full-time hours in the designated pay periods for all paydays in the calendar month. An insurance coverage month is the current calendar month.

Grandfathered Health Plan Under the Patient Protection and Affordable Care Act

Oregon Health & Science University believes the OHSU Kaiser plan is 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 OHSU Kaiser 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 plan administrator at 503 494-0302.

Status Change Summary

Status Changes	Medical/Dental	Employee/ Spouse/Domestic Partner (DP) Life
Marriage/Affidavit of Domestic Partnership	Enroll or delete dependent(s) or opt out. May change plans.	Enroll spouse/DP. May enroll or increase employee coverage. May not decrease or drop coverage.*
Divorce/Termination of Domestic Partnership	Enroll dependent(s) if losing coverage, or enroll if previous opt out. Must cancel coverage for spouse/DP or ineligible dependents.	Must cancel coverage on ineligible dependents. May not enroll, increase, decrease or stop coverage.
Birth/Adoption/ Legal Ward	Enroll new dependent(s). May change plans.	No changes
Death of a Dependent	Enroll other dependent(s) if losing coverage, or enroll if previous opt out. Must cancel coverage on deceased dependent(s). May not change plans.	Must cancel coverage on deceased dependent(s). May not enroll, increase, decrease or stop coverage.
Employee/Spouse/DP/ Dependent Losing Other Coverage	Enroll dependent(s) if losing coverage, or enroll if previous opt out.	No changes
Employee/Spouse/DP/ Dependent Gaining Other Coverage	Must cancel coverage on ineligible dependent.	No changes
Termination of Employee	COBRA rights, if applicable	Portability available within 31 days of last day worked
Significant Change in Cost	Enroll or delete dependents or opt out. May change plans.	No changes

**A Medical History Statement Form must be sent to Standard Insurance for all increases in life insurance. Increases in life insurance will not go into effect until approval is received.*

AD&D	Dependent Life	Disability	Dependent Care Flexible Spending Account	Health Care Flexible Spending Account
Enroll Spouse/DP. May enroll in or increase coverage.	Add coverage if spouse/DP or eligible child(ren) is first eligible dependent	No changes	Enroll, increase, decrease or stop	Enroll, increase, decrease or stop
Must cancel coverage on ineligible dependents. May not enroll, increase, decrease or stop coverage.	Must cancel coverage on ineligible dependents. May not enroll.	No changes	Enroll, increase, decrease or stop	Enroll, increase, decrease or stop
May enroll new dependent(s). May enroll in or increase coverage.	Enroll if gaining first dependent.	No changes	Enroll, increase, decrease or stop	Enroll or increase
Must cancel coverage on deceased dependent(s). May not enroll, increase, decrease or stop coverage.	Must cancel coverage if only dependent. May not enroll in coverage.	No changes	Enroll, increase, decrease or stop	Decrease or stop
No changes	No changes	No changes	Enroll, increase, decrease or stop	Enroll, increase, decrease or stop
No changes	No changes	No changes	Enroll, increase, decrease or stop	Enroll, increase, decrease or stop
Continuation is not available	Continuation is not available	Continuation is not available	Continuation is not available	COBRA rights if applicable
No changes	No changes	No changes	If applicable, enroll, increase, decrease or stop. Minimum \$50 change in cost per month.	If applicable, enroll, increase, decrease or stop. Minimum \$50 change in cost per month.

Health Plan Notice of Privacy Practices

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.

Oregon Health & Science University (OHSU) is committed to preserving the privacy of health information. In fact, we are required by law to do so for any information created or kept by us. We are also required to provide you with this Health Plan Notice describing the health information duties and practices of the OHSU Group Health Plan and any third party that assists in the administration of the Plan. As used in this Notice, "OHSU Group Health Plan" or "Plan" refers collectively to the health insurance plans or benefits provided to employees of OHSU.

A. PURPOSE OF THIS HEALTH PLAN NOTICE.

This Health Plan Notice tells you how OHSU uses and discloses health information that OHSU maintains for the purpose of processing health claims reimbursed under the Plan for Plan administration purposes. It also tells you about our responsibility to Plan participants and how we can and cannot use health information.

Note: When we use the words "health information," we mean any information that we have gathered about a Plan participant and their health in the course of administration of the Plan (including health information provided to OHSU by those outside OHSU).

