



# 5 Easy Enrollment Steps

Enroll for health insurance plans in just five easy steps

Para obtener información en español visite [www.hubbinsurance.org](http://www.hubbinsurance.org).

Для информации на русском языке, посетите страницу на интернете [www.hubbinsurance.org](http://www.hubbinsurance.org).

1

## Identify your medical plan based on your service area.

Kaiser Medical-for employees who reside within the Kaiser service area.  
ODS Medical-for employees who reside outside of the Kaiser service area.

2

## Identify your dental plan based on your service area.

Kaiser Dental-for employees who reside within the Kaiser service area.  
ODS Dental-for employees who reside anywhere in the state of Oregon.

3

## Complete the enrollment form.

4

## If enrolling family members, attach your initial premium payment payable to "HUBB Trust".

5

## Mail your enrollment form to HUBB.

HUBB, LLC  
SEIU Local 503, OPEU  
1730 Commercial Street SE  
PO Box 12159  
Salem, OR 97309-0159

## Please keep HUBB informed of all address changes.

For additional information visit [www.hubbinsurance.org](http://www.hubbinsurance.org) or call customer service at 866-364-4822.



## Our commitment to you...

### Services you can expect from HUBB:

- HUBB determines who is eligible for medical and dental insurance based on hours worked reported by Department of Human Services (DHS).
- HUBB sends enrollment materials to eligible homecare workers.
- HUBB processes homecare worker's enrollment forms.
- HUBB sends homecare workers confirmation of enrollment.
- HUBB bills the State of Oregon for insurance premium for eligible homecare workers.
- HUBB collects insurance premium from the State of Oregon and from homecare workers.
- HUBB sends the insurance premium to the insurance companies.
- HUBB answers homecare worker's questions about plan benefit coverage, enrollment and eligibility.
- HUBB advocates for homecare workers with the insurance companies and the State.
- HUBB assists homecare workers with appeals regarding eligibility, enrollment and claims payment.
- HUBB provides a full range of customer service assistance to homecare workers regarding their medical and dental insurance.
- HUBB works with Family Health Insurance Assistance Program (FHIAP) to assist homecare workers in paying for family coverage.



# Contents

*This booklet provides information about the insurance benefits available to you through the Homecare Union Benefits Board, LLC (HUBB) for the plan year beginning April 1, 2011 and ending December 31, 2011.*

*HUBB administers medical and dental insurance coverage for eligible homecare workers and their eligible family members. Enrollment forms must be processed through HUBB for coverage to be effective.*

*If you have any questions about your medical and dental insurance benefits, call the HUBB Office at (503) 364-HUBB (4822) or toll-free (866) 364-HUBB. You can email your questions to HUBB at this address: [HUBB@opeuseiu.org](mailto:HUBB@opeuseiu.org)*

*This benefit summary does not fully describe the HUBB Insurance Program. In the case of conflict between this summary and the plan contracts, the plan contracts will prevail.*

- Frequently Asked Questions ..... 1*
- Cost of Coverage ..... 3*
- Eligibility & Enrollment ..... 4*
- Kaiser Permanente Overview..... 7*
- Kaiser Permanente Medical Plan..... 8*
- Kaiser Permanente Dental Plan ..... 10*
- ODS Overview..... 11*
- ODS Medical Plan ..... 12*
- ODS Dental Plan ..... 14*
- Mandated Benefit Notices ..... 15*
- Eligibility Rules ..... 18*
- Smoke-Free Oregon ..... 23*
- Services Directory ..... **back cover***



# Frequently Asked Questions

## Enrollment and Eligibility

### Am I eligible?

You are eligible to enroll if you are a full-time, part-time, hourly or live-in publicly funded Homecare Worker and you are employed through the Client-Employed Providers (CEP), Spouse Pay Providers or Oregon Project Independence and compensated by the Department of Human Services (DHS); and you work 80 hours or more per month for two consecutive months; and you are not covered by any other medical or dental coverage except Medicare and Veteran's benefits.

### Who pays for my insurance?

Oregon Homecare Workers who qualify for HUBB insurance receive health coverage paid for by a contribution from the State of Oregon. This contribution is available under the Union contract between the Oregon Home Care Commission and SEIU Local 503, OPEU.

### When does HUBB send enrollment packet to homecare workers?

HUBB sends enrollment packets to homecare workers upon request and when:

- A homecare worker begins meeting eligibility requirements by working 80 hours for one or two months in a row. This is the first and/or second month of the qualifying period. This applies to new homecare workers and homecare workers who were previously enrolled and lost HUBB insurance. Homecare workers who lose HUBB insurance can reenroll again by meeting eligibility requirement again.
- An Open Enrollment is announced.

### What is the "qualifying period"?

A qualifying period is a three month period consisting of 80 or more hours worked for two consecutive months followed by a one month waiting period. When an enrollment form is received and date stamped at HUBB during a qualifying period, coverage will be effective first of the month following the waiting period.

Here is an example: If you work 80 or more hours in January and February, you are eligible for coverage April 1st as long as HUBB receives your enrollment form by March 31st. (March serves as your waiting period.) In this same example, if HUBB receives your enrollment form April 5th, your coverage will be effective May 1st.

### When does my coverage go into effect?

If you are enrolling as a newly eligible homecare worker, you may enroll any time during the qualifying period by completing the medical and dental enrollment form. When the enrollment form is received and date stamped at HUBB during the qualifying period, coverage will be effective the first of the month following two consecutive months of 80 hours or more plus the waiting period.

### When does my family coverage go into effect?

When the initial enrollment form enrolling your family members is received and date stamped at HUBB, coverage will be effective the first of the following month as long as the homecare worker has met the qualifying period and submitted the premium payment for the cost of family coverage. If you have applied for a premium subsidy through the Family Health Insurance Assistance Program (FHIAP), coverage for your family members is effective the first of the month following the FHIAP approval date. FHIAP will invoice you for your share of the monthly premium. Family members can be added due to a qualified status change event or during an open enrollment period.

### How will I pay for family coverage?

There is an additional cost for family coverage. HUBB members are responsible for the monthly premium for all family members covered. Upon receipt of your first month's family premium payment, HUBB will mail you a supply of coupons to use when submitting subsequent monthly premium payments to HUBB. HUBB and the Family Health Insurance Assistance Program (FHIAP) created a partnership to provide affordable health insurance coverage for family members through a subsidy program. FHIAP sends monthly invoices to participants in this program. Participants make their premium payments directly to FHIAP.

### When will I receive my I.D. Cards and Plan Handbook?

The insurance company will send you an ID card when your coverage becomes effective. When you seek services, show your medical or dental provider your ID card to identify your coverage. If you need services before you receive your ID card, contact the HUBB office for the group number. If you lose your ID card, a replacement may be requested by contacting the insurance company's membership services department.

Once enrolled in the medical and dental plan, you will receive a confirmation letter from HUBB. You may request a copy of your plan handbook from HUBB with the post card included in your enrollment confirmation. You can also view and/or print your plan handbook from [www.hubbinsurance.org](http://www.hubbinsurance.org). Your member handbook describes your responsibilities and provides detailed

information about your plan benefits, what services require pre-authorization, limitations and procedures. Become familiar with your benefits so you can be a well-informed health care consumer.

## Status Change Events

### What if I move and no longer reside in my plan's area?

If you move out of a plan's service area while enrolled on the plan, you are no longer eligible for that plan. It is important to notify the HUBB Office so that your enrollment can be changed to the responsible insurance carrier in your new area.

### I have been enrolled on another plan but recently lost that coverage. Can I enroll in the HUBB plan now?

If you did not enroll in the HUBB plan because you were enrolled in another plan and you lose that coverage, you may request enrollment in the HUBB Program by completing the enrollment form within 60 days of the last day of coverage on the other plan. HUBB will confirm that you have met the hours-worked requirement. You will be given credit for hours worked in the most recent two-month period plus the waiting period. If eligibility can be established, your coverage will be effective the first of the month after your previous coverage ended. If HUBB is not able to establish eligibility with the most recent months look-back, you will have a gap in coverage until eligibility is established.

### What happens to my coverage if my hours drop below 80?

Once you are enrolled in the HUBB insurance program, you must continue to work 80 hours or more to remain on the plan. If your hours drop below 80 for one month, you will still be covered. However, if your hours drop below 80 hours for two consecutive months, your coverage will be cancelled after a one month waiting period.

Here is an example: If you are enrolled on the plan and your hours drop below 80 in June and July, you will lose coverage September 1st. August serves as the waiting period.

When you lose coverage, HUBB will send you information about continuation of coverage through the COBRA Program. The COBRA program allows you to continue your coverage by self-paying the monthly premium. (See Mandated Benefit Notices in this handbook).

### How do I re-enroll if I re-qualify for coverage after my coverage ends due to a reduction of hours?

HUBB will automatically send you an enrollment packet when you have completed the first month of a new qualifying period.

Your coverage will be effective the first of the month following receipt of the enrollment form (date stamped at HUBB) and completion of the qualifying period.

### If I am unable to work due to an on-the-job injury, will I lose my health insurance?

Once you are enrolled in the HUBB medical plan and your hours drop below 80 hours for one month due to an on-the-job injury, you will still be covered. However, if your hours drop below 80 for two consecutive months, your coverage will be cancelled.

When you lose coverage, HUBB will send you information about continuation of coverage through the COBRA Program. The COBRA Program allows you to continue your coverage by self-paying the monthly premium.

## Plan Coverage

### Do I have to choose a primary care provider (PCP) before I go to my doctor's appointment?

Yes, with ODS Medical Plan you must select a PCP who is participating with ODS before your first office visit. If you do not use a participating ODS physician, you may not receive coverage for your visit.

Kaiser Permanente encourages you to select a PCP. You may choose a doctor, nurse practitioner, or physician's assistant in family practice or internal medicine. However, you are not required to select your PCP before your first visit.

### What is Routine Vision Coverage?

Routine vision coverage covers the cost of your routine eye exam (where no medical problems exist), the refraction, frames, lenses and contact lenses up to the plan allowance.

### Do I have to enroll separately for routine vision coverage?

No. Routine vision coverage is part of your medical plan. Enrollment in the medical plan will provide routine vision coverage.

### I am enrolled on a HUBB medical plan and Medicare Part B. Where should my health care providers send claims?

The HUBB group health benefit plan is primary coverage and Medicare is secondary coverage. Your health care providers should send claims to your HUBB medical plan first.

# Cost of Coverage

## Employee Coverage

The State of Oregon pays the full cost of employee-only health insurance (medical, dental and vision coverage) through a state contribution required by the collective bargaining agreement. You must be enrolled in the medical plan to enroll in the dental plan.

## Family Coverage

The State of Oregon does not pay the premium for family members. HUBB members are responsible for the monthly premium for all family members covered. Family members must be enrolled in the medical plan to enroll in the dental plan.

HUBB members can self pay the monthly premium for their eligible family members. The table below shows the employee cost of family coverage. Premium payments are due no later the 1st of the month for that month's coverage. For example, HUBB must receive your premium payment for April insurance coverage by April 1 for family coverage to be effective on April 1. Include your check or money order payable to: HUBB Trust.

When available, HUBB also coordinates premium subsidies for family coverage with the Family Health Insurance Assistance Program (FHIAP) through the Office of Private Health Partnerships (OPHP).

## 2010 Insurance Premium Rates

**Premium - State Contribution = Employee Cost for Family Coverage**

	Monthly Premium	State Contribution	Employee Cost
<b>Kaiser Permanente Medical Plan</b>			
Employee	562.43	562.43	0.00
Employee & Spouse/Domestic Partner	1,124.86	562.43	562.43
Employee & Child(ren)	1,012.37	562.43	449.94
Employee & Family	1,687.28	562.43	1,124.85
<b>ODS Medical Plan</b>			
Employee	761.73	761.73	0.00
Employee & Spouse	1,452.44	761.73	690.71
Employee & Child(ren)	1,161.08	761.73	399.35
Employee & Family	1,911.88	761.73	1,150.15
<b>Kaiser Permanente Dental Plan</b>			
Employee	44.35	44.35	0.00
Employee & Spouse	87.82	44.35	43.47
Employee & Child(ren)	80.28	44.35	35.93
Employee & Family	122.41	44.35	78.06
<b>ODS Dental Plan</b>			
Employee	36.79	36.79	0.00
Employee & Spouse/Domestic Partner	72.85	36.79	36.06
Employee & Child(ren)	66.56	36.79	29.77
Employee & Family	101.66	36.79	64.87

## What is FHIAP?

FHIAP is a state program that pays 100% of your child's monthly health insurance premium and from 50 percent to 95 percent of the adult's premium costs. You pay copays and other plan costs. If you qualify, the subsidy is good for one year and you may reapply every year.

**Call FHIAP at 1-888-564-9669  
9 AM – 5 PM Monday – Friday**

**Website: [www.oregon.gov/OPHP/FHIAP](http://www.oregon.gov/OPHP/FHIAP)**

# Summary of Eligibility Requirements & Enrollment Rules

*A complete set of HUBB Eligibility Rules can be found in this handbook beginning on page 18.*

## ELIGIBILITY

### Homecare Workers

You are eligible for medical and dental insurance coverage under HUBB if:

1. You are a full-time, part-time, hourly or live-in publicly funded Oregon Homecare Worker; and
2. You are employed through the Client Employed Providers (CEP), Spousal Pay Providers, or Oregon Project Independence and compensated by the Department of Human Services (DHS); and
3. You work 80 or more hours per month for two consecutive months; and
4. You are not covered by any other medical or dental coverage other than Medicare and Veteran's benefits. If you are covered by another group or individual medical or dental plan, you must cancel that plan in order to be eligible to enroll in HUBB insurance.

### Family Members

Family members of homecare workers are eligible for medical and dental insurance under HUBB as follows:

1. If you are married, your legal spouse is eligible for insurance. Your domestic partner of the same or opposite gender is eligible for coverage if he or she meets the eligibility criteria on the HUBB Domestic Partner Affidavit or you present a Certificate of Registered Domestic Partnership.
2. Any child under the age of 26 who is a biological or adopted child or a child placed for adoption of the eligible employee, employee's spouse, or the employee's domestic partner and is not covered by any other medical and dental insurance and does not have other employer sponsored medical and dental insurance available to them.

### Loss of Eligibility

Employees lose eligibility when their hours-worked are less than 80 hours for two consecutive months. Coverage ends one month after their work hours fall below 80 hours for two consecutive months.

Family members lose eligibility when they no longer meet the definition of family member or when the employee loses eligibility due to a reduction in hours of work.

Once enrolled in the program, employees and family members who lose eligibility may continue coverage through the COBRA Continuation of Coverage program by self-paying the monthly premium.



## ENROLLMENT AND EFFECTIVE DATES

### Eligible Homecare Workers

Homecare workers may enroll during the qualifying period by completing the Medical and Dental Enrollment Form according to their area of residence. When the enrollment form is received and date stamped at HUBB during the qualifying period, coverage will be effective the first of the month following two consecutive months of 80 hours or more plus the waiting period.

Workers who submit the enrollment form after the qualifying period will receive coverage the first of the month following receipt of the form (date stamped at HUBB) if the employee continues to meet the eligibility requirements.

### Re-Enrolling for Coverage

Homecare workers who lose HUBB coverage and then later work enough hours to qualify for HUBB insurance again, may enroll for insurance.

Employees who return to benefit eligible status following a period of ineligibility and loss of coverage must work 80 hours or more for two consecutive months and meet the one-month waiting period to qualify to enroll for coverage.

Employees who return to qualified status after a break in coverage must complete a new enrollment form and submit it to HUBB during the qualifying period. When the enrollment form is received and date stamped at HUBB during the qualifying period, coverage will be effective the first of the month following two consecutive months of 80 hours plus the waiting period.

### Family Member Enrollment

Workers may enroll family members for medical and dental coverage as follows:

1. At the time of the employee's initial enrollment;
2. At the time the employee re-qualifies for coverage;
3. As a result of a status change event; or
4. During Open Enrollment.
5. Family members must be enrolled in the medical plan to be eligible to enroll in the dental plan.

6. Family members cannot participate unless the homecare worker is enrolled in the HUBB plans.
7. Family members cannot be patients (clients) of the homecare worker.