OHSU will follow this Health Plan Notice of Privacy Practices (Notice) and any future changes to the Notice that we are required or authorized by law to make. We have the right to change this Notice and to make the revised or changed Notice effective for health information we already have, as well as any information we receive in the future. We will have a copy of the current Health Plan Notice with an effective date available by request in the OHSU Human Resources Department and on our website at www.ohsu.edu/cc/hipaa.

The health information practices listed in this Health Plan Notice will be followed by OHSU and OHSU will by contract require that any third party involved in administration of the Plan follow these practices.

We may use or disclose health information for purposes of treatment, payment, and healthcare operations, as further described in this Health Plan Notice.

B. USES AND DISCLOSURES OF HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS.

Treatment, Payment and Health Care Operations. The following section describes different ways that we use and disclose health information for treatment, payment and health care operations. For each of those categories, we explain what we mean and give one or more examples. Not every use or disclosure will be noted and there may be incidental disclosures that are a by-product of the listed uses and disclosures. The ways we use and disclose health information will fall within one of the categories.

a. For Treatment. We may use or disclose health information to facilitate medical or dental treatment or services. We may disclose health information to staff physicians, staff dentists, post-graduate fellows, midwives or nurse practitioners, and other personnel or students who require it in order to provide treatment.

b. For Payment. We may use and disclose health information for Plan administration such as determining eligibility for Plan benefits, facilitating payment for the treatment and services a Plan

participant receives from health care providers, determining benefit responsibility under the Plan, or coordinating Plan coverage. For example, we may ask your health care provider about your medical history to determine whether a particular treatment is experimental, investigational, or medically necessary or to determine whether the Plan will cover the treatment. We may also share medical information with a utilization review or pre-certification service provider. Likewise, we may share medical information with another entity to assist with the resolution of health claims or to another health plan to coordinate benefit payments.

c. For Health Care Operations. We may use and disclose health information for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use health information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; submitting claims for stop-loss (or excess loss) coverage; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; business planning and development such as cost management; and business management and general Plan administrative activities.

We may use or disclose a Plan participant's health information without his or her permission in the following circumstances, subject to all applicable legal requirements and limitations:

- 1. Disclosure to Health Plan Sponsor:** To another health plan maintained by OHSU for purposes of facilitating claims payments under that plan. In addition, medical information may be disclosed to OHSU personnel solely for purposes of administering benefits under the Plan.
- 2. Required By Law:** As required by federal, state, or local law.
- 3. Public Health Risks:** For public health reasons in order to prevent or control disease, injury or disability; or to report births, deaths, suspected abuse or neglect, non-accidental physical injuries, reactions to medications or problems with products.
- 4. Health Oversight Activities:** To a health oversight agency for audits, investigations, inspections, licensing purposes, or as necessary for certain government agencies to monitor the health care system, government programs, and compliance with civil rights laws.
- 5. Lawsuits and Disputes; Law Enforcement:** In response to a subpoena or a court or administrative order, if a Plan participant is involved in a lawsuit or a dispute, or in response to a court order, subpoena, warrant, summons or similar process. In addition, subject to Oregon law, we may release health information if asked to do so by law enforcement in the following circumstances:

- In response to court order, subpoena, warrant, summons or similar process;
- To identify or locate a suspect, fugitive, material witness, or missing person;
- About the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement;
- About a death we believe may be the result of criminal conduct;
- About criminal conduct at the hospital; and
- In emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

6. Coroners, Medical Examiners and Funeral Directors: To a coroner or medical examiner, (as necessary, for example, to identify a deceased person or determine the cause of death) or to a funeral director, as necessary to allow him/her to carry out his/her activities.

7. Organ and Tissue Donation: To organizations that handle organ procurement or organ, eye or tissue transplantation, or to an organ donation bank, as necessary to facilitate a donation and transplantation.

8. Serious Threat to Health or Safety; Disaster Relief: To appropriate individual(s)/organization(s) when necessary (i) to prevent a serious threat to a Plan participant's health and safety or that of the public or another person, or (ii) to notify his or her family members or persons responsible for the Plan participant in a disaster relief effort.

9. Military and Veterans: As required by military command or other government authority for information about a member of the domestic or foreign armed forces.

10. National Security; Intelligence Activities; Protective Service: To federal officials for intelligence, counterintelligence, and other national security activities authorized by law, including activities related to the protection of the President, other authorized persons or foreign heads of state, or related to the conduct of special investigations.

11. Workers' Compensation: For workers' compensation or similar programs in connection with claims and/or benefits for work-related injuries or illnesses.