## ENROLLMENT CHANGES

### Status Change Events

Workers can make changes to their enrollment if the enrollment change request is consistent with and a result of a qualified status change as outlined below. Enrollment change requests must be received and date stamped at HUBB within 60 days of the status change event in order to be honored. When the enrollment form is received and date stamped at HUBB during the 60-day enrollment period for status change events, coverage will be effective the first of the following month as long as the worker continues to meet eligibility requirements.

In the case of a newborn child, coverage will be effective retroactive to date of birth as long as the enrollment form is received (date stamped at HUBB) during the 60-day enrollment period for status change events.

### **Status Change Events Include:**

1. You marry or establish a domestic partnership through Affidavit or Certificate of Registered Domestic Partnership.
2. Your spouse or domestic partner dies; or you divorce or dissolve your domestic partnership.
3. Your biological child is born; you adopt a child or a child is placed with you for adoption.
4. A dependent child dies.
5. A child becomes eligible as a dependent for coverage under your benefit plan.
6. A child is no longer eligible as a dependent for coverage under your benefit plan.
7. Your employment status changes.
8. Your spouse's or domestic partner's employment status changes.
9. The cost of your benefit coverage changes.
10. You, your spouse or domestic partner or dependent child lose other benefit coverage.

11. You, your spouse or domestic partner receive a Qualified Medical Child Support Order
12. You, your spouse or domestic partner move out of the plan's service area.
13. Your family member is approved or denied for a FHIAP premium subsidy or the amount of your FHIAP premium subsidy changes.
14. You or a family member gains eligibility for assistance or loses eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP).

#### Move Out of Service Area

If a worker moves out of the service area of the medical and/or dental plan in which he/she is enrolled and is no longer eligible to participate in that plan, they must re-enroll in the plan available in the new area.

#### Covered Under another Plan – Loss of Coverage

Workers not enrolled in the insurance plan because they are covered under another plan, who subsequently lose the other coverage, may request enrollment in the Homecare Insurance Program. To establish eligibility after loss of other coverage, HUBB must evaluate eligibility based on a look-back of the reported previous months hours worked. The employee will receive credit for hours worked for the most recent two-month period and the waiting period. If eligibility can be established, the employee's coverage will be effective the first of the month after the previous coverage is lost. If eligibility is not established with the most recent months look-back, the employee will experience a gap in coverage until eligibility is established.

## **Questions about Eligibility and Enrollment?**

Contact: HUBB

1.866.364.HUBB (4822) *toll free*

*8am - 5pm Monday - Friday*

website: [www.hubbinsurance.org](http://www.hubbinsurance.org)

email: [HUBB@opeuseiu.org](mailto:HUBB@opeuseiu.org)



# KAISER PERMANENTE®

## Type of Plan

Health Maintenance Organization (HMO)

## Service Area

The Kaiser Permanente service area is approximately a 30-mile radius of any Kaiser Permanente facility. The service area is defined by zip codes. If you live in one of the zip codes listed here, your coverage will be provided through the Kaiser Permanente Medical Plan.

You are eligible for enrollment and continued coverage as long as you reside in the service area. The service area consists of the following counties within the following ZIP codes:

### In Oregon

**Benton:** 97330, 97331, 97333, 97339, 97370

**Clackamas:** 97004, 97009, 97011, 97013, 97015, 97017, 97022, 97023, 97027, 97034, 97035, 97036, 97038, 97042, 97045, 97049, 97055, 97067, 97068, 97070, 97086, 97089, 97222, 97267, 97268, 97269

**Columbia:** All ZIP codes

**Hood River:** 97014,

**Linn:** 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389

**Marion:** 97002, 97020, 97026, 97032, 97071, 97137, 97301, 97302, 97303, 97305, 97306, 97307, 97308, 97309, 97310, 97311, 97312, 97313, 97314, 97317, 97325, 97342, 97346, 97352, 97362, 97373, 97375, 97381, 97383, 97384, 97385, 97392

**Multnomah:** All ZIP codes

**Polk:** All ZIP codes

**Washington:** All ZIP codes

**Yamhill:** All ZIP codes

### In Washington

**Clark:** All ZIP codes

**Cowlitz:** All ZIP codes

**Lewis:** 98591, 98593, 98596

**Skamania:** 98639, 98648, 98671

**Wahkiakum:** 98612, 98647

## Out of Network Care

Not covered, except for emergency and urgent care when you are not able to get to a Kaiser Permanente facility.

## Covered Providers

You must use Kaiser Permanente providers and facilities to be eligible for benefit coverage under this plan. Kaiser encourages you to choose a primary care physician to coordinate your medical care and authorize referrals to other Kaiser physicians and specialists.

You can review the providers at each Kaiser facility by going to [www.kaiserpermanente.org](http://www.kaiserpermanente.org) or you can request a list of physicians and facilities by telephone to HUBB or Kaiser Permanente Member Services.

## Dependent Age Limits

Your group plan covers enrolled dependents to age 26 (see Eligibility Rules, Section 1 for definition of eligible family members).

## Member Services (M-F, 8am-6 pm)

Portland area...503-813-2000. All other areas...1-800-813-2000. TTY...1-800-735-2900. Language Interpretation Services, all areas...1-800-324-8010



KAISER PERMANENTE®

# Summary of Medical Plan Benefits

April 1, 2011 – December 31, 2011

OREGON HOME CARE COMMISSION	11428-001
<b>Annual individual deductible</b>	None
<b>Annual family deductible</b>	None
<b>Annual individual out-of-pocket maximum</b>	\$600 <sup>1</sup>
<b>Annual family out-of-pocket maximum</b>	\$1,200 <sup>1</sup>
<b>Lifetime benefit maximum</b>	None

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan provider)	<b>You pay</b>
<b>Office visits</b>	
Preventive care	\$0
Primary care	\$20
Urgent Care	\$20
Specialty care	\$20 <sup>2</sup>
Prenatal care	\$0
Routine eye exam	\$20
Allergy shots and other injections	\$5
Routine immunizations	\$0
Rehabilitative therapies	\$20 <sup>3</sup>
Outpatient surgery	\$20 <sup>2</sup>
<b>X-rays, imaging, laboratory, and special diagnostic procedures</b>	\$0
<b>Outpatient prescription drugs</b>	\$10 generic/ \$20 brand. You get up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two copayments. <sup>4</sup>
<b>Hospital inpatient care</b>	\$0 <sup>5</sup>
<b>Hospital maternity care for mother and newborn</b>	Same as hospital inpatient care.
<b>Emergency department visit– Kaiser-affiliated hospital</b>	\$75 <sup>6</sup>
<b>Emergency department visit– Kaiser Emergicenter or Urgent Care Clinics</b>	\$20
<b>Ambulance services</b>	\$75
<b>Mental health services</b>	
Inpatient and Residential care	\$0 <sup>5</sup>
Day treatment	\$20 copay per day
Outpatient treatment	\$20 copay
<b>Chemical dependency services</b>	
Inpatient and Residential care	\$0 <sup>5</sup>
Day treatment	\$20 copay per day
Outpatient treatment	\$20 copay



KAISER PERMANENTE®

# Summary of Medical Plan Benefits

April 1, 2011 – December 31, 2011

**Benefit** (when provided, prescribed, or authorized by a Kaiser Permanente Plan physician)

**You pay**

<b>Skilled nursing facility care</b>	\$0 for up to 100 days per year
<b>Home health care</b>	\$0 for up to 130 visits per year
<b>Infertility services</b>	50% for diagnosis and treatment
<b>Durable medical equipment</b>	20%
<b>Prescription eyeglasses and contact lenses</b>	Balance after \$150 credit is applied. Your benefit renews every 24 months on a rolling year basis from date of service. <sup>7</sup>

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on your benefit coverage, claims review, and adjudication procedures, please see your evidence of coverage (or EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.

**Footnotes:** <sup>1</sup>Per calendar year. <sup>2</sup>\$0 for preventative procedures. <sup>3</sup>Limited to 20 visits per therapy year. <sup>4</sup>Kaiser Permanente formulary applies. We cover nonformulary drugs only when you meet exception criteria. <sup>5</sup>Includes room and board, surgery, anesthesia, X-rays, imaging, laboratory, and drugs. <sup>6</sup>Copay waived if admitted. <sup>7</sup>Professional fees for cosmetic contact lenses not covered. If the full credit is not used in the first visit, the balance is forfeited. No charge for standard frames and lenses post cataract surgery.





OREGON HOME CARE COMMISSION	11428-001
<b>Dental office visit charge</b>	\$10*
<b>Annual deductible</b>	None
<b>Annual benefit maximum</b>	\$1,500

<b>Benefit</b> (when provided, prescribed, or authorized by a Kaiser Permanente Plan dentist)	<b>You pay</b>
<b>Preventive and diagnostic services</b>	
Oral exams and X-rays, teeth cleaning, fluoride treatments, instruction in care of your teeth and gums, and prescribed space maintainers	\$10
<b>Basic restorative services</b>	
Routine fillings, plastic and stainless steel crowns	20%
<b>Simple extractions</b>	
	20%
<b>Oral surgery</b>	
Surgical tooth extractions, including diagnosis and evaluation	20%
<b>Periodontics</b>	
Diagnosis, evaluation, and treatment of gum disease, including scaling and root planning	20%
<b>Endodontics</b>	
Root canal and related therapy, including diagnosis and evaluation	20%
<b>Major restorative services</b>	
Gold or porcelain crowns, inlays, and bridge abutments and pontics	50%
<b>Removable prosthetic services</b>	
Full and partial dentures, relines and rebases	50%
<b>Emergency treatment</b>	
From Plan providers:	\$25 for emergency and urgent care visits on the same or next business day plus any other charges that normally apply.
From non-Plan providers:	Balance after you are reimbursed up to \$100 for qualifying claims outside the service area.
<b>Orthodontics</b>	
	Not a covered benefit

**Please note:** \*applies to each office visit

- You pay \$15 for nitrous oxide for adults and children 13 and older.
- You pay 10 percent of charges for night guards.

**Limitations and Exclusions**

Benefits for work-in-progress are excluded for the following services and related materials: a) a prosthetic or other appliance, or modification of one, where an impression was made before your coverage became effective; b) a crown, bridge, or gold restoration for which a tooth was prepared before your coverage became effective; c) root canal therapy if the pulp chamber was opened before your coverage became effective is covered at 50 percent of charges.

This is not a contract. This benefit summary does not fully describe your benefit coverage with Kaiser Foundation Health Plan of the Northwest. For more details on your benefit coverage, claims review, and adjudication procedures, please see A Guide to Your Benefits (or EOC) or call Membership Services. In the case of conflict between this summary and the EOC, the EOC will prevail.



### Type of Plan

Medical- Managed Care

Dental -Premier

### Service Area

**Medical**– All areas statewide outside the Kaiser Permanente Service Area.

**Dental**– All areas statewide.

### Providers

**Medical**- You must use in-network providers in order to be covered, except in the case of a medical emergency or authorized referral to an out-of-network provider. You must select a Primary Care Physician (PCP) from the ODS Plus Network which is available at [www.odscompanies.com](http://www.odscompanies.com) or if currently enrolled, by logging into myODS at [www.odscompanies.com/members](http://www.odscompanies.com/members). The PCP coordinates all healthcare needs including referrals and specialty care authorization, hospitalization authorization and severe healthcare problems. Each family member may choose a different PCP. Benefits under this plan will not be available to you if you receive care from a participating provider or from any other physician without a referral from your PCP.

**Dental**- You may choose services from any licensed dental provider. Reimbursement to ODS Premier dental providers and Non-contracted dental providers may differ. To maximize your benefits, you can find ODS Premier dental providers by visiting [www.odscompanies.com](http://www.odscompanies.com).

### Pre-existing Condition Limitation –Medical only

This plan has a six-month pre-existing condition limitation for members age 19 and older. A pre-existing condition is a physical or mental condition that was diagnosed and for which you received medical advice or treatment during the six-month period immediately before your enrollment date.

**Your six-month exclusion period will be reduced if you had prior coverage and your prior coverage ended within 63 days of the enrollment date of coverage under this Plan. Please submit a certificate of creditable coverage form from your prior plan to receive credit.**

For more information about this pre-existing condition limitation, contact ODS.

### Dependent Age Limits

Your group plan covers enrolled dependents to age 26 (see Eligibility Rules, Section 1 for definition of eligible family members).

### Member Services

**Medical Customer Service**  
(503) 265-2964  
(888) 217-2363

**Dental Customer Service**  
(503) 265-2965  
(888) 217-2365

**Pharmacy Customer Service**  
800-913-4284

# Summary of Medical Plan Benefits

April 1, 2011 – December 31, 2011

OREGON HOME CARE COMMISSION

10001759

## Service

## ODS Network you pay

Calendar Year Deductible Member / Family

\$100<sup>1</sup>

Calendar Year Maximum Out-of-Pocket Per Member

\$2,500 (2x for family)

Essential Benefit Annual Maximum (Medical and Rx)

\$750,000

### PREVENTIVE CARE (refer to schedule in member handbook)

### NO DEDUCTIBLE

Routine Physical Exams

\$0

Routine Immunizations (all ages)

\$0

Well Baby Exams

\$20

Women's Routine Mammograms

\$0

Women's Annual Exams

\$0

Routine X-ray & Lab Services (related to routine physical exams)

20%

### VISION

This Plan pays for vision examinations for you and your insured dependents, corrective lenses and frames when prescribed by a licensed Ophthalmologist or licensed Optometrist.

Eye exam, lenses, frames and contact lenses paid at 100% up to a maximum total of \$200 every calendar year for those under age 18 and every 2 calendar years for those 18 and older.

### PHYSICIAN / PROVIDER SERVICES

### NO DEDUCTIBLE

Office Visits

\$20

Outpatient Rehabilitation

\$20

Urgent Care Office Visit

\$20 visit

### OUTPATIENT PRESCRIPTION DRUGS

Generic

40% Copay

Brand Name

40% Copay

Up to a maximum of \$150 copayment per prescription. See your ODS Plan Handbook for information on limitations and exclusions.

### HOSPITAL SERVICES

### DEDUCTIBLE APPLIES

Inpatient Care (including X-ray & Lab Services)

20%

Outpatient Surgery (including surgery performed in physician/provider's office)

20%

Surgery Center / Surgery Facility Charge

20%

Physician Visits While Hospitalized

20%

Surgeon Fees

20%

### EMERGENCY SERVICES

### DEDUCTIBLE APPLIES

Emergency Room Facility (\$100 per visit waived if admitted)

\$100 copay, then 20%

Ambulance

20%

# Summary of Medical Plan Benefits

April 1, 2011 – December 31, 2011

## Service

### OTHER SERVICES

- Diagnostic X-ray & Lab Services (office and outpatient)
- Specified Imaging (MRI, CT, CAT, PET scans)
- Allergy Shots & Other Therapeutic Injections
- Medical Equipment & Supplies
- Hospice Care (subject to limitations)
- Mental health/chemical dependency (outpatient)
- Mental health/chemical dependency (residential)
- Mental health/chemical dependency (inpatient)
- Home Health Care
- Skilled Nursing Facility

## ODS Network you pay

### DEDUCTIBLE APPLIES

- 20%
- 20%
- 20%
- 20%
- 20%
- \$20 (no deductible)
- 20%
- 20%
- 20%
- 20%

<sup>1</sup> Fixed dollar copays, prescription drug copays, and disallowed charges do not apply to the annual deductible or to the out of pocket maximum.

This benefit summary does not fully describe your benefit coverage with ODS Medical Plan. For more details on your coverage, see your ODS Member Handbook or call ODS Customer Service. In the case of a conflict between this Summary and the ODS Member Handbook, the Handbook will prevail.