12. Inmates: To a correctional institution (if a Plan participant is an inmate) or a law enforcement official (if the participant is in that person's custody) as necessary (a) for the institution to provide the Plan participant with health care; (b) to protect his or her or others' health and safety; or (c) for the safety and security of the correctional institution.

C. WHEN WRITTEN AUTHORIZATION IS REQUIRED.

Other than for those purposes identified above, we will not use or disclose a Plan participant's health information for any purpose unless the Plan participant gives us specific written authorization to do so. If we are given authorization, it can be withdrawn at any time. To remove an authorization, deliver or fax a written revocation to the OHSU Human Resources Department, Attention: Health Plan Administration. If a Plan participant revokes an Authorization, we will no longer use or disclose health information as allowed by the Authorization, except to the extent that we have already relied on the Authorization.

D. YOUR RIGHTS REGARDING HEALTH INFORMATION.

Plan participants have certain rights regarding their health information that we list below. In each of these circumstances, if a Plan participant wants to exercise his or her rights, he or she must do so in writing by completing a form that can be obtained from the OHSU Integrity Office, at 2525 S.W. First Ave. Suite 140, Portland, OR 97201, on the web at www.ohsu.edu/cc/hipaa, or from the OHSU Department of Human Resources. In some cases, we may charge the Plan participant for the costs of providing materials to you. The Plan participant can get

information about how to exercise his or her rights and about any costs that we may charge for materials by contacting the OHSU Department of Human Resources at (503) 494-8060.

Submit the form to: Oregon Health & Science University, Mail code HR, 3181 S.W. Sam Jackson Park Road, Portland, OR 97239-3098, Attn: Health Plan Administrator.

1. Right to Inspect and Copy. With some exceptions, a Plan participant has the right to inspect and receive a copy of his or her health information that may be used to make decisions about Plan benefits. We may deny a request to inspect and/or copy in certain limited circumstances, and if we do this, the Plan participant may ask that the denial be reviewed.

2. Right to Amend. You have the right to amend your health information maintained by or for OHSU, or used by OHSU to make decisions about you. We will require that you provide a reason for the request, and we may deny your request for an amendment if the request is not properly submitted, or if it asks us to amend information that (a) we did not create, (unless the source of the information is no longer available to make the amendment); (b) is not part of the health information that we keep; (c) is of a type that you would not be permitted to inspect and copy; or (d) is already accurate and complete.

3. Right to an Accounting of Disclosures. A Plan participant has the right to request an accounting of disclosures. This is a list of certain disclosures we made of his or her health information. The list does not include all disclosures. For example it does not include disclosures to the Plan participant, disclosures for treatment, payment, and health care operations purposes described above, or disclosures made with an Authorization as described above.

4. Right to Request Restrictions. A Plan participant has the right to request a restriction or limitation on the health information we use or disclose (a) for treatment, payment, or health care operations, or (b) to someone who is involved in the Plan participant's care or the payment for it, such as a family member or friend. For example, the Plan participant could ask that we not use or disclose information about a surgery he or she had. We are not required to agree to such a request, and any time OHSU agrees to a restriction, it must be in writing and signed by the OHSU Privacy Officer or his or her designee.

5. Right to Request Confidential Communications. A Plan participant has the right to request that we communicate about health matters in a certain way or at a certain place. For example, you can ask that we only contact you at work or by mail.

6. Right to a Paper Copy of This Health Plan Notice. A Plan participant has the right to a paper copy of this Health Plan Notice, whether or not he or she may have previously agreed to receive the Health Plan Notice electronically.

E. QUESTIONS OR COMPLAINTS

If you have any questions about this Health Plan Notice, please contact OHSU (503) 494-8311. If you believe your privacy rights have been violated, you may file a complaint with OHSU or with the Secretary of the Department of Health and Human Services. To file a complaint with OHSU, contact OHSU at (503) 494-8311. You will not be penalized for filing a complaint.

Oregon Health & Science University includes four schools; OHSU Hospital and Doernbecher Children's Hospital; numerous primary care and specialty clinics; multiple research institutes and centers; and several community service and outreach units.

OHSU is an equal opportunity, affirmative action institution. 0403(130)

Important Notice from OHSU About Your Prescription Drug Coverage and Medicare

The purpose of this notice is to advise you that the prescription drug coverage listed below under the OHSU medical plan is expected to pay out, on average, at least as much as the standard Medicare prescription drug coverage will pay in 2012. This is known as “creditable coverage.”