OREGON HOME CARE COMMISSION 10001759

**Calendar year maximum benefit, per member** **\$1,500**

**Calendar year deductible, per member** **\$50**

## Service

## Benefit

**PREVENTIVE CARE (no deductible)** **100%**

Examination/X-rays (routine exam & bitewing x-rays once every six months)  
Prophylaxis (cleanings - once every six months)  
Fissure Sealants  
Space Maintainers  
Flouride

**BASIC** **80%**

Restorative Dentistry (treatment of tooth decay with amalgam or composite)  
Oral Surgery (surgical extractions & certain minor surgical procedures)  
Endodontic (pulp therapy & root canal filling)  
Periodontics (treatment of tissues supporting the teeth)

**MAJOR** **50%**

Crowns  
Cast Restorations  
Implants  
Denture and Bridge Work (construction or repair of fixed bridges, partials, and complete dentures)

## ORAL HEALTH, TOTAL HEALTH

Research confirms that regular visits to the dentist may help in the diagnosis and management of diabetes; and dental cleanings during a woman's third trimester of pregnancy may help prevent pre-term and low-birth-weight babies. This new Oral Health, Total Health program is developed based on this new evidence. The program's benefits include:

- A third trimester cleaning for pregnant women
- Two additional cleanings or periodontal maintenance per year for individuals with diabetes

To register for in the ODS *Oral Health, Total Health* program, call ODS at 1-877-277-7280.

### Limitations and Exclusions

Limitations and Exclusions apply. Services started prior to the individual's effective date under the program are not covered.

This benefit summary does not fully describe your benefit coverage with ODS Dental Plan. For more details on your coverage, see your ODS Member Handbook or call ODS Customer Service. In the case of a conflict between this Summary and the ODS Member Handbook, the Handbook will prevail.

# Mandated Benefit Notices

## 1. Important Information About Your COBRA Continuation Coverage Rights

### Introduction

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you when you would otherwise lose your group health coverage. It can also become available to other members of your family who are covered under the Plan when they would otherwise lose their group health coverage. For additional information about your rights and obligations under the Plan and under federal law, you should review the Plan's Summary Plan Description or contact the Plan Administrator. The Plan Administrator is the Homecare Union Benefits Board, LLC. (HUBB)

### What is COBRA Continuation Coverage?

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse/domestic partner, and your dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

**If you are an employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because either one of the following qualifying events happens:

- Your hours of employment are reduced, or
- Your employment ends for any reason.

**If you are the spouse/domestic partner of an employee**, you will become a qualified beneficiary if you lose your coverage under the Plan because any of the following qualifying events happens:

- Your spouse/domestic partner dies;
- Your spouse/domestic partner's hours of employment are reduced;
- Your spouse/domestic partner's employment ends for any reason;
- Your spouse/domestic partner becomes entitled (enrolled in) to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse; or dissolve your domestic partnership.
- Your spouse/domestic partner gains eligibility for assistance or loses eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIPs)

**Your dependent children** will become qualified beneficiaries if they lose coverage under the Plan because any of the following qualifying events happens:

- The parent-employee dies;
- The parent-employee's hours of employment are reduced;
- The parent-employee's employment ends for any reason;

- The parent-employee becomes entitled to (enrolled in) Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or domestic partnership is dissolved;
- The child stops being eligible for coverage under the plan as a "dependent child."
- The Parent-Employee gains eligibility for assistance or loses eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIPs)

### How long will continuation coverage last?

In the case of a loss of coverage due to end of employment or reduction in hours of employment, coverage generally may be continued for up to a total of 18 months. In the case of loss of coverage due to an employee's death, divorce or legal separation or dissolution of domestic partnership, the employee's becoming entitled (enrolled in) to Medicare benefits or a dependent child ceasing to be a dependent under the terms of the plan, coverage may be continued for up to a total of 36 months. When the qualifying event is the end of employment or reduction of the employee's hours of employment, and the employee became entitled to (enrolled in) Medicare benefits less than 18 months before the qualifying event, COBRA continuation coverage for qualified beneficiaries other than the employee lasts until 36 months after the date of Medicare entitlement (enrollment). This notice shows the maximum period of continuation coverage available to the qualified beneficiaries.

Continuation coverage will be terminated before the end of the maximum period if:

- any required premium is not paid in full on time,
- a qualified beneficiary becomes covered, after electing continuation coverage, under another group health plan that does not impose any pre-existing condition exclusion for a pre-existing condition of the qualified beneficiary,
- if a qualified beneficiary enrolls in Medicare benefits (under Part A, Part B, or both) after electing continuation coverage, or
- if the employer ceases to provide any group health plan for its employees.

Continuation coverage may also be terminated for any reason the Plan would terminate coverage of a participant or beneficiary not receiving continuation coverage (such as fraud).

### How can you extend the length of continuation coverage?

If you elect continuation coverage, an extension of the maximum period of 18 months of coverage may be available if a qualified beneficiary is disabled or a second qualifying event occurs. You must notify the Plan Administrator of a disability or second qualifying event in order to extend the period of continuation coverage. Failure to provide notice of a disability or second qualifying event may affect the right to extend the period of continuation coverage.

### Disability

An 11-month extension of coverage may be available if any of the qualified beneficiaries is disabled. The Social Security Administration (SSA) must determine that the qualified beneficiary was disabled at some time during the first 60 days of continuation coverage and the disability must last at least until the end of the 18-month period of coverage. You must notify the HUBB COBRA

Administrator of that fact within 60 days of the SSA's determination and before the end of the first 18 months of continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined by SSA to no longer be disabled, you must notify the Plan Administrator of that fact within 30 days of SSA's determination.

### Second Qualifying Event

An 18-month extension of coverage will be available to spouses/ domestic partners and dependent children who elect continuation coverage if a second qualifying event occurs during the first 18 months of continuation coverage. The maximum amount of continuation coverage available when a second qualifying event occurs is 36 months. Such second qualifying events may include the death of a covered employee, divorce or legal separation or dissolution of domestic partnership from the covered employee, the covered employee's becoming entitled to (enrolled in) Medicare benefits (under Part A, Part B, or both), or a dependent child's ceasing to be eligible for coverage as a dependent under the plan. These events can be a second qualifying event only if they would have caused the qualified beneficiary to lose coverage under the plan if the first qualifying event had not occurred. You must notify the Plan Administrator within 60 days after a second qualifying event occurs if you want to extend your continuation coverage.

### How can you elect continuation coverage?

A qualified beneficiary has a right to elect continuation coverage. A qualified beneficiary must elect coverage by the date specified on the Election Form. Failure to do so will result in loss of the right to elect continuation coverage under the Plan. A qualified beneficiary may change a prior rejection of continuation coverage any time until that date. Each qualified beneficiary has a separate right to elect continuation coverage. For example, the employee's spouse/domestic partner may elect continuation coverage even if the employee does not. Continuation coverage may be elected for only one, several, or for all dependent children who are qualified beneficiaries. A parent may elect to continue coverage on behalf of any dependent children. The employee or the employee's spouse/ domestic partner can elect continuation coverage on behalf of all of the qualified beneficiaries.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you can lose the right to avoid having pre-existing condition exclusions applied to you by other group health plans if you have more than a 63-day gap in health coverage, and election of continuation coverage may help you not have such a gap. Finally, you should take into account that you have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's/domestic partner's employer) within 30 days after your group health coverage ends because of the qualifying events listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time

available to you.

### How much does continuation coverage cost?

Each qualified beneficiary pays the entire cost of continuation coverage. The amount a qualified COBRA beneficiary may be required to pay may not exceed 102 percent of the cost to the group health plan for coverage of a similarly situated plan participant or beneficiary who is not receiving continuation coverage (or, in the case of an extension of continuation coverage due to a disability, 150 percent). The required payment for each continuation coverage period for the qualified beneficiary listed on the Election Notice is described on the Election Notice.

### When and how must payment for continuation coverage be made?

#### First payment for continuation coverage

If you elect continuation coverage, you may pay your premium payment with your election form or you must make your first payment for continuation coverage within 45 days after the date of your election. (This is the date the Election Form is post-marked, if mailed.) If you do not make your first payment for continuation coverage within that 45 days, you will lose all continuation coverage rights under the Plan.

Your first payment must cover the cost of continuation coverage from the time your coverage under the Plan would have otherwise terminated up to the time you make the first payment. You are responsible for making sure that the amount of your first payment is enough to cover the entire period. You may contact the Plan Administrator at (503) 364-HUBB (4822) or (866) 364-4822 to confirm the amount of your first payment.

#### Make your check payable to "HUBB Trust" and mail to:

Homecare Union Benefits Board, LLC  
SEIU Local 503, OPEU  
Headquarters: 1730 Commercial Street SE  
PO Box 12159  
Salem, OR 97309-0159

#### Periodic payment for continuation coverage

After you make your first payment for continuation coverage, you will be required to pay for continuation coverage for each subsequent month of coverage. Under the Plan, these periodic payments for continuation coverage are due on the first day of the month. If you make a periodic payment on or before its due date, your coverage under the Plan will continue for that coverage period without a break. The Plan will send periodic notices of payment due for these coverage periods.

Periodic payments for continuation coverage should be sent to the same address as your first payment as shown above.

#### Grace periods for periodic payments

Although periodic payments are due on the dates shown above, you will be given a grace period of 30 days to make each periodic payment. Your continuation coverage will be provided for each coverage period as long as payment for that coverage period is made before the end of the grace period for that payment.

However, if you pay a periodic payment later than its due date but during its grace period, your coverage under the Plan will be suspended as of the due date and then retroactively reinstated (going back to the due date) when the periodic payment is made.

This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

If you fail to make a periodic payment before the end of the grace period for that payment, you will lose all rights to continuation coverage under the Plan.

### **Can you elect other health coverage besides continuation coverage?**

Under the Plan, you may have the right, when your group health coverage ends, to enroll in a portability plan (an individual health insurance policy without providing proof of insurability) offered by your health care insurance company. Eligible individuals may enroll in Portability coverage before, during, or at the end of their COBRA continuation coverage. The benefits provided under such an individual conversion policy may not be identical to those provided under the Plan. You are eligible for portability coverage, if you are an Oregon resident at the time of such application and left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans or meet the eligibility requirements of the Health Insurance Portability and Accountability Act of 1998 (HIPAA). You must apply directly to the health care insurance company not later than the 63rd day after termination of your HUBB group coverage.

#### **For more information**

This notice does not fully describe continuation coverage or other rights under the Plan. More information about continuation coverage and your rights under the Plans is available in your Member Handbook or from the Plan Administrator. You can get a copy of your Plans Member Handbook from the HUBB or your health care insurance company.

For more information about your rights under ERISA, including COBRA, the Health Insurance Portability Act (HIPAA), and other laws affecting group health plans, contact the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit the EBSA website at [www.dol.gov/ebsa](http://www.dol.gov/ebsa).

#### **Keep your Plan informed of address changes**

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

## **2. Individual Portability of Medical Insurance**

### **(An alternative to COBRA)**

If you lose eligibility and coverage under the HUBB plan, you may be entitled to convert to one of the insurance carrier's individual portability plans. The benefit coverage on the portability plans is different from the benefit coverage on the HUBB plans.

You are eligible for portability coverage, if you are an Oregon resident at the time of such application and left coverage that was continuously in effect for a period of 180 days or more under one or more Oregon group health benefit plans or meet the eligibility requirements of the Health Insurance Portability and Accountability Act of 1998 (HIPAA). You must apply directly to the health care insurance company not later than the 63rd day after termination of your HUBB group coverage.

Contact your HUBB insurance carrier directly for information and rates.

## **3. Confidentiality**

The Homecare Union Benefits Board (HUBB) takes its responsibility to protect the confidentiality of your personal information seriously. HUBB is committed to protecting your confidential information.

When conducting HUBB business, HUBB will limit the amount of confidential information it requests to the minimum necessary to accomplish its business. If HUBB needs to share confidential information to assist you with appeals, claims or issues with insurance carriers or medical providers, you will be asked to provide authorization for HUBB to use your personal information.

## **4. Notice of Women's Health and Cancer Rights**

If you are receiving benefits in connection with a mastectomy and you, in consultation with the attending physician, elect breast reconstruction, coverage will be provided for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physician complications of all states of mastectomy, including lymph edemas

Reconstruction benefits are subject to the same provisions as any other benefit provided under the plan.

## **5. Medicare Part D—Prescription Drug Coverage**

The Homecare Union Benefits Board (HUBB) has determined that, effective April 1, 2007, the prescription drug coverage offered by Kaiser Permanente and ODS Medical Plans is, on average for all plan participants, expected to pay out as much as the standard Medicare prescription drug coverage will pay. Because the existing HUBB coverage is on average at least as good as standard Medicare prescription drug coverage, you can keep HUBB coverage and not pay extra if you later decide to enroll in Medicare Part D coverage.

## ELIGIBILITY RULES

### Section 1 – Definitions

- A. Appeal – A request for review of an administrative, eligibility, or claim decision that the member considers to be incorrect.
- B. COBRA – The Consolidated Omnibus Budget Reconciliation Act of 1986 that requires employers of 20 or more employees to offer continuation of group coverage upon termination of employment or reduction of hours. The Act also provides continuation options for dependents losing eligibility due to certain “qualifying events”.
- C. Coinsurance – The cost of a covered service that is shared by the plan and the member, usually expressed in percentages. For example: 80% carrier and 20% member.
- D. Copayment or Copay – A fixed dollar amount such as \$20 that is paid by the member to the medical provider when service is rendered.
- E. Deductible – A dollar amount of covered expense the member must pay before the plan pays.
- F. Eligible Employee – An Oregon Homecare Worker who is a full-time, part-time, hourly or live-in and is employed through the Client Employed Provider (CEP), Spousal Pay Providers, or Oregon Project Independence and is compensated by the Oregon Department of Human Services (DHS). Eligible homecare workers are those who work 80 hours or more for two consecutive months and are not covered by other medical insurance coverage except Medicare and Veteran’s Benefits.
- G. Family Members
1. If you are married, your legal spouse is eligible for insurance. Your domestic partner of the same or opposite gender is eligible for coverage if he or she meets the eligibility criteria on the Domestic Partner Affidavit or if you present a Certificate of Registered Domestic Partnership.
- H. Any child under the age of 26 who is a biological or adopted child or a child placed for adoption of the eligible employee, employee’s spouse, or the employee’s domestic partner and is not covered by any other medical and dental insurance and does not have other employer sponsored medical and dental insurance available to them.
- I. FHIAP – The State of Oregon’s Family Health Insurance Assistance Program helps pay for health insurance. FHIAP pays from 50% to 95% of monthly health insurance premiums when you qualify. The subsidy is good for one year and you may re-apply every year.
- J. HMO - Health Maintenance Organization – A type of health plan in which members must receive all care from network providers, usually under the care of a primary care physician.
- K. HUBB – Homecare Union Benefits Board, LLC – The administrator of the health insurance program for Oregon Homecare Workers.
- L. Maximum Benefit – The total amount payable by the plan for covered expenses. For example, the lifetime maximum benefit for medical care in the ODS Medical Plan is \$2 million.
- M. Monthly Premium – The amount of money paid each month to the insurance carrier to cover the cost of health insurance benefits.
- N. Out of Pocket Maximum – The annual amount a member must pay for deductibles and coinsurance before the plan covers all remaining eligible expenses at 100% for the remainder of the calendar year.
- O. Portability of Medical Insurance – Ongoing medical coverage available from the employee’s current medical carrier after termination of coverage with HUBB.
- P. Pre-Authorization – A plan requirement that a covered service is approved by the plan prior to the date of service.
- Q. Pre-Existing Condition – A physical or mental condition that was diagnosed and for which you received medical advice or treatment during the six-month period immediately before your enrollment date. A condition is diagnosed whenever a physician tells a person that he or she has that condition or makes an entry to that effect in the person’s medical records. This applies even if the physician is examining or treating the person for a different condition.
- R. Primary Care Provider – A physician participating in the plan’s network of providers whom you choose to be responsible for your continuing medical care. Your PCP must approve your treatments, services and referrals to other participating specialists for benefits to be paid by the plan.
- S. Qualified Status Change Event
1. You marry or establish a domestic partnership through Affidavit or Certificate of Registered Domestic Partnership.
  2. Your spouse or domestic partner dies; or you divorce or dissolve your domestic partnership.
  3. Your biological child is born, you adopt a child or a child is placed with you for adoption.
  4. A dependent child dies.
  5. A child becomes eligible as a dependent for coverage under your benefits.
  6. A child is no longer eligible as a dependent for coverage under your benefits.
  7. Your employment status changes.
  8. Your spouse’s or domestic partner’s employment status changes.
  9. The cost of your benefit coverage changes.
  10. You, your spouse or domestic partner, or dependent child loses other benefit coverage.
  11. You or your spouse or domestic partner receives a

National Medical Child Support Order.