Why is this important. If you or your covered dependent(s) are enrolled in any prescription drug coverage during 2012 listed in this notice and are or become covered by Medicare, you may decide to enroll in a Medicare prescription plan later and not be subject to a late enrollment penalty – as long as you had creditable coverage within 63 days of your Medicare prescription plan enrollment. You should keep this notice with your important records.

Notice of Creditable Coverage

Please read this notice carefully. It has information about prescription drug coverage with OHSU and prescription drug coverage available for people with Medicare. It also tells you where to find more information to help you make decisions about your prescription drug coverage.

You may have heard about Medicare’s prescription drug coverage (called Part D), and wondered how it would affect you. Prescription drug coverage is available to everyone with Medicare through Medicare prescription drug plans. All Medicare prescription drug plans provide at least a standard level of coverage set by Medicare. Some plans also offer more coverage for higher monthly premium.

Individuals can enroll in Medicare prescription drug plan when they first become eligible, and each year from October 15 through December 7. Individuals leaving employer/union coverage may be eligible for a Medicare Special Enrollment Period.

If you are covered by Aetna or Kaiser OHSU prescription drug plan(s) listed below, you will be interested to know that coverage is, on average, at least as good as standard Medicare prescription drug coverage for 2012. This is called creditable coverage. Coverage under Aetna or Kaiser OHSU plans will help you avoid a late Part D enrollment penalty if you are or become eligible for Medicare or later decide to enroll in a Medicare prescription drug plan.

List of OHSU plans that provide creditable drug coverage.

OHSU PPO

OHSU PPO Standard

250 PPO

250 PPO Standard

Kaiser Permanente

If you decide to enroll in a Medicare prescription drug plan and you are an active employee or family member of an active employee, you may also continue your OHSU employer coverage. In this case the

employer plan will continue to pay primary or secondary as it had before you enrolled in a Medicare prescription drug plan. If you waive or drop OHSU coverage, Medicare will be your only payer. You can re-enroll in the employer plan during the annual Open Enrollment or if you have a special enrollment event for the OHSU Plan.

You should know that if you waive or leave coverage with OHSU and you go 63 days or longer without creditable prescription drug coverage (once your applicable Medicare enrollment period ends), your monthly Part D premium will go up at least 1% per month for every month that you did not have creditable coverage. For example, if you go 19 months without coverage, your Medicare prescription drug plan premium will always be at least 19% higher than what other people pay. You will have this higher premium as long as you have Medicare prescription drug coverage. In addition, you may have to wait until the following October to enroll in Part D.

You may receive this notice at other times in the future – such as the next period you can enroll in Medicare prescription drug coverage, if this OHSU coverage changes, or upon your request.

For more information about your options under Medicare prescription drug coverage

More detailed information about Medicare plans that offer prescription drug coverage is in the Medicare & You handbook. Medicare participants will receive a copy of the handbook in the mail every year from Medicare. You may also be contacted directly by Medicare prescription drug plans. Here is how to obtain more information about Medicare prescription drug plans:

- Visit www.medicare.gov for personalized help.
- Call your State Health Insurance Assistance Program (see your copy of the Medicare & You handbook for their telephone number)
- Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

For people with limited income and resources, extra help paying for a Medicare prescription drug plan is available. Information about this extra help is available from the Social Security Administration (SSA). For more information about this extra help, visit SSA online at www.socialsecurity.gov, or call them at 1-800-772-1213 (TTY 1-800-325-0778).

Remember: Keep this notice. If you enroll in a Medicare which offer prescription drug Plan after your applicable Medicare enrollment period ends, you may need to provide a copy of this notice when you join a Part D plan to show that you are not required to pay a higher Part D premium amount.

For more information about this notice or your prescription drug coverage, contact:

Date: October 2011

Name of Entity/Sender: OHSU

Contact–Position/Office: Human Resources, Benefits Office

Address: 3181 S.W. Sam Jackson Park Road, Portland, OR 97239

Phone: 503 494-7617

Email: benefits@ohsu.edu



Human Resources Department

Mail code: HR

3181 SW Sam Jackson Park Road
Portland, OR 97239

tel 503 494-7617

fax 503 494-5990

ozone.ohsu.edu/hr

Oregon Health & Science University includes the Schools of Dentistry, Medicine, Nursing, and Science and Engineering, OHSU Hospital and Doernbecher Children's Hospital, numerous primary care and specialty clinics, multiple research institutes and centers, and several community service and outreach units.

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