12. You or your spouse or domestic partner moves out of the plan's service area.

13. You or your family is approved for a premium subsidy or you lose your premium subsidy through FHIAP.

14. You or a family member gains eligibility for assistance or loses eligibility for coverage under Medicaid or the Children's Health Insurance Program (CHIP)

T. Qualifying Period – Once you have worked 80 or more hours for two consecutive months, you must meet a one-month waiting period before coverage goes into effect. The first two months of 80 or more hours plus the waiting period is referred to as the "qualifying period".

U. State Contribution – The amount of money paid by the State of Oregon for eligible homecare workers for purchase of medical insurance provided through HUBB.

V. Subsidy – A benefit provided by the FHIAP to help defray the cost of health insurance. Usually a percentage of the actual cost of the monthly premium.

W. Oregon Prescription Drug Pool (OPDP) – A state program that purchases prescription drugs at discounted cost. In 2007, the Oregon Legislature passed SB 362 that made this program available to groups like HUBB. Homecare workers enrolled in the ODS Medical Plan will receive the benefit of discount prices on prescription drugs through the program.

## Section 2 - Eligibility Requirements

### A. Homecare Workers

Employees eligible for insurance coverage under the Homecare Workers Insurance Program are full-time, part-time, hourly, and live-in publicly funded Homecare Workers employed through the Employer, who are Client Employed Providers (CEPs), Spousal Pay Providers, and providers in the Oregon Project Independence (OPI) Program, and who are compensated by Department of Human Services (DHS) or other public agencies that receive money from DHS. All other Homecare Workers, including those employed by other employers, and supervisors are excluded.

Employees become eligible for homecare medical insurance coverage when they work 80 or more hours per month for two consecutive months. When an employee qualifies for medical insurance, they are also eligible for dental insurance. Employees meeting initial two-month eligibility must meet a one-month waiting period for coverage to be effective. The two consecutive 80-hour months plus the waiting period is referred to as the "qualifying period". Employees are responsible to complete an enrollment form and submit the form to the plan administrator, the Homecare Union Benefits Board (HUBB).

### B. Family Members

Family members of homecare workers are eligible for insurance under the Homecare Workers Insurance Program as follows:

1. A legal spouse or a domestic partner of the same or opposite gender is eligible for coverage if he or she meets the eligibility criteria on the Domestic Partner Affidavit provided by the insurance company or presents a Certificate of Registered Domestic Partnership.
2. Any child under age 26 who is a biological or adopted child or a child placed for adoption of the eligible employee, employee's spouse, or the employee's domestic partner and is not covered by any other medical and dental insurance and does not have other employer sponsored medical and dental insurance available to them.

## Section 3 - Enrollment and Effective Dates

### A. Enrollment Options

Eligible employees who reside in the Kaiser Permanente approved service areas will enroll in the Kaiser Permanente Medical Plan. Employees enrolled in the Kaiser Permanente Medical Plan can choose to enroll in either the Kaiser Permanente Dental Plan or the ODS Dental Plan.

Eligible employees who reside outside the Kaiser Permanente approved service areas will enroll in the ODS Medical Plan. Employees enrolled in the ODS Medical Plan will enroll in the ODS Dental Plan.

Employees enrolled in other health or dental insurance coverage, except Medicare and Veteran's benefits, are not eligible to enroll. Employees will be required to declare on the enrollment form that they are not enrolled in other medical or dental coverage.

### B. Enrollment Procedures and Effective Dates

1. Newly-eligible Employee Enrollment  
Newly eligible employees will receive an enrollment packet from the Homecare Union Benefits Board when they have worked 80 or more hours in one month.

Newly eligible employees may enroll during the qualifying period by completing the medical and dental enrollment form according to their area of residence.

When the enrollment form is received and date stamped at HUBB during the qualifying period, coverage will be effective the first of the month following two consecutive months of 80 hours or more plus the waiting period.

2. Current Employee Enrollment  
Employees who qualify for coverage may enroll by completing the medical and dental enrollment forms for coverage according to their area of residence.

When the enrollment form is received and date stamped at HUBB during the qualifying period, coverage will be effective the first of the month following two consecutive months of 80 hours or more plus the waiting period.

Employees who submit medical and dental enrollment forms after the qualifying period will receive coverage the first of the month following receipt of the forms (date stamped at HUBB) if the employee continues to meet the eligibility requirements.

### 3. Family Member Enrollment

Employees may enroll family members for medical and dental coverage as follows:

- a) At the time of the employee's initial enrollment;
- b) At the time the employee re-qualifies for coverage;
- c) As a result of a status change event;
- d) During open enrollment;
- e) Family members must be enrolled in the medical plan to be eligible to enroll in the dental plan;
- f) Family members cannot participate unless the homecare worker is enrolled in the HUBB plans;
- g) Family members cannot be patients (clients) of the homecare worker.

### 4. Re-Enrolling in Coverage

Homecare workers who lose HUBB coverage and then later work enough hours to qualify for HUBB insurance again, may enroll for insurance.

Employees who return to benefit eligible status following a period of ineligibility and loss of coverage must work 80 hours or more for two consecutive months and meet the one-month waiting period to qualify to re-enroll for coverage.

Employees who return to qualified status after a break in coverage must complete a new enrollment form and submit it to HUBB during the qualifying period. When the enrollment form is received and date stamped at HUBB during the qualifying period, coverage will be effective the first of the month following two consecutive months of 80 hours or more plus the waiting period.

Employees who submit an enrollment form after the qualifying period will receive coverage the first of the month following receipt of the form (date stamped at HUBB) if the employee continues to meet the eligibility requirements.

Eligible employees will receive credit for deductibles incurred within the calendar year before they lost coverage.

## Section 4 – Enrollment Changes

### A. Status Change Events

1. Employees can make changes to their enrollment if the enrollment change request is consistent with and a result of a qualified status change as outlined below. An enrollment change is consistent with a change in status if the change results in the employee, spouse, domestic partner or dependent child gaining or losing eligibility for coverage under the plan or a plan of the spouse, domestic partner, or

dependent child's employer. The enrollment change must correspond with the gain or loss of coverage. An individual who becomes eligible or ineligible for a particular plan (such as moving out of a plan's service area) is treated as gaining or losing eligibility for coverage under the plan.

Enrollment change requests must be received and date stamped at HUBB within 60 days of the status change event in order to be honored. When the enrollment form is received and date stamped at HUBB during the 60-day enrollment period for status change events, coverage will be effective the first of the following month as long as the employee continues to meet eligibility requirements.

In the case of a newborn child, coverage will be effective retroactive to the date of birth as long as the enrollment form is received and date stamped at HUBB during the 60-day enrollment period for status change events.

Qualified Status change events include:

- You marry or establish a domestic partnership through affidavit or Certificate of Registered Domestic Partnership.
- Your spouse or domestic partner dies; or you divorce or dissolve your domestic partnership.
- Your biological child is born; you adopt a child or a child is placed with you for adoption.
- A dependent child dies.
- A child becomes eligible as a dependent for coverage under your benefit plan.
- A child is no longer eligible as a dependent for coverage under your benefit plan.
- Your employment status changes.
- Your spouse's or domestic partner's employment status changes.
- The cost of your benefit coverage changes.
- You, your spouse or domestic partner, or dependent child loses other benefit coverage.
- You, your spouse or domestic partner receives a National Medical Child Support Order.
- You, your spouse or domestic partner moves out of the plan's service area.
- Your family member is approved or denied for a FHIAP premium subsidy, or the amount of your FHIAP premium subsidy changes through FHIAP.
- You or a family member gains eligibility of assistance or loses eligibility Medicaid or Children's Health Insurance Program (CHIP).

### 2. Move Out of Service Area

If an employee moves out of the service area of the medical and/or dental plan in which he/she is enrolled and is no longer eligible to participate in that plan, they must re-enroll in the plan available in the new area.

### 3. Covered Under another Plan – Loss of Coverage

Employees not enrolled in the insurance plan because they are covered under another plan, who subsequently lose the other coverage, may request enrollment in the Homecare Insurance Program. To establish eligibility after loss of other coverage, HUBB will evaluate eligibility based on a look-back of the reported previous months hours worked. The employee will receive credit for hours worked for the most recent two-month period and the waiting period. If eligibility can be established, the employee's coverage will be effective the first of the month after the previous coverage is lost. If eligibility is not established with the most recent months look-back, the employee will experience a gap in coverage until eligibility is established.

4. Loss of Eligibility

a) Employees whose hours-worked are less than 80 hours for two consecutive months lose eligibility. Coverage ends one month after their work hours fall below 80 hours for two consecutive months. Once enrolled in the program, employees who lose eligibility may continue coverage through the COBRA Continuation of Coverage program by self-paying the monthly premium.

b) Family members lose eligibility when they no longer meet the definition of family member or when the employee loses eligibility due to a reduction in hours of work. Once enrolled in the program, family members who lose eligibility due to a "COBRA qualified event" may continue coverage through the COBRA Continuation of Coverage program by self-paying the monthly premium.

**Section 5 – Rights and Responsibilities**

**A. Employee Responsibility**

It is the responsibility of the eligible employee to maintain a valid enrollment.

**B. Declining Insurance**

Employees may decline benefits by waiving their right to the employer contribution and enrollment in the insurance plan. Employees who wish to decline coverage may do so by not submitting an enrollment form.

If an employee declines coverage when eligible to enroll, and at a later time requests enrollment, the employee must meet the eligibility requirements and submit a completed enrollment form. When the enrollment form is received and date stamped at HUBB during the qualifying period, coverage will be effective the first of the month following two consecutive months of 80 hours or more plus the waiting period.

**C. Enrollment Errors and Changes**

The Administrator will review employee requests to make changes or correct enrollment errors. The employee

must demonstrate the error occurred or that the change is necessary. If sufficient evidence is provided for the Administrator to make a determination, and the Administrator approves the enrollment, it will be effective the first of the month following receipt (date stamped at HUBB) and approval of the request.

**Section 6 - Continuation of Insurance**

**A. COBRA**

Employees and family members who lose eligibility for insurance coverage due to a reduction in hours of work or termination of employment have the right to continue their group coverage beyond the date the coverage would expire under the requirements of the COBRA Continuation of Group Coverage procedures.

1. Employees

Under federal law, qualified employees may elect to continue the same coverage they had before losing eligibility due to a reduction of hours of employment or termination of employment by completing the appropriate forms and self-paying the insurance premium. Federal law determines the length of continuation coverage.

2. Family Members

Family members who lose eligibility for insurance coverage due to an employee's qualifying event, have the right to continue their group coverage as follows:

a) Spouse or domestic partner – spouses and domestic partners have independent rights to elect COBRA coverage upon:

(1) Covered employee's termination of employment or reduction of hours

(2) A covered employee's death

(3) A spouse's divorce

(4) A domestic partner's termination of domestic partnership from the covered employee

b) Dependent Children – A dependent child who loses coverage may elect COBRA coverage if one of the following qualifying events occurs:

(1) A covered employee's termination of employment or reduction of hours of employment;

(2) A covered employee's divorce from his or her spouse;

(3) A covered employee's termination of domestic partnership;

(4) A covered employee's death;

(5) A covered employee's enrollment in Medicare benefits and termination of active coverage;

(6) The child no longer satisfies the plan's definition of a dependent child.

3. Employees and family members who lose eligibility for homecare insurance will receive a Notice of COBRA Continuation of Group Coverage from HUBB.

4. Individuals who elect to continue insurance coverage under COBRA are subject to the same provisions as active group members.

**B. Portability**

Employees and family members who lose insurance coverage also have the opportunity to continue insurance coverage through portability. Eligible individuals enrolled in the homecare workers medical plan may continue coverage under the insurance company’s portability provisions before, during, or at the end of the period for which insurance coverage is provided under COBRA if:

1. They were continuously covered for 180 days or more under a plan offered through the Homecare Insurance Program or meet the eligibility requirements of the Health Insurance Portability and Accountability Act of 1998 pursuant to ORS 743.760(1)(b)(ii);
2. They are not covered by other group medical coverage, Medicare, or TriCare;
3. They enroll for portability coverage within 63 days after termination of the group medical coverage.

Eligible individuals who lose coverage under the Homecare Insurance Program will receive a notice of termination of coverage and eligibility for portable coverage from the insurance company.

**Section 7 - Complaint and Grievance Procedures**

**A. Appeal Procedure for Administrative or Eligibility Issues**

HUBB members have the right to appeal an administrative or eligibility issue that they consider to be incorrect or unfair. The following procedure describes how to ask HUBB to review your complaint.

The Insurance Specialist at HUBB will review your appeal of an incorrect or unfair denial from HUBB. Requests for review may be submitted by email, telephone or in writing to the HUBB office. The Insurance Specialist will review the request and make every attempt to resolve it within 30 days.

**B. Appeal Procedure for Insurance Contract Coverage Issues**

HUBB members may appeal a claim denial from the insurance carrier. Contact the insurance carrier’s customer service department for an explanation of the claim denial. HUBB members not satisfied with the explanation may request further review by following the insurance carrier’s appeal procedure described in the plan handbook. The carrier’s customer service representative can provide information about this process. A HUBB Insurance Specialist

can also provide assistance with the carrier’s appeal procedure. HUBB can verify that the insurance company is acting within the scope of its contract. HUBB may require an authorization for release of confidential information because the insurance company requires it.

***Questions about the rules?***

**Contact: HUBB**

**1.866.364.HUBB (4822) toll free**

**8am - 5pm Monday - Friday**

**website: [www.hubbinsurance.org](http://www.hubbinsurance.org)**

**email: [HUBB@opeuseiu.org](mailto:HUBB@opeuseiu.org)**

## Ready to quit smoking?

You can get free help whether or not you have health insurance. Call the Oregon Quit Line to find out how. You may be eligible for free patches or gum.

**The Oregon Tobacco Quit Line is free to every Oregonian and available online or over the phone.**

Talk to a personal coach who understands the struggle to quit and has experience helping people succeed. You may be able to get two weeks of patches or gum delivered directly to your home for free when you sign up with the Oregon Tobacco Quit Line.

**CALL:**

1-800-QUIT-NOW (1-800-784-8669)

Espanol: 1-877-2NO-FUME (1-877-266-3863)

**OR REGISTER ONLINE:**

[www.quitnow.net/oregon/](http://www.quitnow.net/oregon/)

**YOU CAN QUIT!**

A grayscale photograph of a broken cigarette. The cigarette is split into two pieces, with the ash and filter parts separated. A large cloud of ash and tobacco debris is scattered in the air above the broken pieces, suggesting the cigarette has just been crushed. The background is plain white.



# Services Directory



[www.hubbinsurance.org](http://www.hubbinsurance.org)

HUBB Benefit Specialists are available by telephone Monday through Friday, 8 a.m. to 5 p.m. Do not hesitate to give them a call with your questions about the HUBB Insurance Program.

## Location

1730 Commercial St SE

## Hours of Operation

8:00 am - 5:00 pm  
Monday - Friday

## Mailing Address

PO Box 12159  
Salem, OR 97309-0159

## Phone

(503) 364-HUBB (4822)  
Toll free: (866) 364-4822  
Fax: (503) 581-1664

## Email

[HUBB@opeuseiu.org](mailto:HUBB@opeuseiu.org)



[www.seiu503.org](http://www.seiu503.org)

PO Box 12159  
1730 Commercial St. SE  
Salem, OR 97309-0159  
(503) 581-1505  
(800) 452-2146



**KAISER PERMANENTE®**

[www.kaiserpermanente.org](http://www.kaiserpermanente.org)

500 NE Multnomah St  
Suite 100  
Portland, OR 97232

## Medical Customer Service

(503) 813-2000  
(800) 813-2000

## Dental Customer Service

(503) 813-2000  
(800) 813-2000

## TTY

(800)735-2900

## Language Interpretive Services

(800) 324-8010



[www.odskompanies.com](http://www.odskompanies.com)

The ODS Companies  
PO Box 40384  
Portland, OR 97240

601 SW Second Ave  
Portland, OR 97204

## ODS Pharmacy Drug Benefit Customer Service

1-800-913-4284

1-800-433-6313 (TDD)

## Medical Customer Service

(503) 265-2964  
(888) 217-2363

## Dental Customer Service

(503) 265-2965  
(888) 217-2365

## TDD/TTY

(800) 433-6313 (for hearing and speech impaired)

## Language Interpretive Services

available through customer service or TTY